

Description of Policy Options

**Transforming the Health Care Delivery System:
Proposals to Improve Patient Care and Reduce Health Care Costs**

Senate Finance Committee

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Senate Finance Committee

Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs

Our nation's health care providers — physicians, nurses, hospitals, and others — work hard to provide life-saving and life-improving care to millions of Americans. However, the level of quality and efficiency of care provided varies significantly across the country. It has become increasingly evident that the way health care is paid for in our system does not always encourage the right care, at the right time, for each and every patient. Today's payment systems more often reward providers for the quantity of care delivered, rather than the quality of care and discourage providers from working together to offer patients the best possible care.

A reformed health care delivery system will re-orient payment incentives toward services and activities that improve patient care in an effective and efficient manner and bend the curve of growth in national health care spending.

In 2008, the United States spends more than 17 percent of our gross domestic product (GDP) on health care — more than any other industrialized country in terms of total and per capita spending. By 2017, health expenditures are expected to consume almost 20 percent of GDP, or \$4.3 trillion annually. While spending is high, our nation ranks low in many areas of quality. Various reports have concluded that our current health care system is not making progress toward improving quality or containing costs for patients or providers. This combination of high spending and lagging quality is unsustainable for patients, business and state and federal governments.

In addition to inefficiency, the current health system suffers from significant levels of fraud, waste, and abuse. Scarce health care dollars should be spent as effectively as possible. However, the improper payment rate for Medicare in 2008 was 3.6 percent or \$10.4 billion. While it is difficult to know the exact amount of money lost through fraud and abuse, the National Health Care Anti-Fraud Association estimates that fraud is equal to at least three percent of total health care spending, or more than \$60 billion per year. Protecting the integrity of federal health care programs and minimizing fraud, waste, and abuse are important components of reforming the health care system.

The dynamics in our health system affect the care that is delivered in both the public and private sectors. In many cases, changes to federal health programs like Medicare activate and pave the way for system-wide changes. The proposals contained in this document set forth ideas on ways to revise payment systems and policies in the Medicare program to promote higher-quality, and more cost-effective care and to reduce fraud, waste and abuse throughout the health system.

Proposals in this document are organized into the following categories:

- Section I Payment Reform – Improving Quality and Promoting Primary Care**
- Section II Payment Reform – Fostering Care Coordination and Provider Collaboration**
- Section III Health Care Infrastructure Investments – Tools to Support Delivery System Reform**
- Section IV Medicare Advantage – Promoting Quality, Efficiency and Chronic Care Management**
- Section V Public Program Integrity – Combating Fraud, Waste and Abuse**

Section I: Payment Reform - Options to Improve the Quality and Integrity of Medicare Payment Systems

Linking Payment to Quality Outcomes

Establishment of a Hospital Value-Based Program (VBP)

Current Law

As required by Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act (MMA, P.L. 108-173), since FY2005, acute care hospitals that submit required quality data have received higher payments than those hospitals that do not submit such information under Medicare's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, which is also sometimes referred to as the hospital pay-for-reporting program. As subsequently modified by Section 5001(a) of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), beginning in FY2007, hospitals were required to submit data for an expanded set of quality measures to participate in the RHQDAPU program, and nonparticipating hospitals received a reduction of 2.0 percentage points in their Medicare annual update for that fiscal year. Today, nearly all acute care hospitals are successfully participating in the Medicare pay-for-reporting initiative.

The Secretary has authority to expand the set of measures that are included in the RHQDAPU program. Specifically, the Secretary can add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, can include measures set forth by one or more national consensus building entities. The Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

Currently, the total number of measures included in determining the FY2010 payment update is 42; however, hospitals are not required to report data for all 42 measures, since Centers for Medicare and Medicaid Services (CMS) calculates some measures by abstracting claims data. The quality data collected encompasses the following conditions: acute myocardial infarction; heart failure; pneumonia; surgical care improvement; 30-day mortality rates for acute myocardial infarction, heart failure and pneumonia patients; readmission rates for heart failure, AMI, and pneumonia; a nursing sensitive measure; several AHRQ Patient Safety and Inpatient Quality Indicators; and the patients' experience of care through the HCAHPS patient survey.

Procedures for making reported quality data available to the public must be established. These procedures must ensure that a hospital has the opportunity to review the data prior to such data being made public. The required quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings in hospitals must be reported on the Internet website of the CMS. Currently, individual hospital performance on specific quality measures and on certain conditions is available on Hospital Compare available on the CMS website.

DRA also required the Secretary of Health and Human Services to formulate and report on a plan to implement a value-based purchasing program for payments under the Medicare program for acute care hospitals (also referred to as IPPS or subsection(d) hospitals) beginning with FY2009. On November 17, 2007, CMS responded to this mandate by releasing the report, "Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program." This report recommends expanding the

RHQDAPU program in order to financially reward hospitals differentially for performance, rather than for simply reporting quality data. Public reporting of performance would be a key component, as well.

Proposed Option

Building on the success of the RHQDAPU program, the Committee's proposal would establish a hospital value-based purchasing program that moves beyond paying for reporting on quality measures and activities, to paying for hospitals' actual performance on these measures. This value-based purchasing program would provide value-based payments to acute care IPPS hospitals that meet certain quality performance standards beginning in FY 2012. This first year of the program would be a data collection/performance year. Beginning in FY2013, hospital payments would be adjusted based on performance under the VBP program. Certain hospitals would be excluded from the VBP program, including those who fail to report quality measures under the RHQDAPU program; those that have been cited by the Secretary for deficiencies that posed immediate jeopardy to the health or safety of patients during the performance period; and hospitals for which a minimum number of patients with conditions related to the quality measures or a minimum number of quality measures do not apply.

Measures for the hospital Value-based Purchasing Program would be selected from the measures used in the RHQDAPU program. The measures would focus on the same areas that are the focus of the RHQDAPU program: heart attack (AMI); heart failure; pneumonia; surgical care activities; and patient perception of care. Beginning in 2013 and beyond, the Secretary would have the authority to expand the measurement areas beyond those listed above.

Funding for value-based incentive bonuses for qualifying acute care hospitals would be generated through reducing Medicare IPPS payments to the participating hospitals. These reductions would be used to fund an incentive pool and be phased-in as follows: 2.0 percent in FY 2013; 3.0 percent in FY 2014; 4.0 percent in FY 2015; and 5.0 percent in FY 2016 and beyond. The reductions would apply to all MS-DRGs under which a hospital provides services.

IPPS add-on payments such as disproportionate share hospital (DSH) payments, indirect medical education payments (IME) for teaching hospitals, low-volume adjustment payments and outlier payments would not be impacted by the payment reductions. Payment adjustments under the hospital Value-based Purchasing Program would only apply to a relevant fiscal year and not be taken into account in calculating payments in future fiscal years

Performance standards that reward hospitals based on either attaining a certain performance standard or making improvements on performance relative to a previous performance period would be established. Hospitals would be rewarded based on whichever level is higher, attainment or improvement.

Performance standards would be announced at least 60 days prior to the performance period for which they would apply. The standards would be required to take into account the following factors: past hospital experience with the measures; historical performance standards; improvement rates; and opportunity for continued improvement.

The Secretary would establish a performance period for the Value-based Purchasing Program that would begin and end before the beginning of the fiscal year in which value-based incentive bonuses are awarded. A methodology for assessing the performance of each hospital for each condition during the performance period would be developed. Results would include both condition-specific and total hospital performance scores. However, determination of whether the performance standard was met would be based on the hospital's total performance score. The Secretary would have discretion to determine how to weight various categories of measures/conditions when determining the hospital's total score.

Hospitals that meet or exceed performance standards would receive value-based bonus payments. The incentive payments would apply to all MS-DRGs under which a hospital provides services. These incentive payments would be provided on a sliding scale basis depending on levels of performance, according to the following criteria: (1) no incentive payment for hospitals in the bottom quartile of performance; (2) a linear, sliding-scale incentive payment in the 26th-75th percentile; and (3) full incentive payment for those above 75th percentile. Any unused incentive pool funds would be returned to the Medicare Trust Fund. Payment adjustments under the hospital Value-based Purchasing Program would only apply to a relevant fiscal year and not be taken into account in calculating payments in future fiscal years.

Individual hospital performance on each specific quality measure; on each condition or procedure; and on total performance would all be publicly reported. Data regarding the total number of hospitals receiving incentive payments or payment reductions under the Value-based Purchasing Program would periodically be published. Hospitals would continue to be provided with an opportunity to review and correct information before it is publicly reported.

An appeals process would be established that allows hospitals to contest calculated performance scores and value-based bonus payments. There would be no judicial or administrative review of the following items: (1) the methodology used to determine the amount of value-based bonus payments; (2) the determination of the amount of funding available for value-based bonus payments; (3) the establishment of the hospital performance standards; (4) the quality measures that are selected for inclusion in RHQDAPU or the Value-based Purchasing Program; (5) the methodology that is used to calculate hospital performance scores; (6) the methodology for validating hospital performance; and (7) the design of the transition to the Value-based Purchasing Program.

The selection of measures, the development of the methodology for assigning scores and the development of the methodology for calculating payments would be transparent and public through rulemaking.

The Secretary would be required to work with hospitals, patients, researchers, policymakers and other stakeholders to modify the Hospital Compare website to make it more user-friendly.

The Secretary and the Government Accountability Office (GAO) would conduct ongoing monitoring and submit reports to Congress on the program, including any unintended consequences. GAO would be required to submit an interim report to Congress on the program no later than October 1, 2015 and a final report by July 1, 2017. The Secretary would be required to submit a report by January 1, 2015.

The Secretary would be provided the necessary funding to administer the program (amount to be determined).

Three-year demonstration projects would be established to test value-based purchasing models tailored toward critical access hospitals (CAHs) and small hospitals that otherwise would not qualify to participate in the Value-based Purchasing Program. The Secretary would be required to submit a report to Congress 18 months after completion of the project.

Medicare Home Health Agency and Skilled Nursing Facility Value-based Purchasing Implementation Plans

Current Law

As required by Section 5201(c) of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), beginning in 2007, home health agencies were required to submit data for a set of quality measures. Home health agencies that did not submit these data received a reduction of 2.0 percentage points in their Medicare annual update for that year. As a Medicare condition of participation, skilled nursing facilities are required to submit data on quality to the Secretary.

Currently, individual home health agency and skilled nursing facility performance on specific quality measures and on certain conditions is available on *Home Health Compare* and *Nursing Home Compare* available on the CMS website.

Medicare payment demonstrations have been or are to be implemented that will test value-based purchasing for home health agencies and skilled nursing facilities.

Section 5201(d) of the DRA also required the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress on recommendations on a detailed structure of value-based payment adjustments for Medicare home health services. MedPAC submitted this report to Congress in June 2007.

Proposed Option

The Secretary would be directed to complete Medicare value-based purchasing implementation plans for home health agencies and skilled nursing facilities by 2011 and 2012, respectively. Each plan would include consideration of the following issues: (1) The on-going development, selection, and modification process of measures of quality and efficiency; (2) The reporting, collection, and validation of quality data; (3) The structure of value-based payment adjustment, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the source of funding for the value-based bonus payments; and (4) The disclosure of information on performance. In developing each plan, the Secretary would be required to consult with relevant stakeholders and take into consideration experiences with demonstrations that are relevant to value-based purchasing in each setting.

Physician Quality Reporting Initiative (PQRI) Improvements and Requirement

Current Law

The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system that would include an incentive payment, based on a percentage of the allowed Medicare charges for all such covered professional services, to eligible professionals who satisfactorily report data on quality measures. CMS named this program the Physician Quality Reporting Initiative (PQRI). MIPPA made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5 percent in 2007 and 2008 to 2 percent in 2009 and 2010. However, no additional bonus payments were specified for the years following 2010. The following professionals are eligible to participate in PQRI: Medicare physicians, practitioners (e.g. nurse practitioners, physician assistants, clinical psychologists), and therapists.

As directed in MIPPA, CMS is currently developing a plan for transitioning PQRI to a value-based purchasing program that will financially reward physicians based on their performance, rather than for simply reporting quality data. CMS is required to submit the plan to Congress by May 2010.

Proposed Option

A new PQRI participation option would be added to the existing options described above. Eligible professionals could also receive PQRI incentive payments for two successive years if, on a biennial (every two year) basis, the physician (1) participates in a qualified American Board of Medical Specialties certification, known as the Maintenance of Certification or MOC, or equivalent programs, and (2) completes a qualified MOC practice assessment.

For purposes of this proposal, the following definitions would apply.

1. Qualified American Board of Medical Specialties Maintenance of Certification (MOC) or equivalent program would mean a continuous assessment program to advance quality care and the lifelong learning and self-assessment of board-certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism and systems-based practice;
2. MOC programs or equivalent other programs must include the following assessment components:
 - (a) Professional standing – Programs must require physicians to maintain a valid, unrestricted medical license in at least one state or jurisdiction in the United States, its territories, or Canada. A qualified MOC program must also include a survey of patient experience with care;
 - (b) Lifelong learning and self-assessment – Programs must require physicians to participate in educational and self-assessment programs that require an assessment of what was learned;
 - (c) Demonstration of cognitive expertise – Programs must require physicians to demonstrate, through a formalized, secure examination, that they have the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty;
 - (d) Practice performance assessment - A practice assessment must include an initial assessment of physician clinical quality compared to peers and national benchmarks. It also needs to include implementation of a quality improvement intervention to address an identified practice weakness, and a reassessment of performance in the area focused on for improvement; and
 - (e) An audit process that meets standards defined by the Secretary.
3. Qualified MOC practice assessment would mean an initial assessment of a participant's practice, designed to demonstrate the physician's ability to use best evidence and practices in comparison to peers and national benchmarks, and apply best evidence and consensus recommendations to improve quality care using follow-up assessments. Such assessment tools must: (a) Use National Quality Forum (NQF) national endorsed measures, where appropriate, to derive a set of clinical metrics that are at least equivalent in both the methods and measures used to those of the PQRI program; and (b) Require the physician to implement a quality improvement intervention to address a practice weakness identified in the performance assessment report, and then to re-measure to assess performance after this intervention.

Proposals to improve the PQRI program would require CMS to make three additional improvements to the program. First, they would be required to establish an appeals process for providers who participated in the PQRI program but did not qualify for incentive payments during their performance period. Second, CMS would be required to provide more timely feedback to providers during the course of the performance period. Third, CMS would be required to calculate incentive payments in the PQRI program without regard to the existing geographic adjustments in the physician fee schedule since PQRI incentive

payments should be based on the quality of the service performed rather than the eligible professional's geographic location.

The Committee is considering two options for extending PQRI incentive payments beyond 2010. Option 1 would extend the 2 percent bonuses through 2011 and 2012 (for the 2010 and 2011 reporting periods). For the years 2013-2014, eligible professionals who failed to participate successfully in the program in the 2012 and 2013 reporting periods would face a 2 percent penalty, which would be calculated as 2 percent of their total allowable charges. The penalty would be assessed on an annual basis and would not be cumulative. If the Secretary determines that less than 85 percent of eligible professionals are satisfying the requirement to participate in the program, then the Secretary would increase the penalty by 1 percentage point per year (to a max of 5 percent in a single year) until 85 percent of eligible professionals enrolled in the Medicare program comply.

The second option under consideration would be identical to option 1 except that the incentive payments would only be available in 2011 (for the 2010 reporting period) and a non-compliance penalty of 1 percent would begin in 2012 (for the 2011 reporting period). The penalties for non-compliance in 2012 and 2013 for the previous year's reporting period would remain at 2 percent, and the requirement that the Secretary increase the penalty (by 1 percentage point per year up to a 5 percent cap until 85 percent of practitioners meet the requirement) would be the same.

Transparency and Evidence-Based Decision-Making for Imaging Services

Transparency in Self-referrals

Current Law

The Ethics in Patient Referrals Act (the Stark law) prohibits physicians from referring Medicare patients for certain services to providers with which the physician has a financial relationship and prohibits those entities from submitting claims for services provided to patients referred by those physicians with a financial relationship. The law applies to a set of "designated health services" which includes imaging services such as MRI and CT scans. Certain services provided in the physician's office are exempted from the statute through the "in-office ancillary services" exception so physicians can provide radiology services in their offices or facilities and bill Medicare if conditions determined by the Secretary of Health and Human Services are met.

Proposed Option

The proposal would amend the in-office ancillary services exception to the physician self-referral prohibitions under Stark to require that physicians disclose their financial interest in certain imaging services provided through the in-office ancillary services exception, including magnetic resonance imaging, computed tomography, positron emission tomography, and other radiology "designated health services" that the Secretary determines appropriate. The referring physician would be required to inform the individual in writing at the time of referral that the individual could obtain services from another person. The referring physician would also be required to provide the individual with a list of suppliers in the area in which the individual resides. The requirement would be effective January 1, 2010.

Promotion of Adherence to Appropriateness Criteria for Imaging Services

Current Law

In recent years, MedPAC, GAO and other observers have established that the volume of imaging services has increased more than other Medicare physician services. DRA capped the technical component of the payment for services performed in a doctor's office at the level paid to hospital outpatient departments for such services, effective January 1, 2007.

MedPAC has noted that providers vary in their ability to perform quality imaging services and has recommended that the Congress direct the Secretary to set standards for all providers who bill Medicare for performing and interpreting diagnostic imaging services. Beginning January 1, 2012, MIPPA requires that payment may only be made under the physician fee schedule for the technical component of advanced diagnostic imaging services if the supplier is accredited by an accreditation organization. The Secretary is required to establish procedures to ensure that the criteria used by an accreditation organization to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services is specific to each imaging modality.

GAO would be required to conduct a study by imaging modality of the new accreditation requirement and any other relevant questions involving access to and the value of advanced diagnostic imaging services for beneficiaries.

Proposed Option

Several new proposals offered for consideration would modify how Medicare imaging services are delivered and paid. The Secretary would be required to work with national standards organizations to designate nationally recognized appropriateness criteria and related measures for reporting the appropriate use of imaging services. The Secretary would work with medical societies and others to establish transparent standards for reporting patterns of adherence to appropriateness criteria. A new education and confidential feedback program would be developed to report patterns of adherence to these standards of imaging use to physicians. Differential payments to physicians would be established that would include a lower payment for ordering physicians who were determined to be outliers for inappropriate ordering. New imaging information organizations would be established to share information about the use of imaging services and to assist physicians in minimizing duplicative scans and radiation exposure to patients.

Effective in 2010, the Secretary, working with national standards organizations, physician specialty societies, and other stakeholders, would designate nationally recognized, transparent appropriateness criteria and use measures, and would report through vendors and registries the adherence pattern of physicians to these measures and criteria.

In 2011, the Secretary would develop an education and confidential feedback program on these patterns of adherence to imaging appropriateness criteria through standardized reporting, with priority on advanced diagnostic imaging services (ADIS). The feedback would include baseline rates of adherence and goals for patterns of adherence to appropriateness criteria for medical imaging. The confidential comparison reports on patterns of adherence to appropriateness criteria when ordering an advanced diagnostic imaging study, including top inappropriate indications, would be aggregated by ordering physician, ordering practice and interpreting practice, and would be sent to all ordering and interpreting practices. Through rulemaking and in consultation with physician specialty groups, the Secretary would designate the imaging procedures for which mandatory and voluntary reporting will be established. The

designated imaging procedures could include those performed for specified conditions, indications and diagnoses, including but not limited to: low back pain, shoulder pain, musculoskeletal disease, abdominal pain, and headaches. The GAO would develop a report to Congress on the results of the program, including the impact that the appropriateness criteria and the education and feedback program have on ordering patterns.

Beginning in 2013, the Secretary would vary payment to physicians ordering imaging services according to the physician's adherence to appropriateness criteria for Medicare ADIS. Through rulemaking and in consultation with physician specialty groups, the Secretary would designate the imaging procedures for which reporting and differential payment will be mandatory and imaging procedures for which reporting will be voluntary based on baseline rates and amount of progress toward goals. The Secretary would establish a lower payment for ordering physicians who exceed a threshold for inappropriate ordering patterns, based on their patterns of adherence to appropriateness criteria for imaging services designated for mandatory reporting. The Secretary would use 2011 data to identify ordering physicians who are outliers for inappropriate ordering, and apply a reduction of 5 percent to the 2013 conversion factor for outlier physicians who do not incorporate appropriateness criteria into their practice. This reduction would apply to all services furnished by the physician in 2013.

The Secretary would establish a Diagnostic Imaging Exchange Network (DIEN) in five regions of the country, beginning in 2011. The DIEN would assist physicians in determining the necessity, safety and appropriateness of ordering an imaging study, with the intent of minimizing duplicative scans and radiation exposure to patients. Using the Nationwide Health Information Network (NHIN) infrastructure and existing HIT standards, the Secretary would establish an information exchange network that would equip physicians and providers with HIT-enabled systems to access a patient's entire imaging history prior to ordering an imaging study.

The Committee is also exploring other imaging-related options, including the use of radiology benefit managers (RBMs) for certain imaging services.

Medicare Inpatient Rehabilitation Facility and Long-Term Acute Care Hospital Quality Reporting

Current Law

None

Proposed Option

The Secretary would be directed to establish quality reporting programs for inpatient rehabilitation and long-term care hospital providers. Under this policy, the Secretary would be required to select quality measures for inpatient rehabilitation facilities and long-term acute care hospitals by 2011 and implement mandatory quality measure reporting programs for both types of providers by 2012. Selected measures would be endorsed by a consensus-based entity that the Secretary is directed to identify and contract with under the Social Security Act. The selected measures would cover, to the extent feasible and practicable, all dimensions of quality as well as efficiency of care.

Primary Care

Primary Care and General Surgery Bonus

Current Law

Medicare uses a fee schedule to reimburse physicians for the services they provide. In certain circumstances, physicians receive an additional payment 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 demonstrating quality achievements, participating in electronic prescribing, or practicing in underserved areas. For instance, physicians who provide covered services in any rural or urban health professional shortage area (HPSA) are entitled to an incentive payment which is a 10 percent bonus over the fee schedule amount.

Proposed Option

Certain Medicare providers would be eligible for a primary care services bonus payment. Providers who furnish at least 60 percent of their services in specified ambulatory settings would receive a bonus of at least 5 percent over the fee schedule amount for providing certain evaluation and management services, defined as follows: office visits (codes 99201–99215); nursing home visits (codes 99304–99340); and home visits (codes 99341–99350). The bonus would apply to services furnished to both established and new patients. The provision would be in effect for five years, from January 1, 2010 through December 31, 2014.

This option would also establish bonus payments for general surgeons practicing in newly defined rural general surgeon scarcity areas. Beginning January 1, 2010 and ending December 31, 2014, in addition to the amount of payment that would otherwise be made, these physicians would also be paid a bonus of 5 percent or some other amount over the fee schedule amount for the services. The Committee is working with HHS and CBO to determine the appropriate threshold and definitions for these bonuses.

MedPAC recommended in June 2008 that Congress enact a budget-neutral bonus for primary care services. For this reason, the cost of the bonuses in this option would be offset by an across-the-board reduction in payments for services under all other codes. Alternatively, the increases could be paid for through funding from other sources. However, this approach would require finding new offsets.

Payment for Transitional Care Activities

Current Law

None

Proposed Option

This option would support integrated, transitional care management for chronically ill patients who experience hospitalization by reimbursing providers for targeted interventions that have proven successful in the Medicare Coordinated Care Demonstration program, the Medical Home, and other care management models.

Under this option, Medicare would reimburse physicians for certain care management activities performed by nurse care managers (or other qualified non-physician professionals, such as diabetes educators). Qualified activities would include providing in-person care assessment and management, coaching, education, and self-management support to patients. To be eligible for reimbursement, physicians could directly hire qualified care managers or contract with care managers in their community. These services would only be paid for beneficiaries who have been discharged from the hospital within the previous six months for a stay classified by a DRG related to the following major chronic diseases:

- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Asthma
- Diabetes, and
- Depression

Medicare would also pay a modest supplemental fee to a primary care practice for each patient who (1) has been discharged from the hospital after a stay classified in a DRG for one of the major chronic diseases, (2) receives at least one currently covered evaluation and management service or one of the newly covered care management services within 30 days after discharge, and (3) is not readmitted to a hospital for a stay classified as a chronic disease DRG within 60 days after the initial discharge.

The Committee is seeking input on whether this policy should be expanded to include care coordination payments for beneficiaries with high-cost, chronic illness who are at highest risk for hospitalization.

Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration

Chronic Care Management

CMS Chronic Care Management Innovation Center

Current Law

CMS's Medicare Research and Demonstration Program tests new approaches to paying providers, delivering health care services, or providing benefits to Medicare beneficiaries. In accordance with Medicare's demonstration authority, demonstration projects are required to determine whether or not changes in reimbursement would increase the efficiency and economy of health care services without adversely affecting quality. Demonstrations, which typically run from 1 to 5 years, are conducted in select geographic regions and with certain subgroups of beneficiaries. CMS requires that all demonstrations be evaluated. If successful, administrative or payment changes may be implemented nationwide across the Medicare program. For example, results from various demonstration studies helped facilitate the adoption of the inpatient prospective payment system (IPPS) and Medicare managed care. Although demonstrations may be initiated by either the agency or Congress, the number of congressionally mandated demonstrations has increased in recent years and the number of CMS-initiated pilots has declined.

CMS is currently conducting approximately 30 Medicare demonstrations. Many of these demonstrations are designed to test alternative approaches towards improving the care delivered to beneficiaries with chronic conditions. For example, Medicare's Coordinated Care Demonstration, which began in April 2002, tests the use of case management and various coordinated care models to improve the quality of care for beneficiaries with congestive heart failure, coronary artery disease, and diabetes. Another CMS-initiated pilot, the Care Management for High Cost Beneficiaries demonstration, is currently examining various models such as intensive case management, increased provider availability, and restructured physician practices to improve quality and reduce costs for chronically ill beneficiaries.

Proposed Option

Under this option, the Secretary of HHS would establish at CMS a Chronic Care Management Innovation Center (CMIC) for the purpose of testing and disseminating payment innovations that foster patient-centered care coordination for high-cost, chronically ill Medicare beneficiaries. CMIC would be given permanent authority to broadly test care coordination models that show promise of improving the quality and cost-effectiveness of care delivered to chronically ill beneficiaries in fee-for-service Medicare. CMIC would act in consultation with an advisory board comprised of members from relevant federal agencies and outside clinical and analytical experts.

To be considered for wide-scale testing, care models must focus on patients with multiple chronic conditions who are at highest risk for hospitalization or readmission. CMIC would have flexibility in targeting patient populations most appropriate for care management interventions but would be encouraged to include: (1) beneficiaries with multiple chronic conditions and an inability to perform 2 or more activities of daily living (i.e. homebound patients); and (2) beneficiaries with multiple chronic conditions, at least one of which is a cognitive impairment (including dementia).

Initial testing would focus on models that met at least the following criteria: (1) places the patient, including family members and other informal caregivers, at the center of the care team; (2) focuses on in-person contact with beneficiaries; (3) maintains a close relationship between care coordinators and primary care physicians; and (4) relies on a team-based approach to interventions such as comprehensive care assessments, care planning (including end-of-life care planning, such as advanced directives), and self-management coaching. Additional criteria, or amendments to these criteria, could be made by CMIC in consultation with its advisory board.

Examples of models that might qualify include:

- Advanced Patient-Centered Medical Homes
- Transitional care teams
- Patient/physician shared decision-making aids

To reduce the start-up times of new testing, CMIC would develop a standard process for evaluating the design and performance of payment models under consideration for broad-scale testing. Testing in the pilot phase would not be required to meet up-front budget neutrality, but CMIC would have the authority to terminate or modify the design and implementation of models that were determined to be unsuccessful once testing began.

The Secretary would measure and evaluate the initial phase of these pilots based on demonstrated improvement in quality of care (including patient-level outcomes measures) and achievement of cost-reduction or budget-neutrality. The Secretary could expand the duration and the scope of projects under this section, to an extent determined appropriate by the Secretary, if the Secretary were to determine – and the Office of the Actuary certify – that such expansion would result in any of the following conditions

being met: (1) the expansion of the project is expected to improve the quality of patient care without increasing spending under the Medicare program; or (2) the expansion of the project is expected to reduce spending under the Medicare program without reducing the quality of patient care.

This option would also establish a Medicare Rapid Learning Network within CMIC for the purpose of smaller-scale evaluation of emerging evidence-based care management models. CMS would recruit and competitively contract with a diverse network of providers/practices for the purpose of rapid-cycle demonstration testing across a broad array of settings and geographic areas. These sites would exhibit diversity across region, provider size, provider type/setting, and other appropriate factors. The Secretary would have the authority to expand testing to additional populations via the above pilot authority.

The Committee is seeking input from members, CBO, and CMS on the design, score, and implementation of the options proposed in this section.

Hospital Readmissions and Bundling

Current Law

Medicare pays for most acute care hospital stays and post-acute care services, including inpatient rehabilitation facility stays, long-term acute care hospitals stays, skilled nursing facility stays, and home health care visits, under prospective payment systems (PPS) established for each type of provider. Under each PPS, a predetermined rate is paid for each unit of service, such as a hospital discharge, or a payment classification group. Payment classification groups are based on an estimate of the relative resources needed to care for a patient with a specific diagnosis and set of care needs. The patient classification system used by hospitals, for example, is referred to as Medicare Severity Diagnosis Related Groups, or MS-DRGs.

Generally, PPS payments include a national standardized amount adjusted by a wage index that is associated with the area where the provider is located or, for some hospitals, where it has been reclassified. Medicare law provides for annual updates of 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.

As some Medicare beneficiaries with complex health conditions and multiple co-morbidities move between hospital stays and a range of post-acute care providers, Medicare makes separate payments to each provider for covered services across the entire episode of care. The Medicare Payment Advisory Commission (MedPAC), among others, has expressed concern that providers do not have financial incentives to coordinate across episodes of care nor to evaluate the full spectrum of care a patient may receive. There is also a lack of accountability of providers for all care provided during the episode. In addition, in its June 2008 report, MedPAC reported that 18 percent of Medicare hospital admissions result in readmissions within 30 days post-discharge. These readmissions accounted for \$15 billion in spending in 2005, and according to MedPAC, \$12 billion of this spending may represent potentially preventable readmissions. In light of these findings, MedPAC has recommended that Medicare payments to hospitals with relatively high readmission rates for select conditions be reduced. MedPAC also recommended that a bundled payment system be explored for an episode of care where separate payments for distinct types of providers would be eliminated. Under this model, a single provider entity would receive a bundled payment intended to cover the costs of the full range of care needed over the hospitalization episode, including 30 days post-discharge.

Hospital Readmissions and Post-Acute Bundling Policy

The Committee's proposal would take steps to reduce avoidable and preventable hospital readmissions and establish new payment incentives intended to improve patient care through encouraging greater care coordination among acute hospitals and post-acute providers. Specifically, starting in 2010, CMS would be directed to begin calculating national and hospital-specific data on the readmission rates of hospitals participating in the Medicare inpatient prospective payment system (IPPS) related to the eight conditions with the highest volume and the highest rates of readmission. In 2011, CMS would be directed to provide readmission rate information to participating hospitals and would inform such providers of their readmission rates in relation to a national readmissions benchmark for each of the selected conditions.

In developing the readmission policy, the Secretary would have the authority to update the list of conditions subject to the policy as deemed appropriate and would be directed to also consider those conditions with the most significant variation in readmission rates among providers when determining which conditions should be subject to the readmissions policy. Such calculations would include the development of a readmissions benchmark by condition that is based on a weighted average of all DRGs related to each condition and is risk-adjusted for patient's severity of illness and differences in case types. The readmissions benchmark would include all readmissions that are the result of complications or related conditions, but would exclude readmissions deemed by the Secretary not to be potentially preventable, such as planned readmissions or readmissions related to cancer care, burn care, trauma care, scheduled surgeries or other admissions deemed appropriate by the Secretary. If a hospital was the site of a patient's original admission and the patient were to be readmitted to a different hospital, the readmission would count toward the original hospital's readmission rate.

Starting in fiscal year 2013, hospitals with readmissions above the 75th percentile for selected conditions would be subject to a payment withhold on a MS-DRG-by-MS-DRG basis. Such a withhold would be based on the prior year's performance and would be equal to 20 percent of the MS- DRG payment amount. Hospitals subject to a payment withhold could be reimbursed for these funds, not to exceed the withhold amounts in a single year, if the patients involved do not have preventable readmissions within 30 days of discharge. Withheld funds that are not repaid to hospitals would be returned to the Medicare Trust Funds.

The readmissions policy would not apply to any conditions that are included in the bundled payment discussed below. This readmissions policy would expire once the bundled payment policy is fully implemented.

Bundling Policy

Beginning in fiscal year (FY) 2015, acute IPPS hospital services and post-acute care services occurring or initiated within 30 days of discharge from a hospital would be paid through a bundled payment. Under this policy, post-acute payments would include home health, skilled nursing facility, rehabilitation hospitals, and long-term care hospital services.

Bundled payments would be implemented in three phases. Starting in October 2014 (FY2015), phase one of the bundling policy would be implemented and would apply to admissions for conditions that account for the top 20 percent of post-acute spending. In determining which conditions to include in the bundle for phase one, CMS would be required to include a mix of chronic and acute conditions, a mix of surgical and medical conditions, conditions with significant variation in readmission and post-acute spending, and

conditions with high-volume and high post-acute spending. Starting in October 2016 (FY 2017), phase two of the bundling policy would be implemented and apply to admissions for conditions that would account for the next 30 percent of post-acute care spending. Starting in October 2018 (FY 2019), the final phase of bundling would be implemented and would include all other conditions and MS-DRGs that account for the remaining 50 percent of post-acute care spending.

The bundled payments would be calculated as the inpatient MS-DRG amount plus post-acute care costs of treating patients in that MS-DRG. This bundled payment amount would be adjusted to capture savings from the expected efficiencies gained from improving patient care and provider coordination within the bundled payment system. Also included in the bundled payment would be expected or planned readmissions within the 30-day post-acute timeframes. Hospitals or other eligible entities would receive the bundled payment for each patient served, regardless of whether the patient receives post-acute care services. No additional payments would be made to the hospital or organizing provider for readmissions during this timeframe and Medicare would no longer make separate payments to post-acute providers for care initiated within 30 days post-discharge.

Under this policy, payments would be made to one entity, such as the hospital, but CMS would have the authority to allow other legal entities (such as non-profits that include the hospital and/or post-acute care providers) to receive bundled payments, as long as the hospital would be involved.

CMS would be directed to waive applicable laws, as appropriate, to implement these policies and to develop patient protection rules to ensure that patients receive appropriate post-acute care and that access to care is maintained. In addition, as this policy is further developed, consideration must be given to whether payment rules in the existing post-acute payment systems must be modified or are still appropriate in order to allow proper coordination and care management of patients in the bundled payment model. After 3 years, CMS would be required to conduct an evaluation and report to Congress and would be required to conduct on-going monitoring to ensure against unintended consequences.

Proposed Timeline for Implementation of Readmissions and Bundling Policy

Calendar Year	Readmission Policy	Bundled Payment Policy
2010	CMS would develop readmissions policy and data parameters	CMS would develop bundling policy
2011 - 2012	CMS would provide readmission rate information to hospitals and compare that to national readmissions benchmarks for selected conditions	CMS would develop bundling policy
2012	April-August: CMS would issue proposed and final rules FY 2013: Readmissions policy would start in October CMS would publicly report readmission rates	CMS would develop bundling policy
2013	Readmissions policy would continue for those hospitals not paid under the new bundled rates	CMS would develop policy

2014	Policy would continue for those hospitals not paid under the new bundled rates	April-August: CMS would release proposed and final rule FY 2015: 1 st phase would start in October (would apply to first 20% of post-acute spending)
2015	Readmissions policy would continue for those hospitals not paid under the bundled rates	1 st phase continues
2016	Readmissions policy would continue for those hospitals not paid under the bundled rates	April-August: CMS would release proposed and final rules FY 2017: 2 nd phase would start in October (would apply to next 30% of post-acute spending)
2017	Readmissions policy would continue for those hospitals not paid under the bundled rates	1 st and 2 nd phases would continue
2018	FY 2019: Readmissions policy would end in October	April-August: CMS would release proposed rule on final phase of bundling FY 2019: final phase would start in October (would apply to remaining 50% of post-acute spending)

Moving From Fee-for-Service to Payment for Accountable Care

Sustainable Growth Rate (SGR)

Current Law

Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variation in costs. The adjusted relative values are then converted into dollar payment amounts by a conversion factor. The law specifies a formula for calculating the annual update to the conversion factors and, therefore, the resultant fees. Section 101 of the MMSEA increased the update to the conversion factor for Medicare physician payment by 0.5 percent compared with 2007 rates for the first six months of 2008. MIPAA extended the 0.5 percent increase in the physician fee schedule that was set to expire on June 30, 2008, through the end of 2008 and set the update to the conversion factor to 1.1 percent for 2009. The conversion factor for 2010 and subsequent years will be computed as if this modification had never applied; so unless further legislation is passed, the update formula will require a 21 percent reduction in physician fees beginning January 1, 2010 and by additional reductions of roughly 6 percent annually for at least several years thereafter.

The cost of applying a ten-year freeze on physician payment rates is approximately \$285 billion.

Proposed Option

Two policy options are currently under consideration. The first option would update the fee schedule by 1 percent in 2010 and 2011 and by 0 percent in 2012. The calculations under the SGR system to determine updates would then revert to the current law for 2013.

The second option would have the same schedule of updates for 2010-2012 as under option 1, however, once the update calculation reverted to current law SGR for 2012, a floor of -3 percent would be in effect. Beginning in 2014, the fee schedule update for localities with 2-year average fee-for-service growth rates at or greater than 110 percent of the national average would have a -6 percent floor.

Based on the estimated cost of these two options, the committee is continuing to explore other options for physician payment updates.

Medicare Shared Savings Program (i.e. Accountable Care Organizations)

Current Law

There are no existing laws that directly address the ability of organizations or systems of integrated providers to share in the efficiency gains resulting from the joint responsibility and care of fee-for-service Medicare beneficiaries. While some providers who deliver care in a vertically integrated managed care environment under Medicare are able to achieve these efficiency gains (e.g., a staff model managed care organization through Medicare Advantage), other providers face obstacles to this type of practice integration. MedPAC has been among the proponents that have encouraged this type of gain sharing through accountable care organizations (ACOs).

Medicare has some practical experience with ACO-like organizations. The Medicare Physician Group Practice (PGP) Demonstration, mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, created pay-for-performance incentives for physician groups (being paid fee-for-service) to coordinate the overall care delivered to Medicare patients. The physician groups were rewarded for improving the quality and cost efficiency of health care services through increased coordination of Part A and Part B services, investment in care management programs, process redesign, and improved patient health outcomes, especially for beneficiaries with chronic illness, multiple comorbidities and those near the end of life. CMS selected ten physician groups on a competitive basis to participate in the demonstration, favoring multi-specialty physician groups with well-developed clinical and management information systems. The ten physician groups represented 5,000 physicians and 224,000 Medicare fee-for-service beneficiaries. Groups that were able to meet quality-of-care benchmarks and reduce their total expected Medicare spending by more than 2 percent were allowed to share in the savings they generate to the Medicare program.

Results from the PGP demo suggest that the concept shows promise. Preliminary results from the demonstration and reports from participants suggest that the program has achieved its goals of better coordination of care for the chronically ill, careful attention to hospital discharge processes, expanded role for non-physician providers, and investments in IT. In the most recent year of the PGP demo, all participants demonstrated improvements in quality and achieved below average growth in costs. In addition, four were awarded with incentive payments for reducing costs below the 2 percent threshold. Accountable care organizations would go beyond the PGP model, which is based on physician groups, to include additional providers.

Proposed Option

Under this option, the Medicare program would allow groups of providers who voluntarily meet quality thresholds to share in the cost-savings they achieve for the Medicare program. Beginning in 2012, groups of providers – such as individual physician practices, physician group practices, networks of physician practices, hospital/physician joint-ventures, hospitals employing physicians, etc. – would have the opportunity to qualify for sharing of the cost savings they achieve for Medicare.

To qualify, an organization would have to meet at least the following criteria: (1) agree to a minimum two-year participation, (2) have a formal legal structure that would allow the organization to receive/distribute bonuses to participating providers, (3) include the primary care providers of at least 5,000 Medicare beneficiaries, (4) provide CMS with a list of the primary care and specialist physicians participating in the organization, (5) have contracts in place with a core group of specialist physicians, (6) have a management and leadership structure in place that allows for joint decision making (e.g., for capital purchases), and (7) define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care.

To earn the incentive payment the organization would have to meet certain quality thresholds. The ACOs must agree to report annually to the Secretary on a specified set of quality indicators. ACOs would be allowed to report at the group or individual level on measures specified by the Secretary, including measures of: (1) clinical processes and outcomes (e.g. mortality, improvements in functionality), (2) patient perspectives on care, and (3) utilization and costs (e.g. ambulatory-sensitive admissions). For the purposes of calculating quality and cost performance, CMS would assign beneficiaries to ACOs based on the physician from whom the beneficiary received the most primary care services in the preceding year. [Note: This is for the purpose of gauging performance only, and does not impact the ability of beneficiaries to choose their own site of care.] ACOs would continue to be paid on a fee-for-service basis.

The spending baseline for an ACO would be determined on an organizational level by using the most recent three years of total per beneficiary spending (Parts A and B) for those beneficiaries assigned to the ACO. The prospective spending target would be set using the expected national growth rate in fee-for-service Medicare, as determined by CMS. ACOs whose two-year average Medicare expenditures for assigned beneficiaries (Parts A and B) are at least 2 percent below their benchmark for the corresponding period would be eligible to share in 50 percent of the savings generated to the Medicare program.

Other design features under consideration include requiring a three-year performance period; applying a flat-dollar, per-beneficiary spending target to the ACO based on the expected national growth rate; adjusting and/or capping the rate of shared savings; applying a fee-for-service withhold that ACOs could earn back by meeting quality and cost benchmarks; allowing the Secretary to transition ACO payments from fee-for-service to fully- or partially-capped payment structures; and targeted relief from legal or regulatory impediments to provider cooperation. Committee staff is exploring with CBO the budgetary effects of these design adjustments.

Extension and Expansion of the Medicare Health Care Quality Demonstration Program

Current Law

Section 646 of the Medicare Modernization Act required the Secretary to establish the Medicare Health Care Quality Demonstration Program (MHCQ), a 5-year demonstration program to examine factors that encourage improved patient care quality, including incentives to improve the safety of care; examination of service variation and outcomes measurement; shared decision making between providers and patients; among others. Under this program, certain physician groups, integrated health care delivery systems, or regional coalitions may implement alternative payment systems, streamline documentation and reporting requirements, and offer benefit packages distinct from those currently available under the Medicare program. The MMA allows the Secretary to waive provisions of the Stark, anti-kickback, and civil monetary penalties (CMP) statutes as they relate to the MHCQ demonstration. Otherwise, these statutes would prohibit hospitals from rewarding physicians for efficiencies achieved in the care of patients, regardless of whether reductions were due to the elimination of duplicative services or other quality improvements.

In contrast to disease management and coordinated care demonstrations that focus on specific patient populations with specific medical conditions, the MHCQ demonstrations are intended to achieve quality improvements through a major redesign of the health care delivery system and by addressing the entire patient population. CMS has approved two demonstrations, which will begin in 2009. Two others are currently in the final review process.

Proposed Option

The proposal would permanently authorize Section 646, with some modifications. The program must include multi-payer projects and would be given pilot authority. The Secretary could expand the duration and the scope of MHCQ projects if the Secretary determines – and the Office of the Actuary certifies – that expansion is expected to improve the quality of patient care without increasing spending under the Medicare program or that the expansion is expected to reduce spending under the Medicare program without reducing the quality of patient care.

Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform

Health IT

Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals

Current Law

The recently enacted Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act (ARRA), authorized Medicare and Medicaid incentive payments and penalties to encourage physicians and hospitals to adopt and use electronic health records (EHRs). To be eligible for these incentives, physicians and hospitals must demonstrate the “meaningful” use of electronic health record (EHR) technology that is certified as meeting standards of

interoperability, clinical functionality, and security. ARRA directs the Secretary to develop and approve EHR standards by the end of 2009 and to establish a program to certify which EHR systems meet these standards.

Starting in 2011, physicians who meet the definition of a “meaningful” EHR user (including exchanging electronic health information to improve health care quality and coordination) will be eligible for up to \$44,000 in Medicare bonus payments over a five-year period. Physicians who are not meaningful EHR users by 2015 will see their Medicare reimbursement reduced by up to 5 percent in 2019 and subsequent years if the Secretary finds that the proportion of meaningful users is less than 75 percent. Eligible professionals are those that meet the Medicare definition of a physician, i.e., state-licensed doctors of medicine, osteopathy, dentistry, podiatry, and optometry, as well as licensed chiropractors. Eligible professionals are those that meet the Medicare definition of a physician section 1861(r) of the Social Security Act.

Beginning in 2011, hospitals who meet the definition of “meaningful” EHR user will also be eligible for bonus payments. For hospitals subject to the inpatient prospective payment system (IPPS), the amount of the payment incentive depends on when the hospital first demonstrates meaningful use of a certified EHR system, the size of the facility, and the hospital’s Medicare share. The incentive payment will phase-out over a four year period, such that hospitals receive 75 percent of the applicable bonus payment in year two; 50 percent in year three; and no incentive payment in subsequent years. Hospitals that are meaningful users beginning in 2011, 2012 or 2013 will receive a full four year of incentive payments based on the aforementioned schedule. Hospitals that become meaningful users in 2014 or 2015 will only receive three or two years of incentive payments, respectively. Starting in 2015, hospitals that do not show meaningful use of a certified EHR system during the prior year will be subject to reductions in the annual IPPS market basket update.

Starting in 2011, Critical Access Hospitals (CAHs) who demonstrate meaningful use of EHR will receive expedited and increased payments for health IT costs that would otherwise be subject to depreciation. In 2011 through 2015, CAHs can expense health IT costs that would otherwise be eligible for depreciation, which will allow them to receive Medicare reimbursement for these costs shortly after incurring the expense, rather than over a multi-year depreciation schedule. In addition, Medicare reimbursement to CAHs for health IT costs will be enhanced by providing an additional 20 percentage points in extra depreciation payments in addition to the allowable depreciation amount that is calculated based on the Medicare share formula set forth in the bonus payment policy for IPPS hospitals. Starting in 2015, CAHs that do not show meaningful use of a certified EHR system during the prior year will face a reduction in their payment rate that will phase-up over three years to 1 percent of the currently 101 percent cost-based reimbursement available to CAHs.

The HITECH Act also included health IT incentives for eligible professionals and hospitals through the Medicaid program. Beginning in 2011, eligible professionals who treat a high volume of Medicaid patients and demonstrate meaningful use of a certified health IT system are eligible for temporary health IT payments. Payments are not to exceed 85 percent of the cost of purchase, implementation, and maintenance and upkeep of certified systems, subject to an overall cap. Maximum program participation is six years. Eligible professionals include non-hospital professionals (doctors, dentists, nurse practitioners, certified nurse mid-wife, and certain physician assistants) who have at least 30 percent of their patient volume from Medicaid; pediatricians with at least 20 percent of their patient volume from Medicaid; and federally-qualified health centers (FQHCs) or rural health clinics (RHCs) with at least 30 percent of their volume from needy individuals. Eligible providers participating in the Medicaid incentives program are not allowed to participate in the Medicare incentives program described above.

Children's hospitals, and acute-care hospitals that have at least 10 percent of their volume from Medicaid, are also eligible for Medicaid health IT incentives. The formula for determining the amount of Medicaid payment is similar to the Medicare formula referenced above for IPPS hospitals, but with slight modification.

Proposed Option

The Committee is exploring the possibility of expanding eligibility for the EHR Medicare incentive payments to include nurse practitioners and physician assistants under certain conditions, such as those who practice in settings outside of a physician office. Eligible providers would receive the same EHR incentive payments as physicians.

In addition, the Committee intends to further explore providing additional health IT incentives to other health care providers, such as those offering post-acute services, that were not included in the Medicare and Medicaid incentives included in ARRA. In particular, the Committee is analyzing whether additional health IT incentives within Medicare are warranted to help support the care coordination and quality improvement goals and activities related to various proposals included in this document, such as the establishment of value-based purchasing programs, chronic care management models and proposals to bundle acute and post-acute payments. The Committee looks forward to receiving additional input on this topic.

Improving Quality Measurement

Current law

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.110-275) includes a provision that directed the Secretary to identify and contract with a consensus-based entity regarding performance measurement, such as the National Quality Forum, that meets the requirements described below, and required the entity to perform a number of specified duties. Duties of the consensus-based performance measurement organization include:

(a) synthesize evidence and convene key stakeholders to make recommendations on an integrated national strategy and establish priorities for health care performance measurement in all applicable settings. In making such recommendations, the entity would ensure that priority is given to measures: (1) that address the health care provided to patients with prevalent, high-cost, chronic diseases; (2) with the greatest potential for improving the quality, efficiency, and patient-centeredness of health care; and (3) that may be implemented rapidly due to existing evidence, standards of care, or other reasons. The organization would also take into account measures that: (1) may assist consumers and patients in making informed health care decisions; (2) address health disparities across groups and areas; and (3) address the continuum of care a patient receives, including services furnished by multiple health care providers or practitioners and across multiple settings.

(b) endorse standardized health care performance measures. The endorsement process would consider whether a measure: (1) is evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and (2) would be consistent across types of health care providers, including hospitals and physicians.

(c) establish and implement a process to ensure that the standardized health care performance measures endorsed are updated (or retired if obsolete) as new evidence is developed.

(d) promote the development and use of electronic health records that contain the functionality for automated collection, aggregation, and transmission of performance measurement information.

(e) prepare an annual report to Congress and the Secretary by March 1 of each year (beginning with 2010). The report would describe: (1) the implementation of quality measurement initiatives included in MIPPA and the coordination of such initiatives with quality initiatives implemented by other payers; (2) the recommendations made; and (3) the performance by the entity of the duties required under the contract entered into with the Secretary. Not later than 6 months after receiving such a report for a year, the Secretary would review and publish the report in the *Federal Register*, together with any comments of the Secretary on the report.

There are several requirements for the consensus-based performance measurement organization. The organization would be required to be a private nonprofit entity governed by a board, whose members would include: (a) representatives of health plans and health care providers and practitioners or representatives of groups representing health plans and health care providers and practitioners; (b) health care consumers or representatives of groups representing health care consumers; and (c) representatives of purchasers and employers or groups representing purchasers or employers. The membership of the organization would include persons who have experience with urban health care issues, safety net health care issues, rural and frontier health care issues, and health care quality and safety issues.

If the entity were to require a membership fee for participation in other functions of the entity, such fees would be reasonable and adjusted based on the capacity of the potential member to pay the fee. In no case would membership fees pose a barrier to the participation of individuals or groups with low or nominal resources to participate in the functions of the entity.

With respect to matters related to the contract with the Secretary as described above, the organization would be required to conduct its business in an open and transparent manner and to provide the opportunity for public comment on its activities. The entity would operate as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104– 113) and Office of Management and Budget Revised Circular A–119 (published in the *Federal Register* on February 10, 1998).

For purposes of carrying out this subsection, the Secretary would provide for the transfer of up to \$40 million from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (in such proportion as the Secretary determined appropriate), to the CMS Program Management Account for the period of fiscal years 2009 through 2012.

The contract with such consensus-based performance measurement organizations would be for a period of 4 years, and may be renewed after a subsequent bidding process.

Proposed Option

Building on the provision set forth in MIPPA, this proposal would provide additional resources to the Secretary of the Department of Health and Human Services (HHS), working in cooperation with the Agency for Health Care Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS), to further strengthen and improve quality measurement and development processes.

In this proposal, the Secretary would be required to submit a biennial report to Congress that outlines national priorities and strategies for health care quality improvement and performance and a status report on progress toward meeting such goals. The Secretary would also be directed to set forth a process for the development, endorsement, selection, and implementation of quality measures. The Secretary would be

directed to align these quality improvement processes and activities to support the delivery system reform proposals outlined in this document and to support the priorities and goals set forth in the biennial report. To fulfill these tasks, the Secretary would be directed to continue contracting with a consensus-based entity, such as the National Quality Forum. Building on the requirements included in MIPPA, such entity would be directed to conduct, at minimum, the following activities:

- Convene a multi-stakeholder group to provide guidance to Secretary in development of national priorities and goals and identify gaps in performance measurement for national priority areas;
- Convene a multi-stakeholder group to provide guidance to Secretary on the selection of performance measures to be included in public reporting and/or for purposes of payment initiatives in public programs and establish a formal process to receive this input; and
- Endorse and maintain measures for national use through a multi-stakeholder process. Stakeholders must include, but are not limited to representatives of:
 - hospitals, physicians, post-acute providers, quality alliances, nurses and other health providers, health plans, consumer representatives, life sciences industry, employers and public purchasers, labor organizations, and relevant government agency representatives

Measures would be applicable to all age groups, where appropriate, and available to the public free of charge and focus at minimum on the following areas:

- Patient outcomes and functional status
- Coordination of care across episodes of care and care transitions
- Meaningful use of health information technology
- Efficiency and equity of health services and health disparities
- Patient experience and satisfaction
- Other areas deemed appropriate in support of other delivery system reforms set forth in this paper

The Secretary would also develop a strategy for improving the public reporting of quality and performance information that includes making information available on the internet in a standardized, understandable and easy-to-use format for consumers, providers and purchasers.

For purposes of carrying out these activities, the Secretary would provide for the transfer of funding from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (in such proportion as the Secretary determined appropriate), to the CMS Program Management Account. The level of funding will be identified as the Committee continues to develop this policy.

The Committee looks forward to working in cooperation with the Senate Committee on Health, Education, Labor and Pensions (HELP) to further develop these proposals. In addition, the Committee also intends to work with the HELP Committee to explore whether additional funding and requirements should be set forth regarding (1) the development of quality measures in areas that are aligned with national priorities and/or represent gaps in measurement; and (2) the assessment and dissemination of clinical best practices to health care providers related to these quality improvement measures.

Comparative Effectiveness Research

Current Law

Several HHS agencies have authority to synthesize and conduct research comparing the effectiveness of different health care treatments and strategies within their authorizing statutes. In addition, Section 1013 of the Medicare Modernization Act of 2003 directs the Agency for Healthcare Research and Quality (AHRQ) to develop priorities for and conduct an evaluation and synthesis of research comparing the clinical effectiveness and appropriateness of health care items and services covered under Medicare, Medicaid and CHIP. The recently enacted American Recovery and Reinvestment Act of 2009 (ARRA) included \$1.1 billion in discretionary spending for comparative effectiveness research. Of the total, \$400 million was allotted to the National Institutes of Health (NIH), \$300 million to AHRQ, and \$400 million to the Secretary of Health and Human Service (HHS) to fund comparative research as well as support the development of diseases registries that could be reliable data sources for research. The ARRA funds are temporary and must be obligated for research by the end of 2010.

Proposed Options

The Committee will consider options to establish a long-term or permanent framework to set national priorities for comparative clinical effectiveness research and to provide for the conduct of such research.

Finding Out What Works in Health Care. Comparative clinical effectiveness research compares clinical outcomes of alternative therapies or strategies used to prevent, treat, diagnose, and manage the same condition. The purpose of this type of research is to assist patients and clinicians in making informed health care decisions. Better evidence on what works will lead to better health care choices and thus to improved quality of care and improved efficiency.

One option to support this type of research would be to fund existing HHS entities through annual appropriations, as done through ARRA. One limitation of this option is that discretionary funding can be inconsistent and unstable. Also, the research agenda could be unduly influenced through the political process.

An alternative option, as presented in S. 3408 (110th), would be to establish a private, non-profit corporation that would generate and synthesize evidence on what works in health care through a focus on comparative clinical effectiveness research.

As outlined in S. 3408, an independent Institute could be governed by a multi-stakeholder board that would include clinicians, patients, manufacturers, as well as researchers, scientists and private and public payers. The Board composition should be balanced so that no stakeholder interest dominates. As outlined in S. 3408, the duties of an independent Institute could be to establish a national agenda of research priorities, based on the need for better evidence, disease burden, practice variations, the potential for improved care and health, and expenditures associated with a given health condition or care strategy. The Institute could contract with AHRQ, the NIH and other appropriate federal and private entities to conduct comparative clinical effectiveness research, including systematic reviews, observational studies, clinical trials, and randomized controlled trials. Placing the Institute outside of the government would help maintain objectivity and minimize undue political influence. Regular reviews by the Government Accountability Office (GAO) would ensure that the Institute is accountable to the public.

Ensuring Credible and Objective Research. A critical component of supporting comparative clinical effectiveness research is the development of methods and standards for such research. To accomplish this,

an independent, expert committee charged with developing methodological standards for this type of research should be established. Such a committee could be formed by an independent Institute or by the Secretary of HHS. Research conducted by an Institute or HHS could be required to adhere to these standards. To further ensure adherence to methodological standards and to the principles of scientific integrity, research could be guided by expert advisory panels or subject to a peer review process.

Transparency and Public Input. HHS agencies or an independent Institute charged with providing for this type of research should consult with stakeholders broadly and continually during its activities, ensuring that the research is relevant to the needs of patients, physicians, and other stakeholders and that the research is disseminated in ways most useful to health care decision-makers. Expert advisory panels should be established to make certain that research and its findings are relevant to decision-makers at the point of service. Public comment and input should be integral to comparative clinical effectiveness research. Options could include: 1) public comment periods on the research agenda and priorities, 2) peer-review of research designs and findings, and 3) public comment periods on research design, draft reports and dissemination approaches. Research findings should be publicly disseminated in ways that patients and healthcare providers can easily understand.

Patient Safeguards. Any entity approving or conducting comparative clinical effectiveness research should consider potential differences between patient subgroups and their responses to different health care strategies when designing and approving each study. The entity conducting the research should broadly disseminate research findings, but should be prohibited from issuing medical practice recommendations or from making reimbursement or coverage decisions or recommendations.

In addition, the Committee should consider ways of addressing the need for patient safeguards with respect to the use of this type of research, particularly by public programs like Medicare and Medicaid. One option is to create limits on the use of the research by HHS. For example, Medicare could be allowed to use the findings only in circumstances where the processes by which it uses the information is transparent, relies on all available evidence (not only research from the Institute), considers the potential for effects on subpopulations of beneficiaries, and allows for public comment on any draft proposals that use the information. This would prohibit HHS agencies from creating a fast-track process for automatically linking the research findings to coverage or reimbursement decisions in public programs. Such measures could ensure that the information produced by the Institute is used by HHS in an open and transparent manner.

Funding. Comparative clinical effectiveness research could be funded annually by appropriations or by a mix of public and private sector funds. S. 3408 proposes funding this research through a mix of general revenues, contributions from the Medicare trust funds, and an assessment on private insurance in proportion to the share of total national health expenditures accounted for by Medicare, other public programs, and the private sector.

Transparency

Physician Payment Sunshine

Current Law

None

Proposed Option

This proposal would amend part A (General Provisions) of title XI of the Social Security Act to provide for transparency in the relationship between physicians and applicable manufacturers with respect to payments and other transfers of value and physician ownership or investment interests in manufacturers. It calls for the submission of payment and ownership information and procedures to make this information public.

The proposal would require any manufacturer of a covered drug, device, biological, or medical supply that makes a payment or another transfer of value to a physician to report annually, in electronic form, specified information on such transactions to the Secretary of Health and Human Services. The Committee seeks input on whether the reporting of payments and other transfers of value should include additional individuals and entities. The report would include the transfer recipient's name, business address, value of the payment, date of the payment, a description of the form of the payment, a description of the nature of the payment, if the payment is related to marketing, education, or research specific to a covered drug, device, biological or medical supply and its name, National Provider Identifier, and any other category of information that the Secretary determines appropriate. If the recipient requests a transfer of payment to another entity or individual, the manufacturer should disclose that information.

For payments made pursuant to a product development agreement or clinical trial, payments would not be published until the earlier of (1) the date of approval or clearance by the FDA, or (2) four calendar years after the date of payment. Some information would be excluded from these reporting requirements, including payments or transfers of \$10 or less, samples intended for patient use, patient educational materials, loan of a covered device for a short-term time period, discounts and rebates, in-kind items used for charity care, and profit distributions from publicly traded companies. The reporting requirement would begin on March 31, 2012 and remain in effect on the 90th day of each subsequent calendar year. The Committee seeks input on whether a *de minimis* threshold for payments and transfers of value should be implemented or an annual aggregate reporting threshold of \$100 per recipient.

The proposal also requires any such manufacturer or related group purchasing organization to report annually to the Secretary, in electronic form, certain information regarding any ownership or investment interest (other than in a publicly traded security and mutual fund) held by a physician (or an immediate family member) in the manufacturer or group purchasing organization during the preceding year. The Committee seeks input on whether small business entities should be exempted from reporting or if all manufacturers, regardless of size, should be required to comply with the reporting requirements.

Manufacturers or group purchasing organizations would be subject to a civil monetary penalty (CMP) of not less than \$1,000 but not more than \$10,000 for each payment or transfer not reported. The total amount of the penalties for any annual submission shall not exceed \$150,000. Any manufacturer or group purchasing organization that knowingly fails to submit information would be subject to a CMP of not less than \$10,000 but not more than \$100,000 for each payment or transfer not reported. The total amount of the penalties for this failure to report category of submissions shall not exceed \$1,000,000 annually.

The proposal would require the Secretary to establish procedures no later than June 1, 2010 to ensure public availability of this information. Beginning September 30, 2012, and on June 30 of subsequent years, submitted information would be available on an Internet website that meets formatting, search, and usability requirements. In addition to the payment and value transfer information, the website would include information on enforcement actions during the preceding year, background information on industry-physician relationships, a separate listing for payments related to clinical research, and other information that the Secretary deems appropriate. The Secretary would also allow recipients,

manufacturers, and group purchasing organizations an opportunity to submit corrections to their information.

This reporting procedure would be established after consulting the Office of the Inspector General (OIG), affected industry, consumers and other parties in order to ensure that the information is presented in an appropriate context. The Secretary would be required to submit an annual report summarizing the payment and value transfer information to Congress and the states beginning April 1, 2012. Effective January 1, 2011, these provisions would preempt any state law or regulation that requires manufacturers to disclose information regarding payments or transfers. This preemption does not affect information that is not required under this proposal. The Committee seeks input on the extent to which these provisions would preempt state laws or regulations.

The Secretary should consult with the OIG on the implementation of this section.

Physician-Owned Hospitals

Current Law

Physicians are generally prohibited from referring Medicare patients for designated health services to facilities in which the physician (or an immediate family member) has a financial interest. However, among other exceptions, physicians are not prohibited from referring patients to hospitals if they have ownership or investment interests in the whole hospital. An additional exemption from the general ban on “self-referral” is made for providers that furnish substantially all of their designated health services to individuals residing in rural areas.

Proposed Option

The “whole hospital” and rural exceptions to the general ban on self-referral would be eliminated. However, a new exception would be created for hospitals that have physician ownership and a Medicare provider agreement in effect on July 1, 2009. These facilities would be “grandfathered” and allowed to continue to self-refer, subject to certain other specified requirements. These requirements would address potential conflicts of interest and ensure bona fide investments and patient safety.

Specifically, to avoid conflicts of interest, a “grandfathered” hospital would (1) submit an annual report containing the identity of each physician owner or investor and any other information on the nature and extent of all ownership or investment interests in the hospital; (2) have procedures in place to require that any referring physician owner or investor discloses to each patient (by a time that permits the patient to make a meaningful decision regarding the receipt of care) their ownership or investment interest in the hospital and, if applicable, any such ownership or investment interest of the treating physician; (3) not condition ownership or investment, either directly or indirectly, on the physician owners or investors making or influencing referrals to the hospital; and (4) disclose the fact that the hospital is partially owned or invested in by physicians on any public website for the hospital and in public advertising for the hospital. Information from the annual report would be published and updated annually on the Internet website of the Centers for Medicare & Medicaid Services.

“Grandfathered” hospitals would ensure bona fide investment and proportional returns by meeting the following requirements: (1) physician owners or investors in the aggregate could not own more than the value of such ownership or investment interest held in the hospital (or an entity whose assets include the hospital) on the date of enactment; (2) any ownership interest offered to a physician owner or investor could not be offered on more favorable terms than those offered to an individual who is not a physician

owner or investor; (3) the hospital could not provide loans or financing for physician investments in the hospital; (4) the hospital could not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, to any individual physician owner or investor or group of physician owners or investors that is related to investing or acquiring ownership interest in the hospital; (5) ownership or investment returns must be distributed to owners or investors in the hospital in an amount that is directly proportional to the ownership or investment interest in the hospital of such owner or investor; (6) compensation of and ownership or investment returns to physician owners or investors must not include the guaranteed receipt of or an exclusive right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital; and (7) the hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under hospital control on more favorable terms than offered to an individual who is not a physician owner or investor.

To ensure patient safety, those “grandfathered” hospitals that do not have a physician on the premises to provide services during all hours in which the hospital is providing services to such a patient would have to disclose such a fact to the patient before admitting the patient. Following such a disclosure, the hospital would receive informed consent from the patient to receive services in the hospital when no physician will be present. The hospital also would be required to have the capacity to provide assessment and initial treatment for patients and procedures for the referral and transfer of patients to hospitals with the capability to treat the patient.

Generally, grandfathered hospitals would not be permitted to increase the number of operating rooms, procedure rooms, or beds above the number for which the hospital is licensed on the date of enactment. However, a process would be established to allow hospitals that qualify and apply to increase the number of operating rooms, procedure rooms, or beds. In order to qualify to increase the number of procedure rooms, operating rooms, or beds, the hospital must: (1) be located in a county where the population increased during the most recent five-year period at a rate that is at least 150 percent of the state’s population increase; (2) have a Medicaid inpatient admission percentage equal to or greater than the average percentage for all hospitals located in the county; (3) not discriminate against beneficiaries of federal health care programs and not permit physicians practicing at the hospital to discriminate against such beneficiaries; (4) be located in a state with a state average bed capacity less than the national average; and (5) have an average bed occupancy rate that is greater than the state average bed occupancy rate.

Any increases in capacity would be limited to facilities on the main campus of the hospital and could not exceed 200 percent of the number of operating rooms, procedure rooms, or beds on the date of enactment over the hospital’s lifetime. The process for expansion should allow the opportunity for community input and should permit applicable qualifying hospital to apply for an increase in capacity up to once every two years. The Secretary should publish final decisions on an increase no later than 60 days after receiving a complete application. The Secretary should implement this process on January 1, 2011 and shall promulgate regulations to carry out this process no later than December 1, 2010. 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, beginning on their effective date. The Secretary would conduct audits to determine if hospitals violate the requirements beginning not later than April 1, 2011.

Nursing Home Transparency

Current Law

Medicare and Medicaid laws require skilled nursing facilities (SNF) and nursing homes to be administered in a manner that will ensure residents' well-being. The Secretary establishes requirements for SNF and nursing homes that will protect the safety, health, welfare, and rights of residents. Facilities undergo regular survey and certification inspections to ensure their compliance with these standards. SNF and nursing home inspections identify deficiencies where facilities fail to meet federal standards. Deficiencies can range from minor problems to major safety and life-threatening conditions. State and federal officials may impose civil monetary penalties on facilities that fail to meet standards or fail to correct deficiencies. In extreme cases, federal and state officials can install new facility management, assume control of facilities, or even close SNF or nursing homes that jeopardize residents' well-being.

Proposed Option

A number of changes aimed at improving transparency of information about SNF and nursing homes, enforcement of SNF and nursing home standards and rules, and training of SNF and nursing home staff are proposed. These changes would amend both title XVIII and title XIX of the Social Security Act. They include:

Required disclosure of ownership. SNFs and nursing facilities would be required to make available on request by the Secretary, the HHS OIG, the states, and the state long-term care ombudsman, information on ownership (including direct and indirect ownership) and additional disclosable parties as well as information describing the governing body and organizational structure of the facility. Information would be made available to the Secretary, the HHS OIG, the state and state long-term care ombudsman programs upon request. To the extent that the required information is submitted to the IRS as part of Form 990, to the SEC, or to the Secretary, facilities would be permitted to make the information available in these formats.

Information to be disclosed would include the identity of and information on each member of the governing body of the facility (name, title, period of service); each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility; and each person or entity who is an additional disclosable party of the facility.

Additional disclosable parties would be defined as any persons or entities (1) that exercise operational, managerial or financial control over the facility or part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility; (2) lease or sublease real property to the facility, or owns a whole or part interest equal to or exceeding five percent of the total value of such real property; (3) lend funds or provide financial guarantees which is equal to or exceeds \$50,000; and (4) that provide management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

The reporting of a person or entity's organizational structure would also be required. Organizational structure would be defined as officers, directors and shareholders who have an ownership interest equal to or greater than five percent in the case of corporations. For a limited liability company, organizational structure would be defined as members and managers; for a general partnership, the partners; for a limited partnership, general partners and any limited partners who have an ownership interest equal to ten percent or greater in the limited partnership; for a trust, the trustees; for an individual, contact information; and for any other person or entity, such information as the Secretary determines appropriate.

The Secretary and the states would be required to develop a standardized format through regulation for facilities to report information about ownership and additional disclosable parties within two years of enactment.

The Secretary, within one year of promulgating regulations requiring reporting by facilities, would be required to make available to the public information about ownership and additional disclosable parties. The Secretary would also be required to provide guidance and technical assistance to states on how to adopt the standardized format.

Accountability requirements. SNF and nursing homes would be required to develop and implement compliance and ethics programs to be followed by their employees and agents. The Secretary would be required to develop regulations, working with the HHS Inspector General, for an ethics and compliance program, which may include a model compliance program, within two years of enactment. The Secretary may vary program requirements on the elements and formality of the program based on the size of the organization. The compliance program would be required to have standards and procedures designed to detect criminal, civil and administrative violations under the Social Security Act.

The Secretary would create regulations on quality assurance and performance improvement (QAPI) plans. SNF and nursing homes would be required to implement QAPI plans and submit those plans to the Secretary. The Secretary would be required to provide technical assistance to facilities on development of “best practices” in order to meet QAPI standards.

Nursing Home Compare website. The Secretary would be required to include additional information in the Medicare *Nursing Home Compare* website. This additional information includes: (1) standardized staffing data on nursing staff and other staff providing medical and therapy services available on facilities that is submitted by facilities in a uniform format; (2) links to state internet websites regarding state survey and certification programs, and links to Form 2567 (or successor form) inspection reports, links to facility plans of correction or responses to such reports and information to guide consumers in how to interpret and understand these reports; (3) a standardized complaint form including explanatory material on how to use the complaint forms, and how to file a complaint with the state survey and certification program and the state long-term care ombudsman program; (4) a summary of information on enforcement action against the facility that includes substantiated complaints and remedies proposed and imposed during the preceding three years; and (5) a summary of facility expenditures for direct care staffing based on data submitted.

The Secretary would be required to establish a process to review the accuracy, clarity of the presentation, timeliness, and comprehensiveness of information currently reported on *Nursing Home Compare*; and a process to modify or revamp the site in accordance with comments received after review. In conducting the review, the Secretary would be required to consult with state long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, and other representatives of programs or groups as the Secretary determines appropriate.

States would be required to submit survey information to the Secretary no later than they send such information to the facility, and requires the Secretary to use this information to update *Nursing Home Compare* as expeditiously as practicable. Facilities would be required to have available on request the preceding three years’ of inspection reports (Form 2567 reports), complaint investigations and the facility’s plan of correction or other response to the Form 2567 report. Facilities would also be required to post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. The Secretary would be required to issue guidance to states on establishing electronic links to Form 2567 reports, to facility plan of correction reports or other responses to 2567 reports, and posting of complaint investigation reports.

Reporting of expenditures. This change would amend the Social Security Act by adding requirements that SNF and nursing homes report expenditures for wages and benefits for direct care staff on facility cost reports. The reporting of expenditures on wages and benefits for direct care staff would be required to be broken out into categories including registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff.

The Secretary would be required to consult with government and private sector cost report experts to assist in categorizing by functional area SNF expenditure data, as well as in making it available.

Standardized complaint form. The Secretary would be required to develop a standardized form for SNF and nursing facility residents and their representatives to use in submitting quality of care complaints. States would be required to develop a process for resolving complaints. The new standard complaint form would not prevent nursing facility residents from submitting claims in other ways too, including orally.

States would be required to establish complaint resolution processes with procedures to assure accurate tracking of complaints received, including a notification to the complainant that a complaint has been received; procedures to determine the likely severity of a complaint and for the investigation of a complaint; and deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation. Such processes would be required to ensure that legal representatives or other responsible parties are not denied access to a resident or otherwise retaliated against if they have complained about the quality of care provided by the facility, or other issues relating to the facility.

Ensuring staffing accountability. The Secretary would establish a process to require SNF and nursing facilities to regularly report staffing data, including agency and contract staff, by staff position categories (based on payroll and other verifiable and auditable data). The reporting requirements would include the category of work an employee performs, resident census data, information on employee turnover and tenure, and the hours of care provided per resident per day. The Secretary would be required to consult with stakeholders in developing the reporting requirements. The process would be electronic and data would be reported in a uniform format. The Secretary would submit a report to Congress no later than six months after the completion of a one-year design phase. Not later than one year following the evaluation, the Secretary would require facilities to begin electronically submitting staffing information in a uniform format.

The Secretary would develop a program for facilities to report staffing information in a uniform format based on payroll data, and to also take into account services provided by any agency or contract staff. These standards must specify the category of work an employee performs, such as whether the employee is an RN, LPN, LVN, CNA, or other medical or therapy staff providing direct resident services. Standards must also include resident census data, information on employee turnover and tenure, and the hours of care provided per resident per day.

The Secretary is charged with submitting a report to Congress no later than six months after the one-year design phase has ended. Not later than one year following the evaluation, the Secretary shall require facilities to begin electronically submitting nurse staffing information in a uniform format.

Civil monetary penalties. The Secretary would be required to promulgate regulations providing facilities with the opportunity for participation in an independent informal dispute resolution process that would produce a written record and occur within 30 days of imposition of the penalty. In instances where deficiencies are cited at the level of actual harm and immediate jeopardy, the Secretary would have the authority to place civil monetary penalties (CMPs) in an escrow account following completion of the

informal dispute resolution process, or the date that is 90 days after the date of the imposition of the CMP, whichever is earlier. Monetary amounts collected and placed in escrow would be kept in an interest-bearing escrow account pending the resolution of any appeals. The Secretary and states would have the authority to reduce CMPs if the deficiency was self-reported and promptly corrected within ten calendar days after imposition. Reductions would not be made for self-reported deficiencies cited at the immediate jeopardy level, at the actual harm level if the harm was found to be a “pattern” or “widespread,” and for deficiencies that result in the death of a resident. Facilities cited for a repeat deficiency that had been self-reported during the preceding year would not be eligible for a reduction.

The Secretary would be authorized to use a portion of collected CMPs to fund activities that benefit residents. These activities include projects that strengthen and support resident and family councils, offset the costs of relocating residents to home and community-based settings or another facility, and support and protect residents in situations where a facility closes or is decertified. Such funds would also be used for facility improvement initiatives approved by the Secretary, including joint training of facility staff and surveyors; technical assistance for facilities implementing quality assurance programs; and appointment of temporary management firms.

National independent monitor pilot program. The Secretary would be required to develop, test, and implement a two-year pilot for an independent monitor program. The independent monitor program would oversee large interstate and intrastate SNF and nursing home chains. The Secretary would develop protocols for addressing quality and safety problems at the corporate management level occurring in individual homes that are owned or operated by certain chains, including those with homes in the Special Focus Facility program, and those with a record of repeated serious safety and quality of care deficiencies.

Chains that receive a report containing findings and recommendations from the independent monitor would be required to submit a report outlining corrective actions that will be taken within ten days. If a chain declines to implement the independent monitor’s recommendations, the chain would be required to submit reasons why it will not do so. After receiving the chain’s response, the independent monitor would be required to finalize recommendations and to submit a report to the chain and the facilities of the chain, the Secretary, and the relevant state or states, as appropriate. Chains would be responsible for a portion of the costs associated with appointment of independent monitors. The Secretary would have authority to waive Medicare and Medicaid laws under in order to carry out the independent monitor pilot program. The OIG would evaluate the independent monitor program to determine the feasibility of establishing a permanent independent monitor program, as well as appropriate procedures and mechanisms to implement such a permanent program.

Notification of facility closure. SNF and nursing homes would be required to notify in a timely fashion state, federal, and stakeholder officials, as well as residents and their representatives of an impending nursing facility closure. Facilities would be required in the notice to issue a plan for the transfer and relocation of residents.

The administrator of a facility that is preparing to close would be required to provide written notification to residents, legal representatives of residents or other responsible parties, the state, the Secretary and the long-term ombudsman program. This notification would have to be made at least 60 days before closure. Facilities would have to prepare a plan for closing the facility by a specified date specified by the state. The state would be required to approve it and ensure the safe transfer of residents to another facility or alternative setting that the state finds appropriate in terms of quality, services and location and takes into consideration the needs and best interests of each resident.

In the case of a facility where the Secretary terminates the facility's participation, the Secretary would be required to provide written notification to the parties above not later than the date that the Secretary determines appropriate. Facilities would not be permitted to admit new residents on or after the date on which written notification is submitted. The Secretary would continue making payments to a facility to support residents until they are relocated, as the Secretary determines appropriate.

Demonstration projects on culture change and use of information technology in nursing homes.

The Secretary would conduct two demonstration projects for nursing homes and SNF: (1) for the development of best practices for facilities involved in culture change; and (2) for the development of best practices in facilities for the use of information technology to improve resident care. The Secretary would be required to submit a report to Congress after completion of the demonstration projects that evaluates the projects and makes recommendations for legislation and administrative actions. The demonstration projects cannot exceed three years.

Dementia and abuse prevention training. This change would add staff training requirements for SNF and nursing homes. The Secretary would revise initial nurse aide training, competency, and evaluation program requirements to include dementia management training and patient abuse prevention. If determined to be appropriate, the Secretary also may include dementia management training and patient abuse prevention in ongoing nurse aide training, competency, and evaluation program requirements.

Study and report on training required for certified nurse aides and supervisory staff. The Secretary would be directed to study and prepare a report to Congress on the content of certified nurse aide and supervisory staff training and whether the number of required training hours is adequate, and if not, what the training level should be.

Workforce

Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians

Current Law

With certain exceptions, the Balanced Budget Act of 1997 limited the number of allopathic and osteopathic residents that Medicare will reimburse a teaching hospital at the level reported in its cost report ending on or before December 31, 1996. The limit does not include dental or podiatry residents. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) authorized the redistribution of up to 75 percent of each teaching hospital's unused resident positions to hospitals seeking to increase their medical residency training programs. Any adjustments made to teaching hospitals' resident limits would be permanent. Rural teaching hospitals with less than 250 beds were exempt from the redistribution of any of their unfilled positions. Under the redistribution program, teaching hospitals were allowed to request up to an additional 25 full time equivalent (FTE) positions for direct graduate medical education (DGME) and indirect medical education (IME) payments. Hospitals were required to demonstrate the likelihood that the redistributed positions would be filled within 3 cost reporting periods beginning July 1, 2005. MMA required that the unused slots be redistributed according to specific priorities: rural hospitals, urban hospitals located in areas with a population of one million or less, specialty training programs that are the only specialty program in a state, and all other hospitals. The redistribution was effective for portions of cost reporting periods starting July 1, 2005. The redistributed resident slots have different IME and DGME payment formulas from those used to reimburse hospitals' previous residents.

Proposed Option

Similar to the proposal set forth in the MMA, the Committee's plan would establish a re-distribution of currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery. In this proposal, the Centers for Medicare and Medicaid Services (CMS) would calculate the number of unused resident slots over the last three fiscal years. Unused slots would be defined as the difference between total available resident slots and a hospital's actual FTE of residents. Based on this calculation, 80 percent of unused slots would be included in a pool for redistribution. Rural teaching hospitals with less than 250 beds would be exempt from the redistribution of any of their unfilled positions.

The Secretary would be authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application addressing the criteria below, by such number determined by the Secretary. Seventy-five percent of new slots would be allocated toward primary care or general surgery residency training positions for at least 5 years. Teaching hospitals would be allowed to request up to 50 resident FTE positions from the pool of re-distributed slots. Programs applying to receive the slots will be prioritized based on certain criteria, which may include, but not be limited to: sponsoring institutions located in a Primary Health-Health Professional Shortage Area (HPSA), as determined by the Health Resources and Services Administration; sponsoring institutions located in rural areas; sponsoring institutions located in urban areas with a population of a million or less; sponsoring institutions located in states with a higher proportion of medical graduates relative to number of available residency slots within the state; and states with higher than average population growth. Hospitals that qualify for additional resident slots would display a demonstrated likelihood of filling the positions within the first three cost reporting periods and would be involved in an innovative delivery model.

Slots would be redistributed among teaching hospital sponsors. For a sponsoring institution to receive additional residency slots, they must maintain the level of primary care residency positions at a level that is at least equal to the average number of primary care positions over the past 3 fiscal years. However, if the primary care positions cannot be filled through the National Resident Match Program over that period of time, the hospital would be allowed to transfer the slot to a different specialty. The redistributed resident slots would be subject to the same IME and DGME payment formulas as is used to reimburse hospitals' previous residents.

Promoting Greater Flexibility for Residency Training Programs

Current Law

Medicare pays teaching hospitals the costs of approved medical residency training programs through two mechanisms: an indirect medical education (IME) adjustment within the inpatient prospective payment system (IPPS) and direct graduate medical education (DGME) payments made outside of IPPS. With respect to training that occurs in hospital settings, Medicare will not include the time that residents spend in non-patient care activities, including didactic activities, when calculating IME payments. With respect to training that occurs in nonhospital settings, Medicare will not count the time that residents spend in non-patient care activities, including didactic activities, when calculating DGME or IME payments.

Medicare will reimburse the direct costs of DGME for approved residency training programs without regard for the setting where the residents' activities relating to patient care are performed as long as the primary training hospital incurs all, or substantially all, of the costs for the training program in that setting. Through regulations, CMS has defined all, or substantially all costs, as 90 percent of residents'

stipends and fringe benefits and any costs associated with a supervisory physician. However, as presently administered, a hospital cannot include the time spent by residents working at a non-hospital site if it incurs, all or substantially all of the costs for only a portion of the residents in that program at the non-hospital site.

Proposed Option

In order to promote training in outpatient setting and to ensure the availability of residency programs in rural and underserved areas, the Committee is considering ways to provide more flexibility in laws and regulations governing graduate medical education funding in the Medicare program. Proposals being considered include counting time for certain non-patient care activities, such as didactic and scholarly activities in a nonhospital setting for purposes of calculating GME payments, removing current disincentives placed on training programs that rely on volunteer supervisory physicians to provide training in outpatient settings and providing flexibility in the operation of residency programs involving more than one teaching hospital. The Committee looks forward to continuing to receive input on these topics.

TANF Health Professions Competitive Grants

Current Law

The Temporary Assistance for Needy Families (TANF) block grant provides grants to states for a wide range of benefits and services for needy children and their caretakers. States may use TANF funds for activities that seek to achieve any of TANF's statutory goals. One goal is to end the dependence of needy parents on government benefits, and one means to achieve this goal is job preparation. Thus, TANF funds may be used for education and training of low-income parents, both those who receive assistance (cash welfare) and other low-income parents. Though TANF funds may be broadly used for education and training for low-income parents, there are limits to counting education and training toward TANF work requirements for adult recipients of assistance.

In addition to block grants to the states, TANF also has categorical grants awarded on a competitive basis to states and other organizations for research and demonstration projects for responsible fatherhood and healthy marriage initiatives. These funds are in addition to block grant funds to the states which also may be used for these types of activities.

Proposed Option

The Secretary of Health and Human Services (HHS), in consultation with the Secretary of Labor, shall make competitive awards for research and demonstration projects to provide disadvantaged parents with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

Grants would be awarded to States, Localities, Indian Tribes and Tribal Organizations, Higher Education Institutions, Community Based Organizations, and local Workforce Investment Boards. Grantees that are not state TANF agencies would be required to consult and coordinate with state TANF agencies. Grantees who are not local Workforce Investment Boards (WIBs) would be required to consult and coordinate with both the local and state WIB.

Low-income parents would receive financial aid, child care, case management, and other supportive services. Aid would not be considered “assistance” for purposes of TANF requirements. Projects may also provide incentive payments to participants for meeting interim training goals. To assess the effectiveness of these programs, grantees will be required to report on their programs’ participants and HHS will be required to make reports to Congress. The Committee is continuing to review the appropriate funding level for these grants and looks forward to input on this topic.

Proposal on Development of a National Workforce Strategy

Current law

In the Department of Health and Human Services, the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) play key roles in supporting workforce development and training.

In CMS, the Medicare program provides an important funding source for graduate medical education through two distinct payments made to teaching hospitals. Medicare makes direct graduate medical education (DGME) payments to compensate teaching hospitals for costs directly related to residency programs, such as residents’ stipends and benefits and the costs associated with supervisory physicians. These payments are made based on the number of residents and the hospital’s proportion of Medicare inpatient caseload. Medicare also makes indirect medical education (IME) payments to compensate hospitals for costs indirectly associated with medical education, such as higher patient costs and other costs associated with teaching hospitals. These payments are based on a hospital’s intern/resident to bed (IRB) ratio along with a national adjustment factor.

At HRSA, a number of health care workforce programs authorized by Title VII and Title VIII of the Public Health Service Act are administered. HRSA is also the primary federal agency that collects health care workforce data and is responsible for tracking national trends. HRSA is comprised of six bureaus: The Bureau of Primary Health Care, The Bureau of Clinician Recruitment and Service, The Bureau of Health Professions, The Maternal and Child Health Bureau, The HIV/AIDS Bureau, The Healthcare Systems Bureau. The Bureau of Clinician Recruitment and Service and The Bureau of Health Professions focus on all levels of medical education, including undergraduate education, undergraduate medical education, and graduate medical education. HRSA is also responsible for certifying communities as Health Professional Shortage Areas (HPSAs), which take into account factors such as the prevailing rate of poverty and infant mortality; the number of physicians per 1,000 residents; and travel distances to nearest available care. HPSA designations determine eligibility for a number of federal workforce programs, including the National Health Service Corps, Nursing Education Loan Repayment Program and Rural Health Clinic Certification. In addition, HRSA is supported by four health profession committees that advise the agency on various workforce issues. These committees include the National Advisory Committee on Nursing Education and Practice; Advisory Committee on Interdisciplinary and Community Based Linkages; Advisory Committee on Training in Primary Care Medicine and Dentistry; and the Council on Graduate Medical Education.

Proposed Option

Several studies and policy experts have called for a renewed effort to develop a comprehensive and coordinated national strategy to address workforce shortages and encourage training in key focus areas that support delivery system reform goals, such as improving care coordination, health provider use of health information technology and increasing access to primary care services.

Some recommendations have called for the establishment of a national health workforce commission that would be tasked with advising Congress and the Secretary on health care workforce policy and recommendations. Others have promoted, at minimum, a need to provide additional resources to support the workforce-related activities of CMS and HRSA and to encourage increased collaboration among these agencies. As part of this, Secretary should be directed to work with external stakeholders to develop and set forth a national workforce strategy that will set the nation on a path toward recruiting, training and retaining a health workforce that meets our nation's current and future health care needs.

The Committee looks forward to working in cooperation with the Senate Committee on Health, Education, Labor and Pensions to further explore and develop policies in this area.

Section IV: Medicare Advantage – Options to Promote Quality, Efficiency and Care Management

Linking Payment to Quality

Current Law

The Medicare statute requires Medicare Advantage (MA) plans to report certain quality measures to CMS on an annual basis in order to participate in Medicare. Preferred provider organizations were allowed to submit fewer measures than HMOs, and private fee-for-service plans were exempt altogether. But the Medicare Improvements for Patients and Providers Act of 2009 (MIPPA) required that all MA plans (including private fee-for-service plans) report quality measures beginning 2010. The quality measures include HEDIS and HOS measures developed by NCQA. These measures address a range of health issues—such as how well MA plans care for patients with asthma, heart attacks and diabetes. Some measures of health outcome, such as blood sugar control for diabetics, are also included. In addition, CMS collects consumer satisfaction information from Medicare beneficiaries who are enrolled in MA plans.

In 2006, CMS began compiling these measures into 5-star ratings of MA and prescription drug plans to report overall plan performance. CMS publishes the 5-star ratings of MA plans in the *Medicare&You* Handbook and the web-based plan finder tool to give Medicare beneficiaries better information to choose among plans. CMS also uses plan ratings for oversight and monitoring purposes to ensure plan quality.

Although MA plans report quality measures and CMS' plan ratings are publicly available, the measures and the ratings are not used to provide financial incentives to MA plans to improve quality of care. This differs from the traditional Medicare program in which a number of financial incentives and penalties are used to encourage hospitals and physicians to improve health care quality. For example, under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, acute-care hospitals that do not successfully report on a series of designated quality measures will see a two-percentage-point reduction in their annual market basket update. For FY2010, hospitals will have to report on 42 measures including clinical processes linked to better quality and coordination of care for patients with chronic disease, and various patient safety indicators.

Proposed Option

Under any proposed payment option, some portion of payment to MA plans should be tied to performance on quality measures. As previously mentioned, current law already requires MA plans to

report on certain quality measures on an annual basis in order to participate in the Medicare program. These measures are recognized by the NCQA, a national, independent accrediting body. CMS compiles performance on these measures, along with consumer satisfaction data, into a 5-star ranking system. This widely available ranking system could be used to determine a portion of MA payments so that higher ranked MA plans receive an increase compared to lower ranked plans.

Developing a More Efficient Payment Structure

Current Law

Section 1853 of the Medicare statute requires the Secretary to calculate benchmark payment rates each year for MA plans for each county of the country (and the territories). Payments to MA plans are determined annually by the Secretary by comparing MA plan bids to the statutory benchmark rates. MA plans submit bids representing their estimated costs for providing the benefits that are covered under Medicare Parts A and B. The bid amount includes their estimated total costs of delivering benefits, as well as profit and administrative costs, sales and marketing and care management activities. (MA plans also submit separate bids to cover the benefits under Part D.) The statutory benchmarks are updated each year by CMS's projection of per capita growth in Medicare spending.

If a MA plan bid is equal to or above the benchmark, its payment is the benchmark, and it must charge an enrollee premium equal to the difference between the bid and the benchmark. If a MA plan bid is below the statutory benchmarks, its payment is its bid. In addition, MA plans that bid below the MA benchmarks are paid 75 percent of the difference between their bids and the benchmarks. Thus, the total payment to an MA plan that bids below the statutory benchmark is equal to its bid plus 75 percent of the difference between its bid and the benchmark rate.

Beginning in 2011, certain MA plans will also be eligible for incentive payments if their physicians and hospitals are meaningful users of electronic health records (EHRs). The Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act (ARRA), authorized Medicare incentive payments and penalties to encourage physicians and hospitals to adopt and use EHRs. The same EHR incentive payments and penalties also apply to certain eligible physicians affiliated with MA organizations that function as an HMO, and to hospitals that are under common corporate governance with a qualifying MA organization and serve enrollees in an MA plan offered by the organization.

Proposed Options

The Committee will consider modifying current MA benchmarks in order to encourage MA plans to provide Medicare covered benefits more efficiently and to promote improvements in quality of care. The goal should be to allow high quality, efficient MA plans to participate in Medicare in a cost effective manner.

The Committee will explore several approaches to modifying the MA benchmark formula. The options will have different distributional impacts on Medicare spending and beneficiary access to plans. Examples of options are described more fully below.

Approach 1: Modify Current Benchmarks

Blend Benchmark Rates. The Committee could consider an option, presented at a recent MedPAC meeting, to blend local and national fee-for-service spending rather than move the benchmarks to 100 percent of local fee-for-service. In this option, beginning in 2012, the Secretary would set MA benchmarks as a blend of the local (county-level) per capita spending in traditional Medicare (75 percent) and the national average per capita spending in traditional Medicare (25 percent). This option would be phased-in over three years. All other components of MA payment, bidding and extra benefits would be maintained as under current law.

This option would lower MA benchmarks in each county and, according to analyses conducted by MedPAC, also move them closer to the costs that plans bid to provide Medicare benefits. The impact of this option would vary significantly by geographic area. In areas where local fee-for-service spending is low, the blended benchmarks would be slightly higher than local fee-for-service but in many cases fall below where plans are able to bid. This means MA plans in low spending areas would have to reduce their costs in order to keep their bids below the blended benchmarks. In areas where local fee-for-service spending is high, blended benchmarks will be lower than local fee-for-service but benchmarks would still remain above where plans are able to bid today. This means that MA plans in high spending areas would not have to lower their costs to ensure their bids are below the blended benchmarks. As result of this option, MA benchmarks would more closely reflect local patterns of fee-for-service spending and utilization of care than they do today.

Benchmark Reduction and Gradual Phase-Down. The Committee could also consider the option of a gradual reduction to Medicare Advantage (MA) benchmarks through a combination of across-the-board reductions and phase-downs to a target ratio for counties in which rates most exceed local fee-for-service (FFS) expenditures. The goal of this option would be to reduce MA county rates in a manner that recognizes the wide geographic variation in local fee-for-service costs across the country and mitigates any negative impact on beneficiary premiums and benefits. Under this option, in 2011, all geographic areas would be subject to a one percent across-the-board reduction in their annual growth update. Starting in 2012, rates in counties with high MA-to-FFS expenditure ratios (above 120 percent) would be reduced by phasing down ratio levels so that, by 2014, the MA-to-FFS expenditure ratio in these counties would equal 120 percent. These are areas where underlying Medicare fee-for-service expenditures are generally lower than the national average and include many rural counties and some urban areas. Counties with ratios between 101-120 percent, which are generally more urban areas, would have rates reduced by applying a 2 percent reduction in their annual growth rates in 2012, 2013, and 2014. Areas with ratios at 100 percent of FFS, which include counties with high fee-for service expenditures, would receive 1 percent growth rate reductions during this same time period. Finally, MA plans that do not utilize certain practices, including health information technology (HIT), pay-for-performance, and emphasizing primary care and wellness, would receive an additional 2 percent reduction in plan payments between 2011 and 2014.

Approach 2: Set Benchmarks Based on Plan Bids

Competitive Bidding Based on Policy in the President's Budget. The Committee could also consider a competitive bidding option in which the Secretary would not set benchmark rates per statute. MA benchmarks would be established by MA plan bids for Parts A and B benefits. This method is similar to the way private plans are currently paid under Part D. Under this option, beginning in 2012, MA benchmarks would be set as the enrollment-weighted average of MA plan bids in each county or geographic area. All MA plans would be paid the new benchmark. MA plans bidding below the new

benchmark would keep 100 percent of the difference between their bid and the benchmark to provide extra benefits, reduce cost sharing, and reduce premiums to their enrollees. As under current law, MA plans that bid above the benchmark would be paid the benchmark and required to charge a supplemental premium to their enrollees. The new benchmarks would be capped at the current MA benchmarks so that new benchmarks could not exceed current levels. This provision would be phased-in over three years.

According to CBO, this option would reduce the amounts paid for enrollees in Medicare Advantage to the levels determined by the MA plan bids. This option might also encourage MA plans to compete more strongly on the basis of price and quality, rather than on the level of extra benefits as they do today. The new benchmarks would be independent from local fee-for-service spending and thus allowed to fall above or below current fee-for-service rates. However, MA plan bids in all parts of the country would be expected to compress tightly around the local area averages. This would mean plans would have few extra benefits to make available at no charge to beneficiaries. MA plans would still be allowed to offer extra benefits relative to traditional Medicare, but they may have to charge premiums.

Competitive Bidding with Bonus Payments. The Committee could also modify competitive bidding to include a phase-in and reward plans that meet certain standards. This approach could establish benchmarks based on MA plan bids for the Parts A and B benefits, as described above. However, beginning in 2012, MA benchmarks would be set as the enrollment-weighted average of MA plan bids in each county or geographic area. The new benchmark would be phased in over 3 years beginning in 2012. In 2012, 67 percent of the benchmark would be based on current law, and 33 percent would be based on plan bids. In 2013, 33 percent of the benchmark would be based on current law, and 67 percent would be based on plan bids. In 2014, the benchmark would be based entirely on MA plan bids for each county.

In addition, competitive bidding would be coupled with financial incentives for plans to implement evidence-based chronic care management programs (as described below) and achieve quality improvement targets mentioned earlier. The added payments would be designed to mitigate pressure on MA plans to compress their bids by reducing activities that improve quality or manage the care of their enrollees. The administrative costs for managing chronic care and improving quality would continue to be included in plan bids. The added payments would be used to offer extra benefits to Medicare beneficiaries who enroll in their plans (as described below).

Pay for Chronic Care Management

Current Law

Current payments to MA plans are risk-adjusted. CMS uses characteristics, such as age, sex, disability status and prior health history to estimate the relative risk of each beneficiary enrolled in a plan. MA plans are paid their base amount (their bids plus 75 percent of any difference between their bids and the benchmarks) adjusted by their enrolled beneficiaries' risk scores. If MA plans enroll beneficiaries with higher costs, they receive an additional payment that gives them more resources to manage the higher costs of treating sicker enrollees. If MA plans enroll beneficiaries with lower costs, their base amount is adjusted downward to reflect the lower cost of covering healthier beneficiaries.

Other than risk adjusting payments, the statute does not contain explicit financial incentives for MA to manage or coordinate care for high cost, chronically ill Medicare beneficiaries.

Proposed Option

In addition to maintaining the current risk-adjusted payment model, the Committee could consider proposals to pay plans a bonus for chronic care management along with competitive bidding. Plans would be eligible for added payments if they manage chronic care in an effective manner. The bonus payments would be designed to mitigate pressure on MA plans to compress their bids by reducing activities of managing and coordinating care. Bonus payments would be available to MA plans that have evidence-based programs to manage the care of chronically ill beneficiaries. The amount available would be based on plan activities and performance targets, as specified below.

Plans that conduct certain activities or meet or exceed specified performance targets would be eligible for bonus payments. There are many ways to design bonus payments for chronic care. One way would be to make an additional payment of 3 to 5 percent of Medicare's national average (fee-for-service) monthly per capita cost. For example, plans could earn 1 to 2 percent for conducting certain care management activities—like having a medical home, gain sharing with their primary care providers. Plans could earn another 1 or 2 percent for meeting or exceeding quality improvement targets. While bonus payments would not be available until the new benchmarks are fully phased in, the following is an example from 2009 to illustrate the proposed bonus payments. In 2009, the national average monthly Medicare cost was \$741. If this option were implemented in 2009, MA plans would be eligible to receive an additional \$22 to \$37 per enrollee per month. This would be a flat amount available across all areas of the country and would not depend on a plan's bid, the benchmark or service area. It would depend solely on how the plan performed.

Simplify Extra Benefits

Current Law

The Medicare statute requires that MA plans use the amount of any difference between their bids and benchmarks to offer extra benefits relative to those covered under Medicare Parts A and B. The amount and type of extra benefits that can be offered by MA plans varies widely by geographic area. Plans have flexibility when determining the extra benefits, reduced cost sharing or reduced premiums to be offered along with the basic A/B benefit package. Plans can use the difference to cover benefits not available under traditional Medicare (such as eyeglasses), reduced cost sharing relative to traditional Medicare (such as \$10 copays for physician visits), reduce Part B premiums, or reduce Part D premiums and cost sharing. Plans are allowed to cover the entire amount of the Part B premium (\$96.40 in 2009). Only plans in certain areas of the country can buy down the entire Part B premium because the benchmarks in those areas are high. Plans cannot offer enrollees further cash rebates. These extra benefits are paid for entirely by the Medicare program at no additional cost to Medicare beneficiaries that enroll in MA plans.

Proposed Option

The Committee could also consider reducing the amount of variation in the amount and type of extra benefits offered by MA plans and funded by Medicare payments (i.e., at no charge to beneficiaries). Moreover, the ability to offer extra benefits could be linked to plan performance and not solely dependent on how high the MA benchmarks are set. Currently, plans in areas with high benchmarks can offer \$200-\$300 per month in extra benefits. Plans in areas with low benchmarks can offer \$0-\$10 per month in extra benefits. In addition, MA plans have wide discretion in how they allocate extra benefits. The Committee could explore ways of simplifying the amount and type of extra benefits that can be offered by MA plans.

One option is to require MA plans that can offer extra benefits with their bonus payments to do so in the following priority: (1) set a maximum limit on beneficiary out-of-pocket copayments, (2) reduce Parts A/B cost sharing, and (3) add new benefits, like eyeglasses, dental coverage, and gym memberships. Plans could also be disallowed from buying down the Part B or D premiums. Plans could also be limited in making cost sharing for Part A/B covered benefits higher than those under traditional Medicare. In other words, plans could not offer worse cost sharing than traditional Medicare. Plans could still be allowed to impose some cost sharing where there is none under traditional Medicare, such as for home health, or some laboratory services.

Section V: Public Program Integrity - Options to Combat Fraud, Waste and Abuse

Provider Screening

Current Law

The Social Security Act provides the Secretary of Health and Human Services (HHS) with general authority to prescribe regulations for the efficient administration of the Medicare program. Under this authority, the Centers for Medicare & Medicaid Services (CMS) has implemented regulations requiring providers and suppliers to submit information to enroll in the Medicare program and receive billing privileges. As part of the enrollment process, providers and suppliers are required to submit information necessary to verify identity and state licensure. CMS reserves the right to perform on-site inspections of a provider or supplier to verify compliance. If enrollment requirements are not met, CMS may revoke Medicare billing privileges. Providers and suppliers must resubmit and recertify the accuracy of their enrollment information every five years. CMS may deny a provider's or supplier's enrollment in Medicare or revoke a provider's billing privileges for the following reasons: non-compliance with enrollment requirements, exclusion from participation in federal health care programs, conviction of a felony, or the submission of false or misleading information on the enrollment application.

CMS manual instructions require that Medicare contractors query the following databases prior to approving an application for enrollment in Medicare: Qualifier.net, the Medicare Exclusions Database (List of Excluded Individuals/Entities or LEIE), and the Government Services Administration (GSA) debarment list. In a 2003 program transmittal, CMS mandated that contractors stop querying the Healthcare Integrity and Protection Data Bank (HIPDB) (discussed subsequently) when providers enroll in the program because, the transmittal stated, the HIPDB is not cost effective and duplicates other efforts.

Proposed Option

Medicare program applications for all providers and suppliers would be evaluated before billing privileges would be granted. The Secretary would determine the level of screening according to assessed risk of providers' noncompliance with statutory and programmatic requirements. This may include submission of fingerprints, investigation of criminal background, licensure checks, unannounced site visits, and multistate database inquiries. Provider and supplier application fees would be imposed to cover the costs of screening. Applicants would be required to disclose previous affiliations with enrolled entities that have uncollected Medicare or Medicaid debt. A provisional participation agreement of six to 12 months would be granted during which some new providers and suppliers would be subject to enhanced oversight, such as prepayment review and payment limitations.

The Secretary would be authorized to require surety bonds of up to \$500,000 (commensurate with the size of the business) and to impose moratoria on the enrollment of new providers as determined to be necessary to prevent or combat fraud. The Secretary could deny participation outright on the basis of undue risk caused by affiliations. Permissive exclusions and/or civil monetary penalties would be established for false statements on provider or supplier enrollment applications.

Data Base Creation and Data Matching

Current Law

Under the Social Security Act, the Secretary of HHS is required to establish a Medicare Integrity Program (MIP) and to contract with organizations to provide a range of services to facilitate the identification of fraud, waste, and abuse in the Medicare program. MIP activities can include cost report auditing, recovery of improper payments, provider education, and data matching between Medicare and other public programs, including state Medicaid programs through the Medicare-Medicaid data matching program. In addition, CMS is required to share data with the Internal Revenue Service (IRS) and the Social Security Administration (SSA). The CMS/IRS/SSA data matching program is used to determine if beneficiaries or their spouses have other health insurance that should pay some or all of Medicare beneficiaries' health care claims.

Medicaid laws require Medicaid program integrity and related fraud and abuse activities at the state level. Medicaid program integrity activities include auditing, identifying federal overpayments, education and training, referring cases of suspected fraud and abuse to Medicaid Fraud Control Units, disclosure of ownership and control information, and development and maintenance of Medicaid Management Information Systems (MMIS computer systems) capable of supporting a full range of fraud and abuse activities, as well as coordination with the Medicare program. States also must operate eligibility determination systems that support data matching through the Public Assistance Reporting Information System (PARIS). Using PARIS, states are able to identify individuals who are receiving benefits under public programs in neighboring states. Additionally, the Secretary is required to establish a Medicaid Integrity Program (MIP) and contract with vendors to provide services to identify fraud, waste, and abuse. States are required to have false claims statutes that are consistent with the federal False Claims Act.

The Social Security Act also requires the Secretary to develop and maintain a national health care fraud and abuse data collection program for the reporting of adverse actions taken against health care providers or suppliers. The HHS Office of the Inspector General (OIG) issues regulations implementing the Healthcare Integrity and Protection Data Bank (HIPDB). The statute requires the following types of health care related adverse actions be reported to the HIPDB: civil judgments; federal or state criminal convictions; actions taken by federal or state licensing agencies; and provider exclusions from Medicare and Medicaid. Only final adverse actions are reportable to the HIPDB. Administrative fines, citations, corrective action plans, and other personnel actions are not reportable except under certain circumstances. Settlements, in which a finding of liability has not been established, are also not reportable. Both federal and state government agencies as well as health plans are required to report to the HIPDB. Health plans that fail to report are subject to a civil monetary penalty of \$25,000. The Secretary is required to publish a report identifying government agencies that fail to report to the HIPDB. HIPDB cannot duplicate the reporting requirements established for the National Practitioner Data Bank.

Title IV of the Health Care Quality Improvement Act of 1986, as amended, established the National Practitioner Data Bank (NPDB). The NPDB collects and releases data related to the professional competence of physicians, dentists, and certain health care practitioners. The types of information

included in the NPDB are medical malpractice payments, certain adverse licensure actions, adverse clinical privileging actions, adverse professional society membership actions, and exclusions from Medicare and Medicaid. The statute defines the entities eligible to report and query the databank. Malpractice payers that fail to report are subject to a civil monetary penalty. Section 1921 of the Social Security Act expanded the scope of reporting requirements for the NPDB to encompass additional adverse licensure actions and actions taken by state licensing and certification agencies, peer review organizations, and private accreditation organizations. Section 1921 also required that actions taken against all health care practitioners be included in the databank. States are required to have a system for reporting adverse actions to the NPDB. A final rule implementing section 1921 has not yet been promulgated.

With respect to existing quality data reporting requirements, the Social Security Act and CMS regulations require multiple facilities to publicly report on certain quality of care measures, including hospitals, home health agencies, nursing homes, and dialysis facilities. Moreover, most states mandate a variety of professionals to report known or suspected cases of elder abuse; however, state laws vary as to who is a mandated reporter and who is encouraged to report incidents of elder/adult abuse.

The Federal Food Drug and Cosmetic Act (FFDCA) requires user facilities (*e.g.*, hospitals and nursing homes) to report specified adverse events involving medical devices to the HHS Secretary. The FFDCA also requires manufacturers of products such as prescription drug and biological products, medical devices, nonprescription drugs, and dietary supplements to report certain adverse events to the Secretary. The National Childhood Vaccine Injury Act requires voluntary adverse reports to be collected from the public, and mandatory reports from manufacturers and some others. The FDA generally collects voluntary reports via Medwatch and mandatory reports in accordance with product-specific regulations. The agency has also launched the Sentinel Initiative with the goal of creating a national, integrated, electronic system for monitoring medical product safety.

Proposed Option

A new comprehensive “One PI” database would be required of CMS, including specific benchmarks and implementation deadlines. The One PI database would expand existing program integrity data sources and expand data sharing and matching across federal and state Medicaid claims and payment data, including HHS, SSA, the Departments of Veterans Affairs (VA), Defense (DOD), and Justice (DOJ), and the Federal Employees Health Benefit Program (FEHBP). The One PI database would enable existing and new data sources to be integrated, such as: (1) quality-of-care under fee for service, managed care, and waivers; (2) Medicaid encounter data; (3) health plan performance; (4) ownership, control, and business relationships; (5) survey and certification; (6) resident/patient neglect or abuse; (7) adverse actions; (8) site visits; (9) penalties and settlements; and (10) data on results from other program monitoring.

The existing provider databases (HIPDB, NPDB, and LEIE) would be expanded and consolidated with a national patient abuse/neglect registry into a centralized sanctions data system. This data system would include information on providers in Medicare and all state Medicaid programs, including provider ownership and business relationships, history of adverse actions, results of site visits or other monitoring by any program. Additional reporting of facility-specific quality-of-care data would be required. Data on the fraud settlements that occur during the year would be reported to the consolidated database. State licensure boards and federal and state law enforcement agencies would be able to access the data. The Medicare and Medicaid programs would be required to verify any applicant’s status in the provider database prior to issuing provider/supplier numbers.

The One PI database would be accompanied by additional authority for appropriate agencies (such as OIG and DOJ) to use these data, including secondary data sources, to identify and investigate potential fraud and abuse, including by coordination of benefits, workers' compensation, auto insurance, and private health/life insurance. New civil penalties would be authorized for instances of intentional fraud and abuse, as well as new sanctions to be imposed on entities that failed to submit necessary data. Failure to report Medicaid encounter data would result in a reduction of federal financial participation available under title XIX of the Social Security Act.

CMS and OIG would be authorized to access all supporting documentation needed to validate Medicare claims and/or payments, including beneficiary medical records of prescribing physicians for prescription drugs paid for through Medicare Part D.

Provider Compliance and Penalties

Current Law

Conditions of Participation and Coverage. The Social Security Act mandates the establishment of minimum health and safety standards that providers (hospitals, hospices, nursing homes, and home health agencies) and suppliers participating in the Medicare and Medicaid programs must meet in order to receive payment. Generally, state agencies, under contract with CMS, survey providers and certain suppliers to determine compliance with the conditions or standards set forth in the statute and regulations. Alternatively, a provider can be deemed to meet these requirements if it has been accredited by an approved national accreditation body which has demonstrated that its inspection program ensures that all applicable conditions are met or exceeded. CMS has the authority to conduct a survey of an accredited provider or supplier to validate its organization's accreditation process. These surveys are conducted on a representative sample basis, or in response to substantial allegations of noncompliance. The remedies available to CMS when a provider is found noncompliant with Medicare's health and safety standards include revoking the provider's participation agreement, denying payment, requiring a corrective action plan, and imposing certain penalties.

Program Sanctions. Under Medicare's peer review or Quality Improvement Organization (QIO) program, the Secretary has the authority to impose sanctions on providers participating in Medicare for noncompliance. Health care providers that receive Medicare payment are required to provide services that are both medically necessary and economically efficient. Medicare providers and suppliers are also required to provide services that meet professionally recognized standards of care. If a QIO finds that a provider has failed in a substantial number of cases to meet these requirements, or has committed a gross violation of care, the Secretary may exclude the provider from participating in federal health care programs. The Secretary may also impose a fine of up to \$10,000 for each instance of medically improper or unnecessary care.

Payment Suspension. CMS and its contractors have the authority to withhold payment in whole or in part if there is reliable evidence of an overpayment or fraud. CMS regulations stipulate the procedures CMS and its contractors must follow when deciding to suspend payment.

Deterrence/Civil and Criminal Penalties. OIG is authorized to impose civil penalties on any person, including an organization, agency, or other entity, that knowingly presents or causes to be presented to a federal or state employee or agent certain false or fraudulent claims. A penalty of not more than \$15,000 may be assessed against individuals that knowingly give false or misleading information to influence the decision when to discharge such person or another individual from a hospital. Entities that are excluded from Medicare or Medicaid but retain an ownership or control interest in a participating entity may be

civilly fined not more than \$10,000 per day. Civil monetary penalties (CMPs) of not more than \$50,000 may be levied against individuals that knowingly and willfully make false statements or receive kickbacks in connection with reimbursement from a federal health program. An individual or entity excluded from a federal health care program that submits a claim for reimbursement to a program, or causes such a claim to be submitted, may be subject to a civil monetary penalty of up to \$10,000 for each item or service furnished during the period that the person or entity was excluded. The individual or entity may also be subject to treble damages for the amount claimed for each item or service. The Secretary may issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence at an investigational inquiry. The Secretary may also delegate this authority to OIG for purposes of any investigation under the civil monetary penalties statute.

The False Claims Act provides penalties for submitting a false claim for payment or approval to an officer or employee of the federal government. Violations may be punished with a civil monetary penalty between \$5,000 and \$10,000, plus treble damages.

The Emergency Medical Treatment and Active Labor Act (EMTALA) imposes a duty on Medicare participating hospitals with an emergency department to provide an initial screening examination, and any necessary stabilizing treatment, to individuals that come to the emergency department and request assistance. Violations of EMTALA by hospitals may be punished with a civil monetary penalty of not more than \$50,000 (\$25,000 in the case of hospitals with fewer than 100 beds). Violations by physicians may be punished with a civil monetary penalty of not more than \$50,000.

Under the Health Insurance Portability and Accountability Act (HIPAA), it is illegal for anyone to willfully prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a "federal health care offense." Section 241 of HIPAA defines "federal health care offense" as a number of criminal acts related to health care under the federal criminal code.

Program Exclusions. OIG has the authority to exclude health care providers from participation in federal health care programs. Exclusions from federal health programs are mandatory under certain circumstances and permissive in others. Exclusion is mandatory for those convicted of certain offenses, including (1) a criminal offense relating to the delivery of an item or service under Medicare, Medicaid, or a state health care program; (2) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service; or (3) a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. OIG has "permissive" authority to exclude an entity or an individual from a federal health program under numerous circumstances, including conviction of certain misdemeanors relating to fraud, theft, embezzlement, breach of fiduciary duty or other financial misconduct; a conviction based on an interference with or obstruction of an investigation into a criminal offense; and revocation or suspension of a health care practitioner's license for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

Generally, in the case of a mandatory exclusion, the minimum period of exclusion cannot be less than five years. However, upon the request of the administrator of a federal health care program who determines that the exclusion would impose a hardship on individuals entitled to benefits under Medicare Part A or enrolled under Medicare Part B (or both), the Secretary may waive the exclusion under certain circumstances with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.

Section 1128 of the Social Security Act provides that any individual or entity that is excluded (or directed to be excluded) from participation in a federal health care program is entitled to reasonable notice and opportunity for a hearing by the Secretary, as well as judicial review of the Secretary's final decision after

such hearing. This section also provides that an exclusion is effective at such time and upon such reasonable notice to the public and to the individual or entity excluded, as may be specified in regulations. However, unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under Medicare or under a state health care program for—(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or (ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion, until the passage of 30 days after the effective date of the exclusion. Further, unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination based on certain false claims, kickbacks, and other prohibited activities is entitled to a hearing by an administrative law judge before any exclusion based upon the determination takes effect.

Proposed Option

As a condition of participation, Medicare and Medicaid providers would be required to implement compliance programs. Intermediate sanctions and program safeguards would be established to provide greater flexibility to CMS and law enforcement to address problems. Payments could be suspended during an investigation.

The CMP law would be amended in several instances to increase monetary penalties and extend use of CMPs. A CMP would be established for each instance of a hospital's failure to report an adverse action affecting the clinical privileges of a physician. The CMP law (at section 1128A(a)(5) relating to beneficiary inducements), would be amended to tailor the prohibition to address harmful conduct and relieve the burden on certain charitable and other innocuous programs currently covered by the broad reach of the statute. The imposition of a CMP would be authorized on an excluded person who orders or prescribes (rather than directly furnishes) items or services reimbursed by federal health care programs.

Penalties for submitting false claims and for violations of EMTALA would be increased. Criminal offenses of the Social Security Act (section 1128B) would be defined as "federal health care offenses." The testimonial subpoena authority would be extended to program exclusion investigations.

Section 1128(c)(3)(B) would be amended to clarify that hardship waivers of an OIG exclusion can be based on hardship imposed on beneficiaries of any federal health care program.

Program Integrity Funding and Reporting Requirements

Current Law

Medicare program integrity and anti-fraud activities are funded through the Health Care Fraud and Abuse Control (HCFAC) and, as mentioned earlier, MIP. HCFAC and MIP were both established by HIPAA, 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.

The purpose of the HCFAC program, which is jointly administered by HHS and DOJ, is to coordinate federal, state, and local law enforcement efforts directed at controlling health care fraud and abuse. To fund the program, HIPAA established within the Hospital Insurance (HI) Trust Fund (Part A) an expenditure account called the HCFAC account. All monies collected from health care investigations and enforcement efforts are to be deposited into the HI Trust fund. The HCFAC account funds anti-fraud

activities conducted by HHS, the HHS OIG, DOJ, and the Federal Bureau of Investigation (FBI). MIP authorizes the Secretary to contract with private entities to conduct the following six activities: (1) medical review; (2) audits of cost reports; (3) Medicare Secondary Payer determinations; (4) provider education; (5) developing and updating a list of items of DME that are subject to prior authorization; and, as mentioned earlier, (6) the Medicare-Medicaid Data Match Program.

Funding for HCFAC increased from \$176 million in FY1998 to \$376 million in FY2008. The Tax Relief and Health Care Act of 2006 (TRHCA) extended and increased the mandatory annual appropriation for HCFAC to 2010. Funding for MIP increased from \$440 million in FY1998 to \$820 million in FY2006. The Deficit Reduction Act of 2005 (DRA) increased funding for the MIP program by \$112 million for FY2006 to implement program integrity and oversight activities for the prescription drug benefit. TRHCA, however, did not increase funding for MIP, so the annual appropriation for MIP remains at \$720 million. Between fiscal years 1998 and 2008, total funding for program integrity and health care fraud activities increased from an estimated \$0.7 billion to \$1.1 billion.

Every year, HHS and the DOJ are required to release a joint annual report to Congress on HCFAC results and accomplishments. These reports include numbers and examples of enforcement actions, program accomplishments, and amounts deposited into the HI Trust Fund resulting from health care fraud enforcement activities. Congress did not require that HHS and DOJ include expenditures or results for the MIP program in these reports.

Established by the DRA, the Medicaid Integrity Program (MIP) is modeled after Medicare's MIP program. MIP provides HHS with dedicated resources to promote Medicaid integrity, to contract with entities to reduce fraud, waste, and abuse, and to add 100 full-time equivalent MIP staff. Annual MIP reports to Congress on program accomplishments and use of funds are required. In addition, the Secretary is required to develop comprehensive five-year plans for Medicaid program integrity.

Proposed Option

HCFAC funding would be increased to allow HHS and DOJ to engage in more of the integrity activities allowed in that program.

With respect to both MIPs, annual reporting requirements would be enhanced and harmonized by expanding the program evaluation requirements for the Medicare Integrity Program. This would allow for more meaningful assessment of the Medicare and Medicaid Integrity Programs.

Description of Policy Options

**Expanding Health Care Coverage:
Proposals to Provide Affordable Coverage to All Americans**

Senate Finance Committee
May 14, 2009

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Senate Finance Committee

Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans

The U.S. is the only developed country that does not guarantee health coverage for all its citizens, with 46 million uninsured and another 25 million underinsured. Today, the cost of caring for the uninsured is largely borne by those with insurance; providers charge higher prices to patients with private coverage to make up for uncompensated care, and these costs are passed on to consumers in the form of increased premiums. A high-performing health system would guarantee all Americans affordable, quality coverage regardless of age, health status, or medical history. This document outlines policy options for providing affordable health care coverage for all Americans.

Proposals included in this document would ensure that the insurance market functions effectively. Reforms proposed for the individual and small group markets would ensure a competitive insurance market in which plans compete on price and quality rather than on their ability to segment risk and discriminate against individuals with pre-existing health conditions. Proposals contemplated in this document would also make purchasing health insurance coverage easier and more understandable by establishing a gateway or marketplace where American consumers could easily compare and purchase the coverage that best fits their needs.

To ensure that coverage is affordable, this document outlines a proposal for targeted tax credits for low-income individuals and small businesses. And for the most vulnerable populations, policy options described here would improve public programs by covering those at the lowest end of the income scale who are least likely to have private coverage through an employer.

Once affordable, high-quality, and meaningful health insurance options are available to all Americans through their employer or the new gateway, individuals would have a personal responsibility to have health coverage. This step is necessary for insurance market reforms to function properly and to end the cost shifting that occurs within the system. It is expected that the vast majority of American employers would continue to provide coverage as a competitive benefit to attract employees.

Finally, this document outlines proposals to promote prevention and wellness services in public programs. By encouraging healthy behaviors, these policy options make a first step in moving our health system away from a focus on treating disease toward one focused on preventing disease.

This document and the options described in it are intended to spur discussion regarding proposed options for policies that the committee is scheduled to act on in June. While these proposed options are jointly offered for discussion, not all the options in this document have the support of Chairman Baucus or Ranking Member Grassley.

SECTION I: Individual Market Reforms

Non-Group and Micro-Group Market Reforms

Current Law

There are no federal rating rules for the non-group market. However, some states currently impose rating rules on insurance carriers in the non-group market. Existing state rating rules restrict an insurer's ability to price insurance policies according to the risk of the person or group seeking coverage, and vary from state to state. Such restrictions may specify the case characteristics (or risk factors) that may or may not be considered when setting a premium, such as gender. The spectrum of existing state rating limitations ranges from pure community rating, to adjusted (or modified) community rating, to rate bands, to no restrictions. Pure community rating means that premiums cannot vary based on any individual characteristic. Adjusted community rating means that premiums cannot vary based on health, but may vary based on other risk factors, such as age.

Rate bands allow premium variation based on health or other factors, but such variation is limited according to a range specified by the state. Rate bands are typically expressed as a percentage above and below the index (or average rate). For example, if a state establishes a rate band of +/- 25%, then insurance carriers can vary premiums up to 25 percent above and 25 percent below the average rate. Both adjusted community rating and rate bands allow premium variation based on any other permitted case characteristic, such as gender. And for each characteristic, the state typically specifies the amount of allowable variation, as a ratio. For example, a 5:1 ratio for age would allow insurers to charge an individual no more than 5 times the premium charged to any other individual, based on age differences. As of December 2008, two states have pure community rating rules, five have adjusted community rating rules, and eleven have rate bands in the non-group market.

HIPAA established federal rules regarding guaranteed issue, guaranteed renewability, and coverage for pre-existing health conditions in the non-group market for certain persons eligible for HIPAA protections. HIPAA guarantees that each issuer in the non-group market make at least two policies available to all "HIPAA eligible" individuals, and renewal of non-group coverage is at the option of such individuals, with some exceptions. HIPAA also prohibits non-group issuers from excluding coverage for pre-existing health conditions for HIPAA eligibles. In addition, a number of states have enacted their own guaranteed issue and pre-existing condition exclusion rules. As of December 2008, 14 states require issuers to offer some or all of their non-group insurance products on a guaranteed issue basis, and 42 states reduce the period of time when coverage for pre-existing health conditions may be excluded.

Proposed Options

Federal Rating Rules. This proposed policy would impose federal rating, issue, and other rules for the non-group and micro-group (2-10 employees) market. Guaranteed issue and guaranteed renewal rules would be imposed (using the same rate adjustment factors used at issue) on all coverage offered in the non-group and micro-group market, and exclusion of coverage for pre-

existing health conditions would be prohibited. Rates in this market would vary based only on the following characteristics: tobacco use, age, and family composition. More specifically, premiums could vary by a certain ratio for each characteristic, as follows:

- Tobacco use not to exceed 1.5:1
- Age not to exceed 5:1
- Family composition
 - single 1:1
 - adult with child 1.8:1
 - family 3:1
 - two adults 2:1

Premiums could also vary among rating areas to reflect geography. Taking all permissible factors together, premiums could not vary by more than a 7.5:1 ratio.

Effective Date. The effective date for these changes could be January 1, 2013 (or sooner if possible), which would provide states sufficient time to enact legislation by June 1, 2011. This schedule anticipates that plans could develop offerings by June 2012 and then begin marketing.

Risk-Adjustment. The Secretary would be required to implement a system for risk adjustment comparable to that used for adjusting Medicare payments to private plans. (In general, Medicare payments to Medicare Advantage 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.)

Under this option, both new market plans and grandfathered plans (described below) would be subject to a collective system of risk adjustment for a combined pool. The Secretary could either administer the risk adjustment system or require the states to do so. The Secretary and states may choose to collaborate with insurers in developing and administering the risk adjustment system.

Small Group Market Reforms

Current Law

There are no federal rating rules for the small group market. Similar to the non-group market, some states currently impose rating rules on insurance carriers in the small group market. As of December 2008, one state has pure community rating rules, eleven have adjusted community rating rules, and 35 have rate bands in the small group market.

HIPAA established federal rules regarding guaranteed issue, guaranteed renewability, and coverage for pre-existing health conditions for certain persons and groups. HIPAA requires that coverage sold to firms with 2-50 employees must be sold on a guaranteed issue basis. That is, the issuer must accept every small employer that applies for coverage. HIPAA also guarantees

renewal of both small and large group coverage at the option of the plan sponsor (e.g., employer), with some exceptions. And HIPAA limits the duration that coverage for pre-existing health conditions may be excluded for “HIPAA eligible” individuals with group coverage. In addition, a number of states have enacted their own guaranteed issue and pre-existing condition exclusion rules, sometimes exceeding federal rules. All states require issuers to offer policies to firms with 2-50 workers on a guaranteed issue basis and reduce the period of time when coverage for pre-existing health conditions may be excluded, in compliance with HIPAA. As of December 2008, 13 states also require issuers to offer policies on a guaranteed issue basis to self-employed “groups of one,” and 21 states had pre-existing condition exclusion rules that provided consumer protection above the federal standard.

As part of its comprehensive health reform plan, Massachusetts merged its small and non-group markets. The practical effect is that insurance risk is now spread across the larger combined pool, upon which premiums are determined.

Proposed Options

Federal Rating Rules. The same federal rating rules that apply to the non-group and micro-group markets would also apply to the remainder of the small group market (as defined by the state).

State Option to Merge Individual and Small Group Markets. At their option, states would merge the pooling and rating rules for the non-group and small group markets. (Generally, “pooling” refers to the spreading of insurance risk across a pool of people to determine the applicable premium.)

Health Insurance Exchange

Current Law

No specific provision in federal law. However, the Health Insurance Exchange concept is similar in some ways to the Massachusetts Connector, as described below for illustrative purposes.

In 2006, in tandem with substantial private health insurance market reforms, Massachusetts created the Health Insurance Connector Authority, governed by a Board of Directors, to serve as an intermediary that assists individuals in acquiring health insurance. In this role, the Health Connector manages two programs; the first is Commonwealth Care, which offers a government-subsidized plan at three benefit levels from a handful of health insurers to individuals up to 300 percent of the federal poverty level (FPL) who are not otherwise eligible for traditional Medicaid or other coverage (e.g., Medicare, employer-based coverage). The second is Commonwealth Choice, which offers an unsubsidized selection of four benefit tiers (gold, silver, bronze, and young adult) from six insurers to individuals and small groups. Under state law, the Board of Directors has numerous responsibilities, including: determining eligibility for and administering tax credits through the Commonwealth Care program, awarding a seal of approval to qualified

health plans offered through the Connector's Commonwealth Choice program, developing regulations defining what constitutes "creditable coverage," constructing an affordability schedule to determine if residents have access to "affordable" coverage and may therefore be subject to tax penalties if they are uninsured, and developing a system for processing appeals related to eligibility decisions for the Commonwealth Care program and the individual responsibility.

Proposed Options

Plan Participation. All state-licensed private insurers in the non-group and small group markets, and the public health insurance option if applicable, operating nationally, regionally, statewide, or locally would be required to participate in the Health Insurance Exchange. Private insurers would also be permitted to sell these policies directly to purchasers.

Small Employer Participation in the Health Insurance Exchange. Micro-groups (2-10 employees) could purchase insurance through the Health Insurance Exchange immediately. The remainder of small employers can purchase through the Health Insurance Exchange once the federal rating rules are fully phased in by their state, but they would have to pick only one of the four benefit levels (lowest, low, medium or high) for their contribution level.

The tax exclusion for employer-provided health insurance allowed under current law would continue to apply in a case where the small business opts to purchase through the Exchange. The small group health insurance policy would be deemed a "group health plan."

Establishment of Exchange. The Secretary would establish an Exchange that enables an individual to receive state-specific information. The Secretary could contract with a private entity to operate the Exchange.

Functions Performed by Secretary. The Secretary of Health and Human Services would be responsible for the following:

- After consultation with state insurance commissioners, develop a standard enrollment application for eligible individuals and small businesses seeking health insurance through the Exchange (both an electronic and paper version);
- Provide a standardized format for presenting insurance options, including benefits, premiums, and provider networks (allowing for customized information so that individuals could sort by factors such as ZIP code or providers);
- Develop standardized marketing requirements modeled after Medicare Advantage (CMS regulates the marketing activities of Medicare Advantage plans in order to protect beneficiaries from unscrupulous marketing practices). For example, marketing rules prohibit most unsolicited door-to-door and outbound sales calls to beneficiaries;
- Maintain call center support for customer service that includes multilingual assistance -- the center would have the ability to mail relevant information to residents based on their inquiry and ZIP code;

- Enable consumers to enroll in health care plans in local hospitals, schools, Departments of Motor Vehicles, local Social Security offices, emergency rooms, and any other offices designated by the state;
- Establish rate schedules for broker commissions (also currently done by CMS for Medicare Advantage plans);
- Establish a Web portal that directs individuals and small businesses to available insurance options in their state, provides a tax credit calculator so individuals and small businesses can determine their true cost of coverage, informs individuals of eligibility for public programs, and presents standardized information related to insurance options, including quality ratings;
- Establish a plan for publicizing the existence of the Exchange; and
- Establish procedures (which could be done through SSA, IRS or state Medicaid offices) for enabling:
 - enrollment of individuals and small businesses;
 - eligibility determinations for low-income tax credits;
 - appeals of eligibility decisions for tax credits;
 - appeals procedures for enforcement actions taken by the Department of the Treasury under the individual responsibility; and
 - annual certification upon request of a resident who has sought health insurance coverage through the Exchange, attesting that, for the purposes of enforcing the individual coverage requirement, no health benefit plan which meets the definition of creditable coverage was deemed affordable by the Exchange for that individual—and maintain a list of individuals for whom certificates have been granted

Exchange Related Functions Performed by State Insurance Commissioners. State Insurance Commissioners would establish procedures for review of plans to be offered through the Exchange and would develop criteria for determining that certain health benefit plans no longer be made available¹. They would also develop a plan to decertify and remove the seal of approval from certain health benefit plans.

Establishment of Multiple Exchanges. Another option would be to establish multiple, competing exchanges. The Secretary would still establish a national Exchange that enables the review of state-specific information and could contract with a private entity to operate the Exchange. Additionally, the Secretary would be required to accept and approve applications from private entities that demonstrate to the satisfaction of the Secretary that they have the capacity and expertise to carry out the required functions of an exchange and have submitted a proposal to the Secretary in such form and manner as the Secretary specifies. Multiple

¹ Under the proposed option, exchanges would be required to provide information on and facilitate enrollment in all plans offered by any issuer in an area. Individuals and small businesses may choose to either purchase plans through the exchange or go directly to an insurer or agent to purchase a plan, but all plans regardless of the point of sale must meet new rating and benefit requirements and individual tax credits will only be available to those purchasing through the Exchange. Insurance Commissioners would review all plans available by any issuer in an area to ensure they meet the new benefit and rating requirements.

exchanges may be permitted to operate in the same geographic area. Insurance carriers could not operate as exchanges or selectively participate in one of the multiple exchanges. The Secretary could limit the number of approved exchanges to three in an area (in addition to the one national Exchange) for the first five years, if the Secretary determines appropriate.

Funding for Operation of the Exchange. The Exchange would receive initial federal funding but then would be self-sustaining through premium assessments.

Transition

Current Law

No specified provision in federal law

Proposed Option

Grandfathered Plans. Individuals who currently have coverage and small employers who currently provide coverage to their employees could maintain such coverage (grandfathered plans). Issuers could continue to provide coverage under a grandfathered plan only to those individuals who are either currently enrolled in such a policy or to new employees hired by an employer offering such coverage. Once the small employer changes their contract for coverage, they must purchase a plan meeting the new federal benefit requirements. No low-income tax credits would be provided to those enrolled in grandfathered plans.

Transition Rules for Rating Requirements. Federal rating rules for non-group and micro-group markets (other than for grandfathered plans) will take effect on January 1, 2013 (or sooner if possible). Federal rating rules for the remainder of the small group market (as defined by the state) would be phased in over a three-to-ten year period, as determined by each state with approval from the Secretary.

Role of State Insurance Commissioners

Current Law

State insurance commissioners are responsible for protecting the interests of insurance consumers by performing functions such as antifraud efforts, addressing consumer complaints, market analysis, producer licensing, and regulatory interventions. They are responsible for enforcing the general rules governing insurance, which include licensing insurers and rules for brokers and agents activities.

HIPAA guarantees the availability of a plan and prohibits pre-existing condition exclusions for certain eligible individuals who are moving from group health insurance to insurance in the individual market. States have the choice of either enforcing the HIPAA individual market guarantees, referred to as the “federal fallback,” or they may establish an “acceptable alternative

state mechanism.” In states using the federal fallback approach, HIPAA requires all health insurance issuers operating in the individual health insurance market to offer coverage to all eligible individuals and prohibits them from placing any limitations on the coverage of any preexisting medical condition. Insurers have options for complying, such as offering the two most popular products and they can refuse to cover individuals seeking portability from the group market if financial or provider capacity would be impaired.

There are no federally-established rating areas in the private health insurance market. However, some states have enacted rating rules in the non-group and small group markets that include geography as a characteristic on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define these areas.

Proposed Option

Roles and Responsibilities. State insurance commissioners would continue to provide oversight of plans with regard to consumer protections (e.g., grievance procedures, external review, oversight of agent practices and training, market conduct), rate reviews, solvency, reserve requirements, and premium taxes. They would provide oversight of plans with regards to federal rating rules and any additional state rating rules and facilitate risk-adjustment within service areas.

Federal Fallback. In a manner similar to HIPAA there would be a federal fallback, so that if states did not adopt federal rating rules (through licensing requirements or legislation), the Secretary could enforce the rules. The Secretary would periodically review state enforcement of rating rules.

Rating Areas. Rating areas would be defined by State Insurance Commissioners and reviewed by the Secretary for adequacy. Rating areas (1) would allow for exceptions, (2) would be required to allow for pooling of similar cost people, and (3) would be risk adjusted across the areas.

SECTION II: Making Coverage Affordable

Benefit Options

Current Law

Generally, federal law only has certain requirements regarding actuarially equivalent benefit options in the context of private plan offerings through federal health insurance programs (e.g., Medicare Parts C and D, the Children’s Health Insurance Program). There is no federal law regarding actuarially equivalent benefit options in group and non-group private health insurance. However, states may have such standards. For example, Massachusetts defines a standard Gold benefit package for private health insurance available in its Connector. A plan with a different design can be qualified as Gold if it has an actuarial value that is within 5% of the standard Gold’s value. The state permits two other benefit packages available to all individuals in the

Connector: Silver is 80% of Gold (plus or minus 7.5%), and Bronze is 60% of Gold (plus or minus 2%). An additional option is available to young adults in Massachusetts that permits plans to exclude prescription drugs and to limit annual plan benefit payments.

Federal law does not define “minimum creditable coverage” benefit package for purposes of individual (non-group), small group (employers with 2-50 workers, 1-50 or up to 99 workers in some states), and other group private health insurance. States have the primary responsibility of regulating the business of insurance and may define what qualifies as minimum creditable coverage. However, federal law requires that private health insurance include certain benefits and protections. HIPAA and subsequent amendments require, for example, that group health plans and insurers cover minimum hospital stays for maternity care, provide parity in annual and lifetime mental health benefits, and offer reconstructive breast surgery if the plan covers mastectomies.

Proposed Options

All health insurance plans in the non-group and small group market would be required, at a minimum, to provide a broad range of medical benefits, including but not limited to, preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, including x-rays, maternity and newborn care, medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services, which at least meet minimum standards set by federal and state laws. In addition, plans could not include lifetime limits on coverage or annual limits on any benefits and cannot charge cost-sharing (e.g., deductibles, copayments) for preventive care services. Another option would be to allow plans to charge nominal cost-sharing for prevention services.

All insurers would be required to offer all four of the following benefit options:

- High option would have an actuarial value (defined as the percentage of health care expenses paid by the plan) of 93 percent;
- Medium option would have an actuarial value of 87 percent;²
- Low option would have an actuarial value of 82 percent.
- Lowest option would have an actuarial value of 76 percent.

Each plan design would be required to apply parity for cost-sharing for treatment of conditions within each of the following categories of benefits: (1) inpatient hospital, (2) outpatient hospital, (3) physician services, and (4) other items and services, including mental health services. Each plan design would also be required to meet the class and category of drug coverage requirements specified in Medicare Part D. Generally, Part D plans must offer two drugs in each class or category. The Secretary could allow some flexibility in plan design to encourage widely agreed

² This is approximately equal to the Federal Employees Health Benefit Program (FEHBP) Blue Cross Blue Shield Standard Option as estimated by the Congressional Research Service. Chris Peterson, “Setting and Valuing Health Insurance Benefits,” *Congressional Research Service*, R40491, (2009): 4.

upon cost and quality effective services but could discourage plan designs that could lead to adverse selection.

Participating insurers in the Exchange would be required to charge the same price for the same products in the entire service area as defined by the state regardless of how an individual purchases the policy (i.e., whether the policy is purchased from the exchange, from a broker or directly from the insurance carrier).

Low-Income Tax Credits

Current Law

Health Coverage Tax Credit. Certain individuals are eligible for the health coverage tax credit (“HCTC”). The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. In general, eligible individuals are individuals who receive a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they have not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation. The credit is available for “qualified health insurance,” which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market.

The credit is available on an advance basis through a program established and administered by the Treasury Department. The credit generally is delivered as follows: the eligible individual sends his or her portion of the premium to the Treasury. The Treasury pays the full premium (the individual's portion and the amount of the refundable tax credit) to the insurer. Alternatively, eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return.

Individuals entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized plans, or with certain other specified coverage, are not eligible for the credit.

COBRA Continuation Coverage Premium Reduction. The Consolidated Omnibus Reconciliation Act of 1985 (“COBRA”) requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment). A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the “applicable premium” for such period and the premium must be payable, at the election of the payor, in monthly installments.

Section 3001 of the American Recovery and Reinvestment Act of 2009 provides that, for a period not exceeding nine months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. Thus, if the assistance eligible individual pays 35 percent of the

premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual generally is any qualified beneficiary who elects COBRA continuation coverage and the qualifying event with respect to the covered employee for that qualified beneficiary is a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment (for other than gross misconduct). In addition, the qualifying event must occur during the period beginning September 1, 2008 and ending with December 31, 2009.

The premium subsidy also applies to temporary continuation coverage elected under the Federal Employees Health Benefits Program (FEHBP) and to continuation health coverage under State programs that provide coverage comparable to continuation coverage. The subsidy is generally delivered by requiring employers to pay the subsidized portion of the premium for assistance eligible individuals. The employer then treats the payment of the subsidized portion as a payment of employment taxes and offsets its employment tax liability by the amount of the premium subsidy. To the extent that the aggregate amount of subsidy for all assistance eligible individuals for which the employer is entitled to a credit for a quarter exceeds the employer's employment tax liability for the quarter, the employer can request a tax refund or can claim the credit against future employment tax liability.

There is an income limit on the entitlement to the premium reduction and subsidy, and it is conditioned on the individual not being eligible for certain other health coverage. To the extent that an eligible individual receives a subsidy during a taxable year to which the individual was not entitled due to income or being eligible for other health coverage, the subsidy overpayment is repaid on the individual's income tax return as additional tax. However, in contrast to the HCTC, the subsidy for COBRA continuation coverage may only be claimed through the employer and cannot be claimed at the end of the year on an individual tax return.

Proposed Options

The proposal would provide a tax credit for low income taxpayers³ who purchase health insurance through the Exchange. The tax credit would be refundable and paid in advance. The tax credit would be in the form of a "premium subsidy" that would help offset the cost of purchasing health insurance. The tax credit would be available for individuals (single or joint filers) with modified adjusted gross income ("MAGI") between 100 and 400 percent of the federal poverty level (FPL).

The level of coverage subsidized would depend on the individual's MAGI. The individual would be required to pay a premium capped at a specified percentage of MAGI that increases as the individual's MAGI increases. The tax credit is available to individuals between 100 and 400 percent of FPL. The subsidized coverage would be divided into three levels: high benefit option for individuals with MAGI between 100 and 200 percent of the FPL; medium benefit option for individuals with MAGI between 200 and 300 percent of the FPL, and low benefit option for

³ Because the premium subsidy is a tax credit, reference is made to individuals, but the coverage generally would be for the individuals in a family group that includes the taxpayer (including a married couple filing jointly), such as single, one adult with children, two adults with no children, or two adults with children.

individuals with MAGI between 300 and 400 percent of the FPL.⁴ The subsidized coverage would be tied to the premium for the second lowest cost option in the individual's area for the level of coverage subsidized. Individuals would be able to buy a higher level of coverage but they would pay the full difference in the premium. As an individual's MAGI increases, the tax credit phases out on a linear scale.

Another option might be that the premium credit would be an amount calculated based on the enrollment-weighted average premium of the qualified low coverage option offered in the service area to be determined by the Secretary of Health and Human Services. In addition, there would be cost sharing assistance to limit the amount of cost-sharing an individual is required to pay up to the valuation of the high coverage option for those between 100 and 200 percent of FPL and the medium coverage policy for those between 200 and 300 percent of poverty.

The tax credit would be effective for months of coverage beginning on or after January 1, 2013 (or sooner if possible).

Small Business Tax Credits

Current law

The Code does not currently provide a tax credit for employers that provide health coverage for their employees. The cost to an employer of providing health coverage for its employees is generally deductible under section 162 as an ordinary and necessary business expense for employee compensation. In addition, the value of employer provided health insurance is not subject to employer paid Federal Insurance Contributions Act (FICA) tax.

Proposed Option

The proposal would provide a tax credit to certain small employers for the purchase of employer provided health insurance. The credit would be provided for each full time employee covered and would be equal to 50 percent of the average total premium cost paid by the employer for employer sponsored coverage in the employer's State. For this purpose, full time employee means an employee who generally works 30 hours a week. The credit would vary based on the type of coverage (i.e., single, adult with child, family or two adults) provided to the employee. The full amount of the credit would be available to an employer with 10 or fewer full time employees, and whose employees have average annual wages from the employer of less than \$20,000. The credit would phase out for employers with more than 10 employees but not more than 25 full time employees. Simultaneously, the credit would phase out for an employer for whom the average annual wages per employee is between \$20,000 and \$40,000.

The credit would only be available to offset actual tax liability and would be claimed on the employer's tax return. The credit would not be payable in advance to the taxpayer or refundable.

⁴ High, medium, and low benefit options are described in "Benefit Options."

SECTION III: Public Health Insurance Option

Current Law

There is currently no federal public health insurance option for non-disabled individuals under 65 years of age. Medicare, however, is an example of a federal public health insurance option for the aged and certain disabled individuals. Under Medicare, Congress and the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services (HHS) determine many parameters of the program including eligibility rules, financing (including determination of payroll taxes, and premiums), required benefits, payments to health care providers, and cost sharing amounts. Despite the public nature of this program, CMS subcontracts with private companies to carry out much of the administration of the program.

Proposed Option A

There are several major issues that must be resolved in detailing a public health insurance option. The first issue is how providers will be reimbursed for services they provide to enrollees of the public option. The second is whether or not the public option will be required to establish provider networks or can it compel providers to participate. The third is whether the public option will be required to have reserve funds to cover their incurred but not reported claims. The fourth is whether or not the premiums collected by the public option will be required to cover costs or can shortfalls will be subsidized by the federal treasury. Finally, there is the issue of administration of the public option and whether it will be done by a federal agency or by a third party.

Three separate options for a public health insurance plan are described below.

Approach 1: Medicare-Like Plan

This proposal would establish a “Medicare-like” public health insurance option to be offered through the Exchange. The public option would be administered by a new agency within the Department of Health and Human Services (HHS). Eligibility rules, markets, and income-related tax credits for the public option would mirror those for all other plans offered through the Exchange. Medicare providers would be required to participate in the public option, and would be paid Medicare rates plus 0-10%. Rating rules would apply to the public option in the same way that they apply to plans offered through the Exchange in the non-group and small group markets. (Rating rules restrict the variation in price of insurance policies according to the risk of the person or group seeking coverage and are explained in the section on non-group market rating rules and risk adjustment.)

Risk adjustment would apply to the public option in the same way that it applies to plans offered through the Exchange in the non-group and small group markets. (Risk adjustment is an adjustment in the payment for an insurance policy which reflects the expected variation in expenditures of sicker or healthier individuals. See the section on non-group market rating rules and risk adjustment.) The public option would incorporate any medical delivery system reforms adopted from the overall reform effort. The public option would not have solvency

requirements. The public option would start and accept enrollees on the same date that the Exchange begins.

Approach 2: Third Party Administrator

Proposal 2 would be similar to Proposal 1 with the following differences. First, instead of being operated by HHS, the public option would be administered through multiple regional third-party administrators (TPAs) who would be required to report to the Secretary. This governance structure will be separate from the agency overseeing competition among other private plan options. Second, the TPAs would be required to establish networks of participating medical providers. Payments for participating providers would be negotiated by the TPAs. Lastly, the public health insurance option would be required to have reserve funds.

Approach 3: State-Run Public Option

Proposal 3 envisions a State-run public option. This option could either be mandatory or optional for States but the details of its administration will be left to the States. One possible option for the States might be to allow individuals to purchase coverage through the State-employee plans.

Proposed Option B

Option B does not include a public health insurance option and instead relies on private options in a reformed and well regulated private market.

SECTION IV: Role of Public Programs

Medicaid Coverage

Eligibility Standards and Methodologies

Current Law

Eligibility for Medicaid is determined not only based on financial criteria, but also on categorical requirements – that is, to be eligible for traditional Medicaid, one must be a member of a covered group, such as children, pregnant women, the aged, or the disabled. For example, “childless adults” (nonelderly adults who are not disabled, not pregnant and not parents of dependent children) are generally not eligible for Medicaid, regardless of their income. Parents are eligible for Medicaid if they would have been eligible for the former federal cash welfare program Aid to Families with Dependent Children (AFDC) as of July 1, 1996. The upper-income threshold for AFDC eligibility in 1996 ranged across states from 11 percent to 68 percent of the federal poverty level (FPL), although states have the flexibility to raise eligibility to higher levels (in some states, parents are eligible for Medicaid up to 200 percent FPL). States are required to make pregnant women and children five and under eligible for Medicaid up to at least 133 percent FPL, and six to 18 year-olds up to 100 percent FPL, but can go higher.

For some Medicaid eligibility groups, states are required to disregard certain amounts and/or types of income (and sometimes expenses, such as child care or health care costs). For some Medicaid eligibility groups, states have the flexibility to disregard additional amounts or types of income and expenses, effectively expanding eligibility to higher-income individuals. Because states must share in the costs of Medicaid, income eligibility expansions may be dependent on the availability of such financing.

Proposed Option

Effective soon after enactment, all state Medicaid programs would be required to raise income eligibility for pregnant women, children, and parents. For example, make parents, pregnant women, and all children eligible up to 150 percent FPL. In addition, states would be required to maintain income eligibility for all previously eligible populations upon enactment, and this maintenance of effort would expire when the Secretary of HHS determines that the Exchange is fully operational. The Secretary would be directed to identify obsolete eligibility categories in light of these eligibility expansions.

No income disregards would be permitted for any Medicaid eligible population. Income would be measured based on modified adjusted gross income (MAGI), the same definition used by the Exchange to determine eligibility for the tax credit. This would ensure alignment between eligibility for Medicaid and eligibility for credits to purchase coverage through the Exchange.

Medicaid Program Payments

Current Law

The federal share for most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa). FMAPs have a statutory minimum of 50 percent and maximum of 83 percent.

The federal share for Medicaid administrative costs does not vary by state and is generally 50 percent. Certain administrative functions have a higher federal matching rate (e.g., 75 percent for survey and certification of nursing facilities, and 90 percent for the startup expenses associated with establishing Medicaid Management Information Systems for claims and information processing).

States have broad authority to establish provider payment rates under Medicaid. Federal law requires that these rates be consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that covered benefits will be available to Medicaid beneficiaries at least to the same extent they are available to the general population in the same geographic area.

Proposed Option

Through 2015, the federal government would fully finance all expenditures for benefits provided to individuals newly eligible for Medicaid as a result of increases in income eligibility. The state share of these costs would be phased in over the next five-year period. Thus, in each year of this period, states would become responsible for an additional 20 percent of the otherwise applicable state share of benefit costs. After this phase-in period, the state share of these costs would be equal to the applicable proportion established under the FMAP formula. Alternatively, the federal government could pay an increased share for benefits provided to all populations for a certain duration.

For services provided to existing eligibility groups, and under existing waivers authorized in section 1115 of the Social Security Act, both the federal and state governments would share in the costs, as established under the FMAP formula. For administrative services, the current law rules for determining the federal and state share of costs would apply.

Finally, this option could require that payments to all providers not fall below a given percent (*e.g.*, 80) of Medicare reimbursement rates for the same or similar services.

Options for Medicaid Coverage

Current Law

There is no provision in federal law for Medicaid enrollees' purchase of public or private health insurance through an Exchange.

Massachusetts currently uses capped Medicaid funding (under a section 1115 demonstration waiver) for subsidies toward the purchase of private health insurance through the Massachusetts Connector. These subsidies are available to individuals up to 300 percent FPL who are not otherwise eligible for traditional Medicaid or other coverage (*e.g.*, Medicare, job-based coverage).

Proposed Options

Approach 1: Increased Coverage through the Current Medicaid Structure

Individuals eligible for Medicaid would be deemed ineligible for tax credits in the Exchange. For people eligible for Medicaid coverage but receiving coverage through employer-sponsored insurance (ESI), a state Medicaid program could provide premium assistance for ESI. A variation on this option would be to require a state Medicaid program to provide premium assistance to Medicaid-eligible individuals with ESI. Requiring the state to provide premium assistance could mitigate the likelihood of Medicaid-eligible individuals dropping ESI.

Approach 2: Increased Coverage through the Exchange

The Medicaid legal entitlement to coverage and services continues to exist under this option for all populations eligible for Medicaid. The disabled, dual eligibles and other special needs populations would continue to receive coverage through the existing state Medicaid program structure. The state Medicaid program would be required to provide coverage for children, pregnant women, parents, and childless adults through insurance plans in the Exchange. A state could also provide premium assistance for employer-sponsored insurance but would not be required to do so.

The state Medicaid program would provide eligible Medicaid enrollees with a choice of Exchange Low Option plans. Premiums for Medicaid-eligible populations in the Exchange would be fully subsidized consistent with the process for providing the low-income subsidy under sections 1860D-14 and 1935. The state Medicaid program would reimburse insurers for the cost of filling in cost-sharing and premiums and seek payment from the federal government consistent with the existing FMAP arrangement.

As part of the ongoing Medicaid entitlement to benefits, the state Medicaid program would arrange to provide coverage for health services of an amount, type, duration, and scope that exceeds or falls outside the limits of Exchange coverage to populations entitled to the coverage – for example, education setting services, transportation, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). This is similar to the legal arrangements states make with Medicaid managed care organizations under current law.

Products sold to Medicaid eligible individuals and families must meet requirements imposed on managed care organizations within title XIX. Plans must submit a contract to the state agreeing to provide services to Medicaid beneficiaries. Products are subject to all rules and regulations applied to all plans in the Exchange.

Variations for this option include, but are not limited to: increasing the reimbursement for states under the FMAP formula, providing eligible populations with a choice of High Option plans, allowing states to choose between this option and existing Medicaid, allowing a state to limit the populations that would be required to receive coverage through the Health Insurance Exchange to non-pregnant, childless adults, allowing states to create or act as a Health Insurance Exchange plan, and allowing states to create Medicaid-only plans to participate in the Health Insurance Exchange.

Approach 3: Increased Coverage through Both the Current Medicaid Structure and the Health Insurance Exchange

This option would expand coverage for children, pregnant women, and parents – mandatory populations – like the first two options. Children, parents, and pregnant women would continue to receive Medicaid in its current structure. However, under this option, childless adults would not become eligible for Medicaid. Instead, childless adults below 115 percent FPL would be eligible for federal tax credits to purchase coverage. There are two choices for purchasing

coverage – private coverage through the Health Insurance Exchange (including the public health insurance option if applicable), and public coverage through the state’s Medicaid program.

The public coverage alternative would be achieved by treating the tax credit administered by the Health Insurance Exchange as a “voucher” that the recipient could use to buy into the state’s Medicaid program. States would be required to accept this “voucher” if a recipient requests to buy into Medicaid. Recipients would get all of the same benefits and protections, including cost-sharing, that Medicaid offers to parents enrolled in the program. In the event that a low-income, childless adult buys into Medicaid and uses services to such a degree that the cost exceeds the value of the “voucher,” the Health Insurance Exchange will reimburse the state in full for all such services at the rate of 100 percent of the amount those services would cost if provided to a parent enrolled in Medicaid.

The private coverage alternative would be achieved by subsidizing the full amount of the premium of a qualified Health Insurance Exchange plan. Because the lowest-income individuals tend to be more vulnerable, additional protections would be attached to their Health Insurance Exchange coverage, including applying Medicaid limits on cost-sharing and requiring plans to include safety net providers (like public hospitals and community health centers) in their networks.

Variations for this option include, but are not limited to, making a subset of childless adults (*e.g.*, those below 50 percent FPL) Medicaid eligible, giving states the option to accept “vouchers” for buying into Medicaid, and making Medicaid accessible to the mandatory populations through the Health Insurance Exchange (similar to Approach 2).

Treatment of Territories

Current Law

Five territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands) operate their Medicaid programs under rules that differ from those applicable to the 50 states and the District of Columbia (hereafter referred to as the states). The territories are not required to cover the same eligibility groups, and they use different financial standards (income and asset tests) in determining eligibility. For example, states must cover certain mandatory groups such as low-income pregnant women and children and qualified Medicare beneficiaries. For the territories, these groups are optional.

In the states, Medicaid is an individual entitlement. In addition, there are no limits on federal payments for Medicaid provided that the state contributes its share of the matching funds. In contrast, Medicaid programs in the territories are subject to annual federal spending caps. All five territories typically exhaust their caps prior to the end of the fiscal year. Once the cap is reached, the territories assume the full costs of Medicaid services, or in some instances may suspend services or cease payments to providers until the next fiscal year.

The federal share for most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which is based on a formula that provides higher reimbursement to states

with lower per capita incomes relative to the national average (and vice versa). FMAPs have a statutory minimum of 50 percent and maximum of 83 percent. Apart from recent, temporary increases in the federal share of Medicaid costs in the states and territories, the FMAP is typically set at 50 percent in the territories.

Proposed Options

Medicaid eligibility categories would be the same for the territories as for the states. The existing funding caps for the territories would be removed. With respect to federal matching dollars, the territories would receive FMAP as determined by the FMAP formula upon enactment, subject to existing statutory minimum and maximum percentages. This option could be effective immediately or phased-in over time.

An alternative to this option is to maintain the current structure of Medicaid in the territories, but increase the caps.

The Children's Health Insurance Program

Current Law

In general, the Children's Health Insurance Program (CHIP) allows states to cover targeted low-income children under age 19 with no health insurance in families with income above Medicaid eligibility levels. States can set the upper income level up to 200 percent of the federal poverty level (FPL), or 50 percentage points above the applicable pre-CHIP Medicaid income level. However, states are able to effectively expand eligibility for CHIP to higher income levels through income disregards. Generally, within broad federal guidelines, states have flexibility to determine what types and amount of income they will consider in determining whether an applicant's effective income is at or below the applicable income eligibility standard.

For states seeking federal approval to expand eligibility, the recent Children's Health Insurance Program Reauthorization Act (CHIPRA; P.L. 111-3) reduces federal CHIP payments for certain higher-income CHIP children. Specifically, the regular Medicaid match rate, which is lower than the CHIP enhanced matching rate (described in more detail below), will be used for CHIP enrollees whose effective family income exceeds 300 percent FPL using the state's policy of excluding "a block of income that is not determined by type of expense or type of income," with an exception for states that already had a federal approval plan or that had enacted a state law to submit such a plan for federal approval.

Under CHIP, states may enroll targeted low-income children in a CHIP-financed expansion of Medicaid, create a new separate state CHIP program, or a combination of both approaches. States choosing the Medicaid expansion option must provide all Medicaid mandatory benefits and all optional benefits covered under the state plan. As an alternative, states may opt for the combination approach and enroll Medicaid/CHIP children in benchmark and benchmark-equivalent plans that are nearly identical to the benefit packages offered through separate CHIP programs described below. For any child under age 21 in one of the major mandatory and

optional Medicaid eligibility groups, including targeted low-income children, the benefits available through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program must be provided, whether through a benchmark plan or otherwise (CHIPRA; P.L. 111-3). Under EPSDT, children receive well-child care, immunizations, and other screening services, as well as medical care necessary to correct or ameliorate identified defects, illnesses, or conditions, including optional services states may not otherwise cover in their Medicaid programs.

States that choose to create separate CHIP programs may elect any of three benefit options: (1) a benchmark package, (2) benchmark-equivalent coverage, or (3) any other health benefits plan that the Secretary of HHS determines will provide appropriate coverage to the targeted population. A benchmark plan is one of the following three options: (1) the standard Blue Cross/Blue Shield preferred provider option plan offered under the Federal Employees Health Benefits Program (FEHBP), (2) the health coverage that is offered and generally available to state employees in the same state, and (3) the health coverage that is offered by a health maintenance organization (HMO) with the largest commercial (non-Medicaid) enrollment in the state involved. Benchmark-equivalent coverage is defined as a package of benefits that has the same actuarial value as one of the benchmark benefit packages, and it must meet certain coverage requirements.

Dental services are also a required benefit under separate CHIP programs (CHIPRA; P.L. 111-3) and include services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. States may provide dental services through benchmark dental benefit packages modeled after the benchmark plans for medical services described above (e.g., dental benefit plans under FEHBP, state employee programs, and commercial HMO options).

Like Medicaid, for each dollar of state spending, the federal government makes a matching payment drawn from federal CHIP allotments. A state's share of program spending for Medicaid is equal to 100 percent minus the federal medical assistance percentage (FMAP). The enhanced FMAP (E-FMAP) for CHIP means a state's share of expenditures is 30 percent lower than under the regular Medicaid FMAP. The temporary Medicaid FMAP increases specified in the recent American Recovery and Reinvestment Act (ARRA; P.L. 111-5) are not considered in calculating the E-FMAP. In FY2009, prior to this temporary increase, the Medicaid FMAP ranged from 50 percent to 75.84 percent across states, and the enhanced FMAP for CHIP ranged from 65 percent to 83.09 percent.

Five territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the Virgin Islands) also receive federal matching funds to provide health insurance to low-income children under CHIP. Between FY1999 and FY2008, earmarked CHIP funds were distributed among the territories based on statutorily set proportions. For FY2009, territories' federal CHIP allotments were based on the largest of their federal CHIP expenditures from FY1999 to FY2008. For FY2010 to FY2013, the territories' allotments will be determined in the same ways as those of the states. The federal CHIP matching rate is 65 percent. All the territories use their CHIP funds to expand their Medicaid programs. These Medicaid programs operate under a

federal funding cap. In general, once this cap is exhausted, the territories provide coverage to eligible children with territory-only funds.

There is no provision in federal law for CHIP enrollees' purchase of private health insurance through a Health Insurance Exchange.

Proposed Option

Once the Health Insurance Exchange is up and running, there will be more coverage options for children of low-to-moderate income levels than exist today. As access to private insurance increases, the need for CHIP as it is currently structured will diminish. Furthermore, if individuals are required to have health insurance, CHIP can play a different role in helping to provide coverage.

Under this option, there would be no federal changes to the structure of CHIP prior to the end of the current reauthorization period (September 30, 2013) or prior to when the Health Insurance Exchange is fully operational, whichever occurs later. Upon enactment, states would be prohibited from decreasing income eligibility for currently eligible child populations until the end of the current authorization period or when the Health Insurance Exchange is fully operational, whichever is later.

After that point, the CHIP income eligibility would be increased to 275 percent FPL. In addition, CHIP programs would no longer be able to use income disregards, and income would be measured based on modified adjusted gross income (MAGI) as defined under the Health Insurance Exchange and Medicaid proposals.

Federal financial participation for CHIP will continue. With respect to benefits, as of the end of the current authorization period or when the Health Insurance Exchange is fully operational, whichever is later, CHIP coverage would include the Medicaid EPSDT benefit. Rules for the territories would be harmonized with the states as in Medicaid.

Once the Health Insurance Exchange is fully operational, CHIP enrollees would obtain their primary coverage through the Health Insurance Exchange. CHIP would serve as a secondary payer, with states arranging coverage for health services of an amount, type and scope that exceeds or falls outside the limits of Health Insurance Exchange coverage (e.g., EPSDT).

Health Insurance Exchange plans would have to contract with the state to provide services to CHIP beneficiaries, while also being subject to all rules and regulations applied to all plans within the Health Insurance Exchange.

The cost-sharing for CHIP children would be limited to Medicaid's cost-sharing rules. For children in family plans in the Health Insurance Exchange, the portion of the premium that goes toward coverage of the CHIP-eligible child would be fully subsidized.

Variations for this option include, but are not limited to: allowing states to create or act as an Health Insurance Exchange plan, allowing states to create Medicaid-only plans to participate in

the Health Insurance Exchange, and limiting premium reimbursement to those services covered by Medicaid (e.g., EPSDT) that are not in the Health Insurance Exchange plan.

Quality of Care in Medicaid and CHIP

Current Law

The Children's Health Insurance Program Reauthorization Act (CHIPRA; P.L. 111-3) included several provisions designed to improve the quality of care under Medicaid and the Children's Health Insurance Program (CHIP). The law directs the Secretary of HHS to develop child health quality measures, a standardized format for reporting information, and procedures to encourage states to voluntarily report on the quality of pediatric care in these two programs. Examples of these initiatives include: (1) grants and contracts to develop, test, update and disseminate evidence-based measures, (2) demonstrations to evaluate promising ideas for improving the quality of children's health care under Medicaid and CHIP, (3) a demonstration to develop a comprehensive and systematic model for reducing child obesity, and (4) a program to encourage the creation and dissemination of a model electronic health record format for children enrolled in these two programs. The federal share of the costs associated with developing or modifying existing state data systems to store and report child health measures is based on the matching rate applicable to benefits (FMAP) rather than one of the typically lower matching rates applied to different types of administrative expenses.

CHIPRA also established a new Medicaid and CHIP Payment and Access Commission (MACPAC). This commission will engage in a number of activities. MACPAC will review program policies under both Medicaid and CHIP affecting children's access to benefits, including: (1) payment policies such as the process for updating fees for different types of providers, payment methodologies, and the impact of these factors on access and quality of care, (2) the interaction of Medicaid and CHIP payment policies with health care delivery generally, and (3) other policies, including those relating to transportation and language barriers. The commission will make recommendations to Congress concerning such access policies. Commission reports are due annually, beginning in 2010.

Proposed Option

The proposal would apply similar quality measures established in CHIPRA to all Medicaid eligible populations.

The proposal would appropriate \$10 million for MACPAC, with \$8 million through Medicaid funds and \$2 million through CHIP funds.

Other Improvements to Medicaid

Enrollment and Retention Simplification

Current Law

States have considerable flexibility to simplify and expedite the Medicaid eligibility determination and enrollment process (*e.g.*, allowing applications to be submitted by mail or fax, eliminating face-to-face interviews or asset tests, extending the length of time between initial enrollment and redeterminations of eligibility).

The Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) included several provisions to remove barriers to enrollment and created a bonus payment structure to encourage states to do so. For states to be eligible for CHIP bonus payments, they must increase Medicaid child enrollment by certain amounts and implement at least five out of eight specific outreach and enrollment activities. CHIPRA also permitted states to rely on findings from specified "Express Lane" agencies (*e.g.*, those that administer programs such as Temporary Assistance for Needy Families, Medicaid, CHIP, and Food Stamps) and the Social Security Administration (SSA) to determine whether a child has met one or more of the eligibility requirements (*e.g.*, income, assets, citizenship, or other criteria) necessary to determine initial eligibility or redeterminations of eligibility for Medicaid or CHIP. Also as a part of the outreach-related provisions, CHIPRA requires the Secretary of HHS, in consultation with state Medicaid and CHIP directors and organizations representing program beneficiaries, to develop a model process for the coordination of enrollment, retention, and coverage of children who frequently change their residency due to migration of families, emergency evacuations, and educational needs, for example.

Proposed Options

The proposal would eliminate the state option to rely on face-to-face interviews when determining eligibility for Medicaid and the ability to apply an assets test when determining eligibility for acute care services. States would also be required to: (1) implement 12-month continuous eligibility beginning on the date of application (or last renewal); (2) establish a Medicaid enrollment website to promote seamless enrollment in Medicaid should a Medicaid-eligible person apply for tax credits through the Health Insurance Exchange website; (3) permit states to enroll and redetermine Medicaid eligibility for all Medicaid beneficiaries at Disproportionate Share Hospitals, Federally Qualified Health Centers (FQHCs) and State Departments of Motor Vehicles; and (4) extend administrative automatic renewal and Express Lane renewal to all Medicaid beneficiaries. States complying with these requirements and others listed in CHIPRA to achieve the five-of-eight standard would be deemed as meeting the CHIPRA bonus payment enrollment and retention requirements, making them eligible to receive such bonus payments. Finally, as under CHIPRA, the proposal would require the Secretary of HHS, in consultation with state Medicaid and CHIP directors and organizations representing program beneficiaries, to develop a model process for the coordination of enrollment, retention, and coverage of all Medicaid beneficiaries who frequently change their state residency.

Family Planning Services and Supplies

Current Law

“Family planning services and supplies” is a mandatory Medicaid benefit that must be available to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the state Medicaid plan and who desire such services and supplies.

Proposed Option

The proposal would add a new optional categorically needy eligibility group to Medicaid. This new group would be comprised of (1) non-pregnant individuals with income up to the highest level applicable to pregnant women covered under the Medicaid or CHIP state plan, and (2) at state option, certain individuals eligible for existing section 1115 waivers that provide family planning services and supplies. Benefits would be limited to family planning services and supplies (as per section 1905(a)(4)(C)) and would also include related medical diagnosis and treatment services. The proposal would also allow states to make a “presumptive eligibility” determination for individuals eligible for such services through the new optional eligibility group. That is, states may enroll such individuals for a limited period of time before full Medicaid applications are filed and processed, based on a preliminary determination by Medicaid providers of likely Medicaid eligibility. Under current law, such presumptive eligibility determinations can be made for children, pregnant women, and certain women with breast or cervical cancer. In addition, states would not be allowed to provide Medicaid coverage through benchmark or benchmark-equivalent plans, which are permissible alternatives to traditional Medicaid benefits, unless such coverage includes family planning services and supplies.

Treatment of Selected Optional Benefits

Current Law

Some Medicaid benefits are mandatory for most Medicaid groups (*e.g.*, inpatient hospital services, physician services, family planning services and supplies, federally qualified health center services, nursing facility services for persons age 21 or older), others are optional. Examples of optional benefits for most Medicaid groups that are offered by many states include prescription drugs (covered by all states), other licensed practitioners (*e.g.*, optometrists, podiatrists, psychologists), and nursing facility services for individuals under age 21.

While there is statutory authority to pay for services rendered by nurse midwives, there is no statutory authority to provide for direct payment to birthing centers for facility services.

Proposed Option

Podiatrists, optometrists, and free-standing birth centers would be given provider status.

Interstate Coordination Requirements for Child Medicaid Beneficiaries

Current Law

The Medicaid statute authorizes the Secretary to prescribe state plan requirements for furnishing Medicaid to state residents who are absent from the state. Federal regulations prescribe further details related to this statutory authority. A state must pay for services furnished in another state to the same extent that it would pay for services furnished within its boundaries if the services are provided to a Medicaid beneficiary who is a resident of the state and if any of the following four conditions are met: (1) medical services are needed because of a medical emergency, (2) medical services are needed and the recipient's health would be endangered if he/she were required to travel to the state of residence, (3) the state determines, on the basis of medical advice, that the needed medical services and supplementary resources are more readily available in the other state, and (4) it is general practice for beneficiaries in a particular locality to use medical resources in another state. Home states may require out-of-state providers to enroll in their programs, or otherwise enter into a service agreement as a condition of receiving payments.

For non-institutionalized individuals under age 21 whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the individual is living. For other non-institutionalized individuals under age 21, the state of residence is based on the rules governing residence under the former AFDC program. Generally, in such cases, the individual is a resident of the state in which he or she is living other than on a temporary basis.

In general, states must establish procedures to facilitate the furnishing of medical services to individuals who are present in the state and are eligible for Medicaid under another state's plan. States cannot deny Medicaid eligibility because an individual has not resided in the state for a specified period of time. Also states may not terminate a resident's eligibility because of that person's temporary absence from the state, if the person intends to return when the purpose of the absence has been accomplished, unless another state has determined that the person is a resident there for Medicaid purposes. Finally, a state may (but is not required to) have a written agreement with another state setting forth rules and procedures for resolving cases of disputed residency. When two or more states cannot resolve which state is the state of residence, the state where the individual is physically located is the state of residence.

Proposed Option

The proposal would require interstate coordination to ensure that the child's home-state Medicaid program will cover the child when he or she is out of the state.

Mandatory Coverage for Prescription Drugs

Current Law

With a number of exceptions, Medicaid is available only to children, parents, pregnant women, and to aged, blind, or disabled people. People who do not fall into these categories—such as childless, single adults and couples—generally do not qualify for Medicaid regardless of their

income level. Historically, Medicaid eligibility has been divided into two basic classes, the “categorically needy” and the “medically needy.” The two terms once distinguished between welfare-related (categorically needy) beneficiaries and those qualifying under special Medicaid rules which allow states to cover people whose incomes are too high to qualify for cash welfare support, but who nevertheless need help with medical bills (medically needy).

However, non-welfare groups have been added to the “categorically needy” list over the years. As a result, the terms categorically and medically needy are no longer especially meaningful in sorting out the various populations for whom mandatory or optional Medicaid coverage has been made available. However, the distinction remains important when considering certain benefits. Some benefits are considered mandatory for categorically needy individuals; that is, states must cover those benefits for the categorically needy, but they are optional for medically needy individuals. Other benefits are optional for both groups of beneficiaries. Some states provide those optional benefits only to categorically needy individuals, while some states provide those benefits to both groups, and still other states provide optional benefits to selected subcategories of the medically needy as well as to all categorically needy beneficiaries.

Under Medicaid law, outpatient prescription drug coverage is an optional benefit, but all states have added prescription drug coverage to their Medicaid state plan benefits. Thus, prescription drug coverage is one of the few optional Medicaid services provided by all states. When states add prescription drug coverage as a state plan benefit, however, they must cover all categorically eligible beneficiaries, but they also may cover other optional eligibility groups, such as the medically needy. In 2005, 33 states covered prescription drugs for medically needy individuals, in addition to categorically eligible beneficiaries.

States have increased coverage of prescription drugs over the years, in part because it has been seen as representing a good value. While overall prescription drug spending has increased substantially, drugs remain relatively less expensive than many other clinical and therapeutic treatments. Appropriate use of prescription drugs is believed to help avoid larger and potentially more costly medical interventions such as emergency room visits and hospital admissions.

Proposed Options

This option would make prescription drugs a mandatory benefit for the categorically and medically needy.

Change the Status of Some Excludable Drugs

Current Law

Federal Medicaid law excludes 11 drug classes, including barbiturates and benzodiazepines. States still may cover these and other excluded drugs, but they do not receive federal financial participation (FFP) when they do. When Medicare Part D was implemented in January 2006, Medicare began covering prescription drugs for dual eligible individuals. Barbiturates and benzodiazepines were excluded from Part D as well as Medicaid. However, under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-271), Medicare

prescription drug plans and Medicare Advantage plans will be required to include barbiturates or benzodiazepines in their formularies for prescriptions dispensed on or after January 1, 2013. Barbiturates will also be required to be included in formularies for the indications of epilepsy, cancer, or chronic mental health disorder.

Proposed Option

Under this proposal, Medicaid law would be changed to eliminate smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's excluded drug list.

Changes to Medicaid Payment for Prescription Drugs

Current Law

Medicaid law requires the Secretary of HHS to establish upper limits on the federal share of payments for prescription drug acquisition costs. These limits are intended to encourage substitution of lower-cost generic equivalents for more costly brand-name drugs. When applied to multiple source drugs, those limits are referred to as federal upper payment limits (FULs). FULs apply to aggregate state expenditures for each drug. CMS calculates FULs and periodically publishes these prices. Under the Deficit Reduction Act of 2005 (DRA; P.L. 109-171), new FULs issued after January 2007 were to equal 250 percent of the average manufacturer price (AMP) of the least costly therapeutic equivalent (excluding prompt pay discounts). AMP is defined in statute to be the average price paid to the manufacturer by wholesalers for drugs distributed to the retail pharmacy class of trade. Manufacturers are required to report AMP to CMS.

Proposed Option

Under this proposal, Medicaid law would be changed to increase the FUL percentage from 250 percent to 300 percent of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies. This proposal also would clarify what discounts and other price adjustments were included in the definition of AMP. Other technical modifications to Medicaid prescription drug law would include a revision to the definition of a multiple source drug, changing it from at least one other drug product to two or more drug products. A new prior authorization requirement would prevent more expensive drugs from being dispensed when generic equivalents are available absent medical necessity justifications.

Transparency in Medicaid and CHIP Section 1115 Waivers

Section 1115 Demonstration Waivers

Current Law

Section 1115 of the Social Security Act authorizes the Secretary to waive certain statutory requirements for conducting research and demonstration projects that further the goals of title

XIX (Medicaid) and title XXI (CHIP). States submit proposals outlining the terms and conditions of the demonstration program to CMS for approval prior to implementation.

In 1994, CMS issued program guidance that impacts the waiver approval process and includes the procedures states are expected to follow for public involvement in the development of a demonstration project. States were required to provide HHS a written description of their process for public involvement at the time their proposal was submitted.

In the 1990s, CMS emphasized the importance of public involvement in requests for project extensions. For demonstration extensions granted under the Balanced Budget Act of 1997, HHS required states to hold public hearings during which interested parties were allowed to present oral or written testimony. States were required to respond to questions that surfaced over the course of the hearings and to provide CMS with a summary of the proceedings.

Public involvement requirements for the waiver approval process continued through the early 2000s. In a letter to state Medicaid directors issued May 3, 2002, CMS listed examples of ways a state may meet requirements for public involvement (*e.g.*, public forums, legislative hearings, a website with information and a link for public comment).

Proposed Options

The proposal would impose statutory requirements regarding transparency in the development, implementation, and evaluation of Medicaid and CHIP section 1115 demonstration programs that impact eligibility, enrollment, benefits, cost-sharing, or financing. Options for new requirements on states include: (1) providing notice of the state's intent to develop and/or renew a section 1115 waiver and convene at least one meeting of the state's medical advisory board to discuss the impacts of the proposed changes; (2) publishing for written comment a notice of the proposal that provides information on how the public can submit comments to the state and includes state projections and assumptions regarding the likely impact of the waiver; (3) posting the waiver proposal on the state's Medicaid or CHIP website; and (4) convening open meetings over the course of the development of the proposal to discuss proposed changes. States could also be required to include information regarding the actions taken to meet the above-listed public notice requirements as a part of their waiver submission to CMS.

The proposal could also impose additional transparency-related statutory requirements on the Secretary of HHS. Options for new requirements on the Secretary include: (1) publishing a *Federal Register* notice identifying monthly waiver submissions, approvals, denials, and information regarding methods by which comments on the waiver will be received from the public; (2) publishing a copy of the proposed waiver to the CMS website; (3) allowing for, responding to, and making available public comments received about the proposal after it has been posted to the CMS website. Once approved, the Secretary must post waiver terms and conditions and related waiver approval documents, quarterly state-reported data and three-year evaluations to the CMS website. The Secretary could also be required to publish a *Federal Register* notice identifying monthly waiver approvals, denials, and returns to the state without action.

Medicaid State Plan Amendments (SPA) and Covered Benefits

Current Law

States are required to submit a state plan describing the nature and scope of a state's Medicaid program to the Secretary of Health and Human Services (HHS) for approval. The state plan must provide assurances that the program conforms to the requirements of title XIX and to any other official program issuances (*e.g.*, rules, regulations, program guidance, etc.). After approval of the original state plan by the Secretary of HHS, any subsequent changes (*e.g.*, those required by new federal or state statutes, rules, regulations, policy interpretations, guidance, court decisions, changes in the state's operation of the Medicaid program, etc.) must be submitted by the state to the Centers for Medicare and Medicaid Services (CMS) in the form of a state plan amendment (SPA) so that the Secretary of HHS may determine whether the Medicaid state plan continues to meet federal requirements. Federal regulations dictate the SPA approval process including requirements for Governor's review, CMS regional office review, disapproval of a SPA, and Judicial Review (*i.e.*, after a state's failure to conform to federal requirements). Federal law dictates time frames associated with the SPA review process, and requirements that the Administrator must meet when notifying a state that CMS intends to withhold federal matching payments for portions of the state plan that are out of compliance.

Proposed Option

The proposal would add transparency-related statutory requirements associated with the SPA approval process for proposals that limit benefits. States could: (1) provide notice of the state's intent to develop a SPA and convene at least one meeting of the state's medical advisory board to discuss the impacts of the changes requested in the proposed SPA; (2) publish a notice of the proposal that provides information on how the public can submit comments to the state and includes state projections and assumptions regarding the likely impact of the SPA; (3) post the SPA proposal on the state's Medicaid or CHIP website; and (4) convene at least one open meeting to discuss the proposed SPA. States could also be required to include information regarding the actions taken to meet the above-listed public notice requirements as a part of their SPA submission to CMS.

The proposal could also impose additional transparency-related statutory requirements on the Secretary of HHS. The Secretary could be required to: (1) publish a *Federal Register* notice identifying monthly SPA submissions and information regarding methods by which comments on each SPA will be received from the public; (2) publish a copy of the proposed SPA to the CMS website; and (3) publish a *Federal Register* notice identifying monthly SPA approvals, denials, and returns to the state without action.

Changes to the FMAP Formula

Current Law

Under Medicaid law, the FMAP formula compares each state's per capita income relative to U.S. per capita income, and provides higher reimbursement to states with lower incomes (with a

statutory maximum of 83 percent) and lower reimbursement to states with higher incomes (with a statutory minimum of 50 percent).

The formula for a given state is:

$$FMAP_{State} = 1 - 0.45 \left(\frac{(Per\ Capita\ Inc_{State})}{(Per\ Capita\ Inc_{U.S.})} \right)^2$$

The use of the 0.45 factor in the formula is designed to ensure that a state with per capita income equal to the U.S. average receives an FMAP of 55 percent (*i.e.*, state share of 45 percent). In addition, the formula's squaring of income provides higher FMAPs to states with below-average incomes than they would otherwise receive (and vice versa) without the squaring.

The Department of Health and Human Services (HHS) usually publishes FMAPs for an upcoming fiscal year in the *Federal Register* in the preceding November. Thus, FMAPs for FY2008 (the federal fiscal year that began on October 1, 2007) were calculated and published in 2006, and FMAPs for FY2009 were calculated and published in 2007. The FMAP calculation uses a three year average of state per capita income. The three-year average is used to ensure stability in the matching rates over time.

Proposed Option

This proposal would change the FMAP formula. The proposed FMAP change could be budget neutral. The formula would be changed so that it not only relies on a state's per capita income measure, it would also incorporate data on the state's poverty level. Two-thirds of the formula would be based on a state's relative per capita income compared to the national average. For the per capita income data used, the formula would be based on a two-year average rather than the current three-year average. One-third of the formula would be based on the state's poverty rate relative to the national poverty rate. The formula would remove the squaring factor. Under the revised FMAP formula, year-to-year FMAP fluctuations for states would be capped at +/- two percentage points. A state with a per capita income equal to the national per capita income and a poverty rate equal to the national poverty rate would have an FMAP equal to 55 percentage points. The new formula would be as follows:

$$FMAP_{State} = \left(1 - \left(\frac{2}{3} \left(\frac{(Per\ Capita\ Inc_{State})}{(Per\ Capita\ Inc_{U.S.})} \right) * 0.45 \right) + \left(\frac{1}{3} \left(\frac{(\% Pop_{State} < 100\% FPL)}{(\% Pop_{U.S.} < 100\% FPL)} \right) * 0.45 \right) \right)$$

Automatic Countercyclical Stabilizer

Current Law

The federal government's share of most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which varies by state and is determined by a formula set in statute. In addition to Medicaid, the FMAP is used in determining the federal share of certain other programs (*e.g.*, foster care and adoption assistance under title IV-E of the Social Security Act).

Periods of economic downturn can lead to an increase Medicaid enrollment at a time when state revenues are stagnant or falling. In the past, the Congress has enacted temporary FMAP increases as a part of fiscal relief packages to reduce the amount of state funding that is required to maintain a given level of Medicaid services. For example, the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA, P.L. 108-27) provided temporary fiscal relief for states and local governments through a combination of \$10 billion in FMAP increases and \$10 billion in direct grants.

Most recently, under the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5), all states and territories can receive a temporary FMAP (and/or federal spending cap) increase for a nine quarter period if specified requirements are met. In general, the law holds all states harmless from any decline in their regular FMAPs, provides all states with an across-the-board increase of 6.2 percentage points, and provides qualifying states with an unemployment-related increase. It allows each territory to choose between an FMAP increase of 6.2 percentage points along with a 15 percent increase in its spending cap, or its regular FMAP along with a 30 percent increase in its spending cap.

The unemployment-related FMAP increase is tiered based on a state's unemployment rate in the most recent three-month period for which data are available (except for the first two and last two quarters of the recession adjustment period, for which the three-month period is specified) compared to its lowest unemployment rate in any three-month period beginning on or after January 1, 2006.

Proposed Option

The option would provide an automatic increase in the Medicaid FMAP during periods of national economic downturn occurring after January 1, 2012. The national economic downturn assistance period would begin with the first fiscal quarter for which the Secretary of HHS determines that at least 23 states show a ten percent increase in their rolling average unemployment rate for that quarter (like from five percent to 5.5 percent), compared to the corresponding quarter two years prior.

States eligible for temporary increases in their Medicaid FMAP rates would include those for which the Secretary determines that the state rolling average unemployment rate (*i.e.*, the average of the six most recent months of seasonally adjusted unemployment data) for any quarter

during the national economic downturn assistance period has increased as compared to the corresponding quarter two years prior.

For qualifying states, the state-specific increase in FMAP would be based on the increased Medicaid cost attributable to the state's unemployment rate relative to the state's total Medicaid spending. The cost attributed to the increase in the state's unemployment rate is based on three factors: (a) the increase in the number of unemployed from the base period, (b) a national average amount of federal Medicaid spending attributable to the unemployed, and (c) adjusted by the state's relative Medicaid cost of nondisabled, nonelderly adults and children. The increase in the number of unemployed in the state would be based on a formula that takes into account state increases in the average number of unemployed individuals in a given quarter as compared to a base quarter. The national average amount of federal Medicaid spending per additional unemployed individual in a quarter would equal \$350.00 per person in 2012 (the amount for calendar quarters in succeeding fiscal years would be increased by the CPI-U). The state's adjustment for Medicaid spending is based on the state's relative annual per beneficiary spending on nondisabled, nonelderly adults and children in poverty as compared to the national annual average for such individuals.

The amount of the temporary FMAP increase would only apply to Medicaid benefit expenditures, and would exclude disproportionate share hospital payments, CHIP, and title IV-E. Territories would receive a commensurate increase.

The temporary FMAP increase would be phased-out in order to avoid a sudden drop in federal financial participation and to ensure that states that enter the recession late and are still showing increasing unemployment continue to receive support.

Medicaid Disproportionate Share (DSH) Hospital Payments

Current Law

States must pay DSH adjustments to hospitals serving a disproportionate share of Medicaid patients and patients with special needs.

For FY1998-FY2002, state-by-state DSH allotments were specified in federal statute. A number of changes to these allotments occurred after that time. Most recently, special allotments for 2004 and rates of growth for calculating DSH allotments for all states for the years immediately subsequent to 2004 were established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173). For years after 2004, if a state would have had a lower allotment by using the pre-MMA 2004 amounts, then their allotment for that year is equal to the 2004 MMA amount. Otherwise, the allotment is equal to the prior year's amount adjusted for inflation via the growth of the consumer price index for all urban consumers (CPI-U) for the previous year. State allotments are capped at 12 percent of total benefit payments for the prior year.

Recently the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) provided a temporary increase in DSH allotments. FY2009 state DSH allotments were increased by 2.5 percent above the otherwise applicable amounts. States DSH allotments for FY2010 will be equal to the FY2009 allotments, with the adjustment, increased by 2.5 percent. If states' annual DSH allotments grow at a greater rate than what they would have received without the 2.5 percent adjustment, then states will receive the higher DSH allotments without the recession adjustment. After FY2010, states' annual DSH allotments will return to 100 percent of the amounts as determined under current law.

Special rules apply to "low DSH states," comprised of states in which total DSH payments for FY2000 were less than three percent of the state's total Medicaid spending on benefits. DSH allotments for such states were raised for FY2004 through FY2008 to an amount that is 16 percent above the prior year's amount. For FY2009 forward, the allotment for low DSH states for each year will be equal to the prior year amount increased by the change in the CPI-U, as for all other states.

States cannot obtain federal matching payments for DSH that exceed the state's DSH allotment. Tennessee and Hawaii have special statutory arrangements relating to their state DSH allotments. As a condition of receiving federal Medicaid payments for FY2004 forward, states are required to submit to the Secretary of HHS a detailed annual report and an independent certified audit on their DSH payments to hospitals.

States have flexibility in establishing the designation of DSH hospitals, but must include at least all hospitals meeting either of two minimum criteria: (1) a Medicaid inpatient utilization rate in excess of one standard deviation above the mean rate for the state, or (2) a low-income patient utilization rate of 25 percent. States may not include hospitals with a Medicaid utilization rate below one percent.

States also have flexibility in calculating DSH payment amounts to hospitals, but must pay DSH hospitals at least (1) an amount calculated using the Medicare DSH payment methodology or (2) an amount calculated using a payment methodology that increases each hospital's adjustment as the hospital's Medicaid inpatient utilization rate exceeds the statewide average. DSH hospital payments cannot exceed a hospital-specific cap, set at 100 percent of the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, less payments received from Medicaid and uninsured patients for public hospitals (for all states except California, which is set at 175 percent of those amounts).

Proposed Option

The level of each individual state's current DSH allotment and the definition of a DSH hospital would remain as under current law. Under this proposal, state allotments would be designated as a pool for qualified hospitals within each state. Funds from this pool would be dispersed directly by the Secretary of HHS to qualifying hospitals.

In addition to Medicaid claims data already submitted by states to CMS, hospitals would submit claims data to CMS for uncompensated care. The Secretary, through regulation, must designate

specific services provided by hospitals that would be eligible for DSH payments. For those designated services, the Secretary would determine and pay the appropriate reimbursement rates for Medicaid services and uncompensated care. The payment must be made for services provided during the entire fiscal year, and would be remitted within one quarter after the end of the fiscal year.

The Secretary must report to Congress information relating to the type, variety and frequency of DSH-qualified services, and make a recommendation, based on trends in the level of services provided, for the future of state DSH allotments.

A variation on this option would be to also reallocate DSH funds amongst states.

Dual Eligibles

Under current Medicare and Medicaid rules, some elderly individuals qualify for health insurance under both programs. It was estimated that 8.8 million individuals were dually eligible in FY2005. These dually eligible individuals qualify for Medicare Part A and/or Part B (and Part D as well) and, because they are elderly and have limited income and assets, also are eligible for some type of Medicaid benefits. People qualify for Medicare when they or their spouse or in some cases a parent have worked and paid Medicare taxes, and they are either 65 and over; or are younger, but are blind or have a disability and are receiving cash assistance. People qualify for Medicaid because they have limited income and resources and meet other federal and state requirements such as age or disability.

There are two types of dual eligibles, full- and partial-benefit. In FY2005, there were approximately 7.1 million full-benefit beneficiaries (81 percent of all dual eligibles). Full-benefit duals receive Medicare and full Medicaid benefits. Medicaid fills in the gaps in Medicare coverage, pays Medicare premiums and cost sharing, covers additional services not covered by Medicare, such as long term care (LTC) services and supports, dental services, vision care, medical transportation, and until recently, outpatient prescription drugs. For partial-benefit duals, approximately 1.7 million beneficiaries (19 percent of all duals), Medicaid pays Medicare premiums, so partial-benefit duals have full Medicare coverage, but are not covered for Medicaid's other services. For dual eligibles, Medicaid is always the last payer (the payer of last resort). Thus, for benefits covered by both Medicare and Medicaid, Medicare is the primary payer, while Medicaid covers those costs in excess of Medicare coverage limits and services not covered by Medicare.

Waiver Authority for Dual Eligible Demonstrations

Current Law

States may apply to the Secretary of the Department of Health and Human Service (HHS) to waive Medicaid requirements or to use Medicaid funds to target otherwise ineligible populations, or to use innovative methods for delivering or paying for Medicaid services. Section 1115 of the Social Security Act allows for the waiver of any provision of Medicaid law for demonstrations

“likely to assist in promoting the objectives” of the program. Demonstration waivers have traditionally been granted for research purposes, like testing a program improvement (such as a new reimbursement methodology), and run for a limited period. Some demonstration waivers have been approved under both Medicaid and Medicare authorities. These Medicare and Medicaid demonstrations have mostly been statewide initiatives that have coordinated service delivery, benefit packages, and reimbursement for dual eligibles.

OMB reviews all section 1115 waivers, and since 1982 has required waivers to be budget neutral (there are no statutory requirements for determining budget neutrality). Section 1115 waivers do not have a set duration, but larger demonstrations might be extended to accommodate more start-up time and more thorough evaluation. These statewide reform projects would typically be approved for five years. In addition to demonstration waivers, Congress also has periodically instructed the Secretary of HHS to grant waivers for other initiatives.

Proposed Option

Under this proposal, Congress would establish a new Medicaid demonstration authority of five years for exploration of alternative approaches to coordinating care for dual eligibles.

Cost-Effectiveness Test

Current Law

Section 1915 of the Social Security Act (SSA) permits states to use several types of waivers. Under Medicaid law, section 1915(b), states are permitted to restrict beneficiaries’ choice of providers for obtaining covered services. States may request section 1915(b) waivers to operate programs that impact the delivery system for some or all Medicaid beneficiaries, such as:

- Mandatorily enrolling beneficiaries into managed care programs (although states have the option, through the Balanced Budget Act of 1997 to enroll certain beneficiaries into mandatory managed care via a State Plan Amendment), or
- Creating a “carveout” or selective contracting delivery system for specialty care, such as behavioral health care. Under carveouts or selective contracting, states may negotiate discounts with certain providers, such as hospitals, and then require beneficiaries to obtain covered services only from those providers (except in emergencies).

Section 1915(b), Freedom-of-Choice, waivers do not have to be operated statewide. In addition, they may not be used to expand eligibility to individuals who are not eligible under the approved Medicaid state plan. States also have the option to use savings achieved by using managed care to provide additional services to Medicaid beneficiaries not typically provided under the state plan.

In requesting a section 1915(b) waiver, states must demonstrate that their proposed program will be cost-effective, and must provide assurances that the restrictions established by the waiver will not impair beneficiaries’ access to medically necessary services of adequate quality. The maximum period for waivers is two years, but waivers may be renewed.

To implement these programs, the Secretary of HHS has authority to waive Medicaid requirements (statewide, comparability of services, and freedom of choice of provider.) There are four types of authorities under section 1915(b) that states may request:

- mandates Medicaid Enrollment into managed care;
- utilize a “central broker”;
- uses cost savings to provide additional services; and
- limits number of providers for services.

Proposed Option

Under this proposal, Medicaid 1915(b) waiver authority would be modified to permit states to use savings from coordinating care for dual eligibles between Medicare and Medicaid in their waiver applications. Because Medicare is the first payer and covers most acute care, saving achieved through coordinated care for dual eligibles would primarily be to Medicare in the form of reduced acute care utilization (fewer emergency room visits, less inpatient hospital admissions). Under current law savings to the Medicare program through better coordination of care for dual eligibles, would not count under a 1915(b) waiver application as reduced Medicaid expenditures. This proposal would allow Medicaid 1915(b) waivers to recognize Medicare savings in the 1915(b) cost effectiveness test. The changes in this proposal would give states the option of using 1915(b) waivers to increase contracting with managed care organizations, such as Medicare Advantage Special Needs Plans for dual eligibles, to help coordinate care for dual eligibles. All other 1915(b) authorities would remain unchanged.

Office of Coordination for Dually Eligible Beneficiaries

Current Law

There is no provision in current law for an Office of Coordination for Dually Eligible Beneficiaries within the Centers for Medicare and Medicaid Services (CMS).

Proposed Option

Although dual eligibles (referred to as duals) represent small percentages of Medicare and Medicaid beneficiaries, they are one of the most important beneficiary subgroups, because relative to their numbers, duals account for disproportionately large percentages of Medicare and Medicaid expenditures. In 2005, duals accounted for 46 percent of Medicaid expenditures and 25 percent of Medicare expenditures, yet they accounted for less than 20 percent of either program’s beneficiaries. The concentration of high health care utilization under both Medicare and Medicaid may present opportunities to reduce duals’ overall health care expenditures by better coordinating and integrating the two programs’ services. However, devising policy solutions to coordinate and fully integrate service delivery across Medicare and Medicaid is complex, in part because administration for each is separate, and program authority and policies differ and are sometimes contradictory.

Differing administrative authority and operations coupled with the size of Medicare and Medicaid can make it difficult to identify overlapping and sometimes conflicting policy, financing, and care delivery issues for duals, much less to implement program changes that cut across CMS. Better coordination within CMS between Medicare and Medicaid could help to integrate and improve the efficiency and clinical outcomes for dual eligibles. Although improved Medicare and Medicaid program coordination should occur at many levels, it needs to be initiated and led at CMS central office.

To ensure that coordination for duals occurs, this proposal would establish a new office within CMS, the Office of Coordination for Dually Eligible Beneficiaries (OCDEB). OCDEB would be responsible for identifying and leading agency efforts to align Medicare and Medicaid financing, administration, oversight rules, and policies for dual eligibles. OCDEB would need sufficient organizational stature to be effective, so it will be required to report directly to the CMS administrator. OCDEB also would be required to prepare annual reports which the Secretary of HHS would submit to Congress. OCDEB's annual report would document dual eligible spending with separate subtotals for Medicare and Medicaid and other health care categories, such as hospitals, physicians, home health, longer-term care services, waiver spending, and other expenditures. OCDEB also would develop outreach and training to improve coordination, propose policy changes, identify issues that might need legislative solutions, and develop strategies to ensure good outcomes for duals during care transitions, as well as develop procedures to assist "attainers" (Medicaid beneficiaries who are turning age 65) in navigating the transition from Medicaid only to Medicare and Medicaid.

Medicare Coverage

Reduce or Phase-Out the Medicare Disability Waiting Period

Current Law

Persons under the age of 65 are eligible for Medicare Part A benefits after a 24-month waiting period if they are also eligible for Social Security Disability Insurance (SSDI) benefits or other title II Social Security or Railroad Retirement benefits on the basis of disability. The 24-month Medicare disability waiting period begins when a person becomes eligible for SSDI, title II, or Railroad Retirement benefits.

There is no waiting period for persons with amyotrophic lateral sclerosis (Lou Gehrig's disease). Special waiting periods apply to persons with end stage renal disease (ESRD). A person with ESRD is eligible for Medicare beginning with the fourth month after the beginning of dialysis treatment or in the month of a kidney transplant.

While study results differ, it is estimated that between one-third and one-fifth of individuals in the waiting period do not have health insurance. Some may have health insurance through their spouse, a retiree plan, or continued coverage offered under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or other sources.

Proposed Options

There are four options for change in the Medicare disability waiting period.

Approach 1 would reduce the 24-month waiting period to 12 months beginning in October 2009. A waiting period would continue to exist.

Approach 2 would reduce the 24-month waiting period by one month every quarter beginning in October 2009 until the waiting period reaches zero months in July 2015.

Approach 3 would phase-out the waiting period based on the date of the individual's disability. It would phase-out the waiting period using the following schedule:

- maintain a waiting period of 24 months for persons disabled before October 1, 2009;
- reduce the waiting period to 18 months for persons disabled between October 1, 2009 and March 31, 2010;
- reduce the waiting period to 12 months for persons disabled between April 1, 2010 and September 30, 2010;
- reduce the waiting period to six months for persons disabled between October 1, 2010 and March 31, 2011; and
- eliminate the waiting period for persons disabled after April 1, 2011.

Approach 4 would retain the 24-month waiting period for persons with access to private health insurance coverage, not including COBRA, which meets or exceeds a specified actuarial standard. For others, the waiting period would be phased-out, according to one of the schedules described above.

Temporary Medicare Buy-In

Current Law

Like other adults, people between the ages of 55 and 64 who do not have employment-based or public health insurance coverage must rely on the individual market for private insurance. In the individual market, many people who have health problems are denied coverage or are offered policies that exclude coverage for preexisting conditions. Because older people are sicker, people ages 55 to 64 tend to have greater difficulty obtaining insurance in the individual market than their younger counterparts do. Additionally, many private employers face high legacy costs associated with providing health insurance to early retirees. However, these companies are forced to continue to provide retiree coverage as the non-group market is not a viable option.

There is no provision in current law for a Medicare buy-in or other type of public coverage for the near elderly.

Proposed Options

Approach 1: People ages 55 through 64 who do not have employer-sponsored insurance (ESI) or Medicaid coverage could voluntarily enroll in Medicare beginning January 1, 2011. After the initial enrollment period, enrollment would also be allowed for people of those ages who lose ESI and people who turn 55. The option would end once the Health Insurance Exchange is up and running, though people already enrolled could stay in Medicare.

Enrollees would pay a premium equal to the expected average cost of benefits for Medicare participants plus an administrative fee of five percent. If the actual costs incurred by Medicare exceed the premiums collected for a particular cohort of enrollees, individuals in that cohort would be required to pay an additional premium once they reach normal Medicare eligibility age and to continue doing so until they turn 85. Conversely, if the actual costs plus administrative fees were less than the premiums collected for a particular cohort, individuals in that cohort would receive a rebate on their Medicare premiums once they reach normal eligibility age.

Approach 2: The committee is seeking input from members on alternative ways to meet the needs of the near-elderly before insurance market reforms take effect.

SECTION V: Shared Responsibility

Personal Responsibility Coverage Requirement

Current Law

Federal law does not require individuals to have health insurance. Only Massachusetts, through its statewide program requires that individuals have health insurance. All adult residents of Massachusetts are required to have health insurance that meets “minimum creditable coverage” standards if it is deemed “affordable” at their income level under a schedule set by the board of the Massachusetts Connector. Individuals report their insurance status on state income tax forms. Individuals can file hardship exemptions from the requirement. Persons for whom there are no affordable insurance options available are not subject to the requirement for insurance coverage.

Beginning with tax year 2007, those without insurance and who are not exempt from the requirement lose their state income tax personal exemption. Beginning with tax year 2008, an additional penalty is levied for each month an individual is without insurance, equal to 50 percent of the lowest premium for which he or she would have qualified, to be collected through withholding of state income tax refunds. If no refund is due or the penalty exceeds the refund amount, the state notifies the taxpayer and may use existing state income tax enforcement and collection procedures to obtain the balance owed.

Proposed Options

Open Enrollment Periods in the New Market. All individuals would have a personal responsibility requirement to obtain health insurance coverage. The initial open enrollment

period for eligible individuals in the non-group market would last approximately three months. Special enrollment periods would be allowed for qualifying events, consistent with the special enrollment rights set forth under 9801 of the Internal Revenue Code, such as when an individual becomes a dependent through marriage or birth, or when an individual loses other health insurance coverage. There may be additional special enrollment periods allowed, consistent with those allowed under Medicare Part D (for example, special enrollment periods may be allowed for exceptional circumstances as determined by the Secretary of Health and Human Services). There would also be an annual open enrollment period when individuals could change plans. If an individual takes no action, they will maintain coverage in their current plan.

Another possible option is that during an initial 45-day open enrollment period, all coverage would be guaranteed issue, with no limits on pre-existing conditions. For those who did not enroll during their initial enrollment opportunity, carriers could exclude pre-existing conditions for up to 9 months and charge higher premiums.

Current enrollees could only change plans each year except for special changes allowed for job loss, divorce and other similar instances allowed under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272). A subsequent open enrollment period could also be provided, (presumably in addition to the initial open enrollment period) with guaranteed issue and no limitation on pre-existing conditions. Failure to enroll during the subsequent enrollment period could also result in up to 9-month pre-existing exclusions and increased premiums.

Coverage and Enforcement. All individuals would be required to purchase coverage through (1) the individual market, meeting requirements of at least a lowest cost option, (2) any grandfathered plan, or (3) in the group market, a plan that has an actuarial value equal to the lowest coverage option, with no annual or lifetime limits allowed. Exemptions from the coverage requirement would be allowed for religious objections that are consistent with those allowed under Medicare, and for undocumented aliens.

Consequences of Non-Coverage. In order to ensure compliance, taxpayers would be required to report the months for which they have the required minimum coverage for themselves and family members on their federal income tax returns. In addition, the insurer would be required to report months of qualified health coverage to the individual covered and to the Internal Revenue Service. A similar reporting requirement would apply to employers with respect to individuals enrolled in group health plans if the reporting is not provided by the insurer (for example in the case of self-insured plans).

The consequence for not being insured would be an excise tax equal to a percentage of the premium for the lowest cost option available through the Health Insurance Exchange for the area where the individual resides. The excise tax would be phased-in and would equal 25 percent of the premium for the first year that the requirement is in effect; 50 percent of the premium for the second year; and 75 percent of the premium for the third year and subsequent years. The penalty would apply for any period for which the individual is not covered by a health insurance plan with the minimum required benefit but would be prorated for partial years of noncompliance.

Individuals could apply for an exemption from the penalty in three circumstances: (1) where the lowest cost option available to an individual exceeds 10 percent of income; (2) where an individual is below 100 percent of poverty; and (3) hardship.

Effective Date. The individual requirement would be effective beginning January 1, 2013 (or sooner if possible).

Employer Requirement

Current Law

Currently, there is no federal requirement that employers offer health insurance coverage to employees or their families. However, as with other compensation, the cost of employer provided health coverage is a deductible business expense under section 162 of the Internal Revenue Code. In addition, employer-provided health insurance coverage is generally not included in an employee's gross income.

The Employee Retirement Income Security Act of 1974 ("ERISA") preempts State law relating to certain employee benefit plans, including employer-sponsored health plans. While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State insurance law.

While ERISA does not require an employer to offer health benefits, it does require compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. ERISA was amended (as well as the Public Health Service Act and the Internal Revenue Code) in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), adding other federal requirements for health plans, including rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

The Code imposes an excise tax on group health plans that fail to meet HIPAA and COBRA requirements. The excise tax generally is equal to \$100 per day per failure during the period of noncompliance and is imposed on the employer sponsoring the plan if the plan fails to meet the requirements.

Under Medicaid, states may establish "premium assistance" programs, which pay a Medicaid beneficiary's share of premiums for employer-sponsored health coverage. Besides being available to the beneficiary through his/her employer, the coverage must be comprehensive and

cost-effective for the state. An individual's enrollment in an employer plan is considered cost-effective if paying the premiums, deductibles, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the states' expected cost of directly providing Medicaid-covered services. States are also required to provide coverage for those Medicaid-covered services that are not included in the private plans. A 2007 analysis showed that 12 states had Medicaid premium assistance programs as authorized under current law.

Proposed Option A

Pay or Play. All employers with more than \$500,000 in total payroll for a taxable year will either offer their full-time (defined as 30 hours or more) employees health insurance coverage or pay an assessment. The coverage offered will have an actuarial value equal to the lowest coverage option and which also includes first dollar coverage for prevention services recommended by the U.S. Preventive Services Task Force. The employer will be required to contribute at least 50 percent of the premium for the employer-sponsored health insurance.

If an employee is offered coverage by their employer and takes it (either outside of the Health Insurance Exchange or with an employer who is offering coverage options to their workers through the Health Insurance Exchange), the worker will receive the tax exclusion for employer-provided health insurance (i.e., the employer's contribution is not treated as income) but they cannot receive the income-based tax credit. If an employee opts out of employer coverage (either by refusing a non-exchange plan offered by the employer or, if their employer is offering coverage through the Health Insurance Exchange, by refusing that option), the employee is potentially eligible for the income-based tax credit.

The worker pays into the Health Insurance Exchange in the same way as any other person seeking coverage in the Health Insurance Exchange, and is subsidized in the same way. The employer's normal contribution for a worker is then contributed to the Health Insurance Exchange to help finance tax credits in aggregate (it does not affect what the worker pays). Since the employer payment does not directly relate to the opting out worker's situation, the payment should not be treated as taxable income to the worker.

Employers that do not demonstrate that they have offered the required level of coverage to their employees would have to pay an assessment. The assessment would be an excise tax calculated as an amount per employee per month based on the employer's gross receipts for the taxable year.

For employers with total annual payroll between \$500,000 and \$1,000,000, the excise tax would be \$100 per employee per month. For employers with total annual payroll between \$1,000,000 and \$1,500,000, the excise would be \$250 per employee per month. For employers with total annual payroll greater than \$1,500,000, the excise tax would be \$500 per employee per month. Another option would be to require these employers to pay a tiered penalty based on total annual payroll, equal to: 2 percent of payroll between \$500,000 and \$1,000,000, 4 percent of payroll between \$1,000,000 and \$1,500,000, and 6 percent of payroll over \$1,500,000. A final option might be to require a larger penalty only on firms with total annual payroll of \$1,500,000 or more. Penalty amounts for each of these options would be indexed by Medical CPI.

Medicaid Interaction. States would be required to offer current-law Medicaid premium assistance to individuals eligible for Medicaid who are offered employer-sponsored coverage.

Proposed Option B

Requirements. Option B would not require employers to pay or play, but would still have a coverage requirement for individuals.

Medicaid Interaction. Option B would offer an alternative way to structure the Medicaid interaction. Medicaid eligible individuals offered employer-sponsored insurance could enroll in an individual policy using the premium and cost-sharing assistance provided through Medicaid and the general low-income tax credits offered under this legislation.

SECTION VI: Options to Improve Access to Preventive Services and Encourage Health Lifestyles

Promotion of Prevention and Wellness in Medicare

Personalized Prevention Plan and Routine Wellness Visit

Current Law

Under current law, Medicare covers a one-time initial preventive physical examination (IPPE) and certain preventive services enumerated in law. The goal of the “Welcome to Medicare” visit is “health promotion and disease detection and includes education, counseling, and referral with respect to [covered] screening and other preventive services....” The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) waived the deductible for the IPPE and extended eligibility for the visit from six months to within one year of Medicare Part B enrollment.

Proposed Option

This option would authorize a personalized prevention plan for all enrolled beneficiaries once every five years unless deemed inappropriate. Beneficiaries would first receive a comprehensive health risk assessment including at least a complete medical and family history, age-, gender, and risk appropriate measurements (including height, weight, body mass index, and blood pressure if not already part of the patient’s record). The assessment would also identify chronic diseases, modifiable risk factors, and emergency or urgent health needs. The assessment could be provided through an interactive telephonic or web-based program or during an encounter with a health professional as determined by the Secretary. The Secretary would design the assessment, in consultation with relevant groups and entities, as well as set standards for the electronic tools that could be used to deliver the assessment. No co-payment or deductible would apply.

Within six months of completing the comprehensive health risk assessment (HRA), the option would authorize Medicare payment for a visit to a qualified health professional to create a personalized prevention plan. The plan would include the following elements: review and update medical and family history; measure the patient's blood pressure, body mass index and any other measurements identified above not included the HRA; provide a schedule and referral for recommended, appropriate, covered preventive services and immunizations; provide a strategy to address identified conditions and risk factors; identify all medications currently prescribed and all providers regularly involved in the patient's care; and offer health advice and referral to Medicare-covered health education and preventive counseling or referral to community based interventions to address modifiable risk factors such as weight, physical activity, smoking, and nutrition. Optional elements, if appropriate, include referrals for diagnostic testing, or referrals to review treatment options for beneficiaries with chronic conditions; end of life care planning, and administration of appropriate Medicare covered immunizations and screening tests. No co-payment or deductible applies.

Incentives to Utilize Preventive Services and Engage in Healthy Behaviors

Current Law

All currently covered Medicare preventive services and any applicable cost-sharing requirements, as well as the reduction or elimination of such requirements, are established in statute. Co-payments, deductibles, or both have been reduced or eliminated for many of the clinical preventive services, including pneumococcal and influenza vaccines; cardiovascular disease screening, and diabetes screening tests among others. The Secretary does not have authority to modify cost-sharing requirements for preventive services. Evidence indicates that cost-sharing reduces Medicare beneficiaries' utilization of preventive services. For example, Medicare beneficiaries with supplemental insurance were substantially more like to have had a mammogram screening than women without supplemental insurance. In addition, a National Bureau of Economic Research Working Paper concluded the elderly are "very price sensitive", finding that a \$10 co-payment increase lead to an almost 20 percent decline in physician office visits.

In the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), Congress authorized the Secretary to add coverage for additional preventive services if, they were reasonable and necessary to prevent or detect an illness or disability early, appropriate for the individual entitled to benefits under Part A or enrolled under Part B and recommended by the United States Preventive Services Task Force (rated "A" or "B"). The U.S. Preventive Services Task Force (USPSTF), administered by the Agency for Healthcare Research and Quality (AHRQ), is an independent panel of private-sector experts in primary care and prevention which conducts rigorous, impartial assessments of scientific evidence for the effectiveness of a broad range of clinical preventive services, including, screening, counseling, and preventive medications. At this time no new services have been covered pursuant to this authority.

Proposed Option

This option would remove or limit beneficiary cost-sharing (co-payment, deductible or both) for preventive services covered under Medicare and rated “A” or “B” by the U.S. Preventive Services Task Force (USPSTF). The option would also encourage the Secretary to establish a mechanism to provide refunds or other incentives to Medicare beneficiaries who successfully complete certain behavior modification programs, such as smoking cessation or weight loss. Such programs must be comprehensive, evidence-based as determined by the Secretary, widely available and easily accessible. Finally, the option would explore ways to improve provider education and patient awareness of covered preventive services.

Coverage of Evidence-Based Preventive Services

Current Law

All currently covered Medicare preventive services were established in statute. In the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275), Congress authorized the Secretary to add coverage for additional preventive services if, they were reasonable and necessary to prevent or detect an illness or disability early, appropriate for the individual entitled to benefits under Part A or enrolled under Part B and recommended by the United States Preventive Services Task Force (rated “A” or “B”).

Generally, all beneficiaries age 65 and older are entitled to covered clinical preventive services, regardless of age. In contrast, the United States Preventive Services Task Force (USPSTF) provides recommendations based on the scientific evidence for certain services based on age, gender and risk factors for disease. Consequently, recommendations may change across the age groups or based on gender within older populations. For example, the USPSTF recommends a one-time screening for an abdominal aortic aneurysm (AAA) by ultrasound for men, who have never smoked, until age 75. However, USPSTF recommends against a routine AAA screening for women. It rates this service “D” for women, meaning the evidence provided no net benefit or that the harm outweighed the benefit.

Proposed Option

This option would give the Secretary authority to withdraw Medicare coverage for preventive services that are rated “D” by the United States Preventive Task Force unless deemed medically necessary by a prescribing physician.

Promotion of Prevention and Wellness in Medicaid

Access to Preventive Services for Eligible Adults

Current Law

States are required, under Medicaid, to cover a package of “well-child” and preventive service benefits for the majority of eligible children under the age of 21, called the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. For eligible adults, states are required to cover family planning services and supplies, and certain pregnancy-associated services, including prenatal and postpartum care. Otherwise, state coverage of screening and preventive services for eligible adults is optional. Such services are defined in section 1905(a)(13) as “other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;....”

Proposed Option

The option would clarify the definition of “screening and preventive” services in Medicaid for adults as including services rated “A” or “B” by the United States Preventives Services Task Force (described in an earlier section) and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP). This whole category of services is covered at the states’ option. If a state opts to provide Medicaid coverage for all approved preventive services and immunizations, the state would receive a 1% increase in the federal share of its Federal Medical Assistance Percentage (FMAP) for those services. At a minimum, states would be required to provide Medicaid coverage for comprehensive tobacco cessation services for pregnant women without cost-sharing for such services.

Incentives to Utilize Preventive Services and Encourage Healthy Behaviors

Current Law

Under traditional Medicaid, states may impose on beneficiaries certain costs, such as enrollment fees, premiums, deductions, and cost-sharing. Under specified conditions, states may be prohibited from imposing such costs for services provided to children, or to eligible adults who are in a hospital or other institutional facility, or who are receiving emergency services, family planning services, or hospice care. States are also prohibited from imposing deductions, cost-sharing, or other charges for Medicaid covered pregnancy-related services provided to pregnant women.

Proposed Option

The option would remove or limit cost-sharing for clinical preventive services rated “A” or “B” by the USPSTF. The option would permit states to design a proposal and apply for funds to

explore mechanism(s) to provide refunds or other incentives to Medicaid enrollees who successfully complete certain behavior modification programs, such as smoking cessation and weight loss. Such programs must be comprehensive and evidence-based, as determined by the Secretary, covered under the Medicaid program, as well as, widely available and easily accessible. The state's application must include plans for educating providers and making patients aware of covered preventive services. Funding available will be capped.

Options to Prevent Chronic Disease and Encourage Healthy Lifestyles

“RightChoices” Grants

Current Law

No provision.

Proposed Option

The option contemplates annual, capped grants to states for three or five years – or until insurance options are available through the Health Insurance Exchange – whichever is sooner. These grants would provide access to certain evidence-based primary preventive services such as tobacco use screening, influenza immunization, counseling on daily aspirin use, hypertension screening, or obesity screening for uninsured adults and children.

Prevention and Wellness Innovation Grants

Current Law

None

Proposed Option

This option would establish a competitive grant program to promote health and human services program integration, improve care coordination and access to preventive services and treatments, and better integrate the delivery of health care services to improve health and wellness outcomes. The option identifies three approaches states may choose to implement while allowing flexibility to encourage innovation.

Additionally, the option would require the Department of Health and Human Services (HHS) to review and make improvements in the administration of its low income programs.

Promotion of Team-Based Care. States would submit an application to the Secretary to create locally integrated delivery systems including establishing multidisciplinary care teams.

Multidisciplinary community health teams would be required to provide: 1) comprehensive care management and patient and family support in conjunction with primary care providers; 2) care

coordination and health promotion activities including access to the range of services needed to maintain and improve health, such as behavioral services and nutritional counseling; and coordination with local public health offices; 3) social and economic support to facilitate patient and family assistance with social support services and referral to and coordination with community based programs; and 4) comprehensive transitional care from inpatient to institutional care settings or care provided in community-settings as well as assuring appropriate follow up.

Providing Individualized Plans. This option would allow states to implement service integration and delivery reform activities, including developing an individualized plan for health and human service needs of low-income beneficiaries.

Other Innovative Approaches. States would be allowed to submit a proposal that meets the goals and objectives of this grant. These proposals must include an evaluation component that assesses the impact of the proposed innovation on the health status of participating individuals.

Upon completion of the grants, the Department of Health and Human Services (HHS) would conduct a study of best practices to improve wellness outcomes for low-income families. Following the study, HHS would issue best practices for states on how to establish a well integrated model of care for health maintenance, reducing chronic disease, promoting patient care, and facilitating coordination between health and human service systems. Within two years after HHS issues recommended best practices, states would be required to submit a plan to better integrate services for low-income families, including a description of what programs already provide for individualized plans, and ways to facilitate integration of health and human services.

Employer Wellness Credits

Current law

The expense of an employer-provided wellness program for employees is deductible by the employer as a business expense under section 162.

Proposed Option

Under the option, a tax credit would be allowed for 50 percent of the costs paid by an employer for providing a “qualified wellness program” during a taxable year. The amount of the credit would be limited to an amount not exceeding \$200 for each employee not exceeding 200 employees, plus \$100 for each additional employee in excess of 200 employees. Only employees generally working more than 25 hours per week are taken into account. For purposes of this credit, any amount paid for food or health insurance could not be included as a cost of the wellness program. The credit would not be refundable and would not be paid in advance and would be available for a maximum of five years.

To claim the tax credit for eligible expenditures, an employer would be required to obtain a certification by the Secretary of HHS (in coordination with the Director of the CDC and the Secretary of the Treasury) that its program meets the definition of a qualified wellness program.

In order for a program to be a qualified wellness program under the proposal, all employees would be required to be eligible to participate in the program. Further, under the proposal, a qualified wellness program includes four components: health awareness (such as health education, preventive screenings and health risk assessment); employee engagement (such as mechanisms to encourage employee participation); behavioral change (elements proven to help alter unhealthy lifestyles such as counseling, seminars, on-line programs, self help materials); and a supportive environment (such as creating on-site policies encourage healthy lifestyles, eating, physical activity and mental health). For an employer with 500 or more employees, to be a qualified wellness program, a program would be required to include all four components. For an employer with less than 500 employees, to be qualified wellness program, a program would only required to include at least three of the four components.

In addition, to be a qualified wellness program under the proposal, the program would be required to be consistent with evidence-based research and best practices, as determine by the Secretary, such as research and practices described in the Guide to Community Preventive Services and Guide to Clinical Preventive Services and the National Registry for Effective Programs.

Finally, another option would apply all of the criteria described above as well as provide employers with 50 or fewer employees with a credit limited to \$400 per employee. The credit would not have a sunset requirement for those employers.

SECTION VII: Long Term Care Services and Supports

Medicaid Home and Community Based Services (HCBS) Waivers and the Medicaid HCBS State Plan Option

Current Law

Medicaid HCBS Waiver. Section 1915(c) authority under the Social Security Act gives states the option to extend a broad range of home and community based services (HCBS) to selected populations of individuals with level-of-care needs that would otherwise be offered in Medicaid-covered institutions, such as a nursing home, intermediate care facility for the mentally retarded (ICF/MR), or a hospital. Services that states may choose to offer under the section 1915(c) waiver include case management, homemaker/home health aide, personal care, adult day health, habilitation, respite care, rehabilitation, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not they are furnished in a facility) for individuals with chronic mental illness. States have flexibility to offer additional services if approved by the Secretary of HHS. Section 1915(c) waivers may not cover room and board.

Waivers have been used to cover persons aged 65 or older, individuals with mental retardation and developmental disabilities, persons under age 65 with physical and other disabilities, persons with HIV/AIDS, persons who are medically fragile or technologically dependent, and persons with mental illness. Individuals generally enroll in one HCBS waiver at a time. Average per capita expenditures for waiver participants may not exceed average per capita expenditures that states would have spent for these beneficiaries in institutions, including the costs of other state plan services for which beneficiaries may be eligible (e.g., hospital services).

Medicaid HCBS State Plan Option. Under the Deficit Reduction Act of 2005 (DRA; P.L. 109-171), Congress gave states the option to extend HCBS to Medicaid beneficiaries under the HCBS State Plan Option (section 1915(i) of the Social Security Act) without requiring a section 1915(c) or section 1115 waiver. The section 1915(i) option allows states to select one or more services from the list of section 1915(c) services available, but does not give states the authority to seek approval from the Secretary to offer additional services. Also under 1915(i), states may amend their Medicaid plans without demonstrating budget neutrality as they do under 1915(c) waivers.

Proposed Option

The proposal would allow states to seek approval from the Secretary to offer additional services under section 1915(i), the Medicaid HCBS State Plan Option. It would also allow individuals to simultaneously enroll in more than one Medicaid waiver.

Eligibility for HCBS Services

Current Law

Medicaid HCBS Waiver. As mentioned above, to be eligible for section 1915(c) HCBS waivers, persons must require the level-of-care, as defined by a state's assessment, that would otherwise be offered in a Medicaid-covered nursing facility, intermediate care facility for the mentally retarded (ICF/MR), or a hospital. In addition, eligible persons must be among the waiver's targeted population groups (e.g., persons aged 65 and over or persons with mental retardation, among others) and meet the state's financial standards for that waiver (established within federal parameters).

Persons who are already enrolled in Medicaid and who meet a state's eligibility criteria for a specific waiver may enroll if a slot is available. States may also use the optional eligibility pathway, known as the special income rule or "300 percent rule," to extend section 1915(c) waiver services and other Medicaid benefits to certain individuals with higher income. Thus, section 1915(c) may confer eligibility for persons whose income falls within the standards of the special income rule. Under the special income rule, such persons may have income up to a specified level established by the state, but no greater than 300 percent of the maximum Supplemental Security Income (SSI) payment applicable to a person living at home. A number of states also allow persons to place income in excess of the special income level in a trust, often referred to as a Miller Trust, and still qualify for Medicaid through the special income rule. Following the individual's death, the state becomes the beneficiary of amounts in this trust.

Medicaid HCBS State Plan Option. States that choose to implement the section 1915(i) HCBS state plan option must establish needs-based eligibility rules for services that are less stringent than the section 1915(c) waiver's institutional level-of-care criteria. The criteria established by the state requires an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform two or more activities of daily living (*i.e.*, eating, toileting, transferring, bathing, dressing and continence) or the need for significant assistance to perform such activities, and such other risk factors as the state determines to be appropriate.

Eligibility for services may be extended only to individuals already enrolled in Medicaid and whose income does not exceed 150 percent of the federal poverty level (FPL). Section 1915(i) does not confer eligibility for Medicaid for any populations.

Proposed Option

This proposal would eliminate the existing institutional level-of-care requirement for eligibility for section 1915(c) waivers and require states to replace it with less stringent criteria.

The proposal would also eliminate the prohibition against providing section 1915(i) services to persons with income above 150 percent FPL. In addition, states would have the option to confer eligibility for section 1915(i) HCBS services as well as full Medicaid benefits to individuals with income up to a specified level established by the state, but no greater than 300 percent of the maximum SSI payment, as long as these individuals would also meet the state-defined needs-based criteria. Persons with Miller Trusts would be able to qualify for section 1915(i) and other Medicaid benefits through the special income rule eligibility pathway.

Increase Access to Medicaid HCBS

Current Law

Both sections 1915(c) and 1915(i) allow states to cap enrollment to contain spending. Specifically, section 1915(c) allows states to place an enrollment cap on each of the state's HCBS waivers.

Under section 1915(i), states may limit participation to a projected number of enrollees. If enrollment exceeds state projections, states may modify their needs-based criteria without having to obtain prior approval from the Secretary if: (1) the state provides at least 60 days notice to the Secretary and the public of the proposed modification; (2) the state deems an individual receiving HCBS, on the basis of the most recent version of the criteria in effect prior to the effective date of the change, to be eligible for such services for at least 12 months beginning on the date the individual first received medical assistance for such services; and (3) after the effective date of the change, the state, at a minimum, does not make the criteria more stringent than the criteria used to determine whether an individual requires the level-of-care provided in a hospital, nursing facility, or an intermediate care facility for the mentally retarded. States may

use waiting lists to track those persons who would obtain services but for the cap. Waiting lists may also be used to limit the number of beneficiaries who access HCBS under the cap.

Proposed Options

Approach 1: This proposal would increase the number of persons under the cap that states would be required to enroll in either or both of these authorities.

Approach 2: This proposal would prohibit states from using waiting lists to prevent eligible beneficiaries from accessing HCBS.

Approach 3: The committee is seeking input from members on alternative ways to ensure that eligible beneficiaries are able to access HCBS.

Increase Federal Match for Medicaid HCBS

Current Law

The federal medical assistance percentage (FMAP) refers to the federal government's share of a state's expenditures for most Medicaid services, including the range of HCBS offered by states under waivers and the Medicaid state plan. The FMAP is determined annually and designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes). For FY2009, FMAPs range from 50.00 percent to 75.84 percent. In addition, the 111th Congress enacted a temporary FMAP increase for states in the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5).

Proposed Option

The proposal would increase the federal match for Medicaid HCBS by one percent.

Medicaid Spousal Impoverishment Rules

Current Law

Medicaid law includes spousal impoverishment provisions intended to prevent the impoverishment of a spouse whose husband or wife seeks Medicaid coverage for Long Term Care (LTC) services. The law requires that spousal impoverishment rules for eligibility and post-eligibility treatment of income be applied to non-institutionalized spouses (*i.e.*, community spouses) of persons residing in a medical institution or nursing facility for at least 30 consecutive days. It grants states the option to apply these rules to certain groups of individuals receiving HCBS waiver services under sections 1915(c), (d), and (e) of Medicaid law.

Although Medicaid law grants states the option to apply spousal impoverishment rules to the counting of income and assets for a couple during the eligibility determination for persons applying to section 1915(c) and (d) waivers, it does not allow states to apply these rules to the

eligibility determination for 1915(e) waivers. In addition, Medicaid law prohibits the application of spousal impoverishment rules for the post-eligibility treatment of income for purposes of 1915(c), (d), and (e) waivers for those who qualify for Medicaid through a state's medically needy eligibility pathway. The Secretary of HHS may grant authority for states to apply spousal impoverishment rules for eligibility and post-eligibility determination of income under section 1115 waivers which are sometimes used to offer HCBS instead of section 1915(c) waivers.

Proposed Option

The proposal would amend Medicaid law to require states to apply spousal impoverishment rules to applicants who would receive HCBS under sections 1915(c), (d), (e), (i), and (k), as well as under section 1115 of the Social Security Act. It would also apply to persons applying for HCBS through the medically needy eligibility pathway.

Medicaid Resources / Asset Test

Current Law

Within federal guidelines, states set asset (or resources) standards specifying the maximum amount of countable assets a person may have to qualify for Medicaid, including application for nursing facility services and Medicaid's section 1915(c) waivers. For the treatment of most types of assets, states generally follow SSI's program rules. Under SSI (and thus often under the Medicaid program), countable assets, such as funds in a savings account, stocks, or other equities, cannot exceed \$2,000 for an individual and \$3,000 for a couple. Most states use the more liberal standards for computing resources under section 1902(r)(2) of the Social Security Act to disregard certain types or amounts of assets, thereby extending Medicaid to individuals with higher levels of assets. Asset standards are often the same for all populations of aged and disabled groups applying to Medicaid.

States also check for asset transfers as part of the Medicaid asset test. The asset transfer test has two parts: (1) the transfer look-back and (2) the financial penalty. That is, financial penalties are imposed on people found to have made unauthorized asset transfers in the look-back period. The penalty is calculated by determining how much nursing home time the beneficiary could have paid for had the transfer not occurred. Once this calculation is done, the resulting number of months is then precluded from Medicaid coverage.

The Deficit Reduction Act of 2005 (DRA; P.L.109-171) increased the asset transfer look-back from 36 months to 60 months. The DRA also changed when the financial penalty can be imposed. Prior to the DRA, the penalty was triggered by the act of transfer, meaning that the number of months precluded from Medicaid coverage began with the month of transfer. The DRA changed the trigger to be the time of application for Medicaid.

Proposed Option

The proposal would allow states to treat those applying to Medicaid for HCBS differently by allowing them to retain higher levels of assets. For example, states could exclude from countable

assets up to six months of the average monthly cost to a private patient of nursing facility services in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. States would retain the authority to use section 1902(r)(2) to disregard additional assets for this population. The proposal would also reset the look-back period for asset transfers to 36 months. The time of imposition of the penalty would remain unchanged.

Long Term Care Grants Program

Current Law

There are a number of programs aimed at providing home and community based long term care services, many of which have been funded in part through grants.

Real Choice Systems Change Grant Initiative. In 2000, Congress enacted legislation that included appropriations for discretionary funding for the Real Choice Systems Change grant program under the Consolidated Appropriations Act, 2001 (P.L.106-554) authorized under section 1110 of the Social Security Act. These grants, awarded annually, are intended to help states expand community based LTC options. Since FY2001, CMS has awarded 338 grants totaling \$302.2 million to all 50 states, the District of Columbia, and two territories.

Aging and Disability Resource Centers (ADRC). A collaborative effort of the AoA and CMS, the ADRC initiative provides grants to support states' efforts to streamline information and access to LTC services through funding from CMS Real Choice Systems Change grants and AoA title IV research and demonstration authority. The OAA Amendments of 2006 (P.L. 109-365) allow for continued expansion by authorizing funds for ADRCs in all states. As of October 2008, approximately 175 ADRC pilot sites were operating in 42 states, the District of Columbia, and two territories. From FY2003 through FY2007, the AoA and CMS have awarded over \$42 million in discretionary grants to states.

Informal Caregivers. The National Family Caregiver Support Program (NFCSP) in title III, Part E of the Older Americans Act (OAA), provides direct support to informal caregivers primarily caring for the elderly through information and referral assistance, respite care, and training and support. FY2009 discretionary funding for the NFCSP is \$154.2 million. Under title XX of the Social Security Act (the Social Services Block Grant program) states have broad discretion to provide assistance to caregivers, primarily in the form of information and referral and respite care. Additional support to caregivers is authorized under the Lifespan Respite Care Act (P.L. 109-442), which provides respite care to informal caregivers caring for individuals of all ages. Finally, the Omnibus Appropriations Act of 2009 (P.L. 111-8) appropriates \$2.5 million in discretionary funding under the HHS Office of the Secretary for these activities (compared to \$0 in FY2007 and FY2008).

Prevention and Health Promotion. Prior to the 2006 reauthorization of the OAA, the Administration on Aging (AoA) provided grants to states and local communities to support the delivery of evidence-based disease prevention programs through community based aging service provider organizations (e.g., senior centers, senior housing projects, faith-based organizations).

Since FY2003, AoA has funded discretionary grants totaling \$50 million to 27 states and local communities. Grantees are required to use interventions in one or more of the following subject areas: physical activity, fall prevention, nutrition and diet, and depression and/or substance abuse. The OAA Amendments of 2006 (P.L. 109-365) required the Assistant Secretary to establish criteria for and promote the implementation of these programs.

Green House Model. The Green House Model provides long term, skilled nursing care for frail elderly in a small group home for up to ten persons. Green Houses are designed to look like private homes with common living, dining and kitchen areas, a private room and bath for each resident, and an outside fenced yard and patio. Green Houses have direct care workers that are “universal workers” with core training as a Certified Nursing Assistants (CNAs). In addition to personal care, staffs perform a variety of tasks such as meal preparation, laundry, and housekeeping. There are currently 50 Green House homes operating in 17 long term care settings in 12 states. No federal funding has been used to support this model.

Proposed Option

The proposal would make grants available for the Secretary of HHS to award to eligible states. This additional discretionary funding could facilitate the delivery of HCBS by: (1) creating a Consumer Task Force to assist in the development of real choice systems change initiatives; (2) providing support for informal caregivers; (3) expanding prevention and health promotion education activities; (4) expanding the Green House Model; (5) implementing approved section 1915(i) Medicaid HCBS State Plan Option amendments; and (6) any other activity the Secretary approves to facilitate the use of HCBS. The proposal would also continue funding ADRCs.

Functional Assessment Tool for Post-Acute LTC

Current Law

As a guide to payment policy reform in the Medicare program, the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) directed the Centers for Medicare and Medicaid Services (CMS) to develop a Continuity Assessment Record and Evaluation (CARE) tool to measure the health and functional status of Medicare acute care discharges and changes in severity and other outcomes for post acute care (PAC) Medicare patients. For the purposes of this tool, PAC providers include Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). This work is being conducted under contract by the Secretary of HHS with RTI International. According to RTI, the tool is expected to measure case mix severity differences in the discharge status of Medicare beneficiaries from acute care settings and take into account medical, functional, cognitive impairments, and social/environmental factors of beneficiaries.

Proposed Option

Based on consultation with CMS, the proposal would provide a timeframe for CMS to implement this assessment tool.

Money Follows the Person Rebalancing Demonstration

Current Law

Section 6071 of the Deficit Reduction Act of 2005 (DRA; P.L. 109-171) established the Money Follows the Person Rebalancing Demonstration which authorizes the Secretary of Health and Human Services to award grants to states designed to increase the use of home and community based, rather than institutional long term care services; eliminate barriers that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long term services in the setting of their choice; increase the ability of the state Medicaid program to assure continued provisions of home and community based long term care services to eligible individuals who choose to transition from an institutional to a community setting and ensure that procedures are in place to provide quality community based long term care services and to provide for continuous quality improvement in such services.

Funding is available through September 30, 2011.

Proposed Option

Extend the Money Follows the Person Rebalancing Demonstration through September 30, 2016.

SECTION VIII: Options to Address Health Disparities

Required Collection of Data

Current Law

The Medicare enrollment database (EDB) is the primary source for racial and ethnic data on Medicare beneficiaries. The EDB obtains this information from the Social Security Administration's (SSA) SS-5-FS form (commonly known as the "SS-5"), which is used to apply for a Social Security number. SS-5 data is transferred to CMS when a person enrolls in Medicare. The SS-5 form currently includes five racial categories: non-Hispanic white; non-Hispanic black; Hispanic; Asian, Asian-American or Pacific Islander. Primary language is not reported on the SS-5, though country of origin is reported. Several problems with the SS-5 exist: (1) before 1980 respondents were listed as either "White, Black, other, or unknown;" (2) the current five-item race/ethnicity question on the SS-5 is voluntary, or optional; and (3) a person other than a parent often fills out the SS-5 for a newborn, which may lead to misidentification of race or ethnicity or may increase the likelihood that the question goes unanswered.

The American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) included \$500 million to replace the SSA's National Computer Center and to cover the information technology costs associated with the new center. The current SSA National Computer Center is outdated and uses a programming system that makes upgrades and even the training of new information technology staff difficult. The SSA computer system also lacks the ability to properly interface with the Internet, other government systems, or health information technology networks.

Proposed Option

The proposal would require SSA to collect race, ethnicity, and language data on Medicare enrollees. The proposal would provide funding to upgrade SSA databases so that they can communicate with one another.

Data Collection Methods

Current Law

While federal data collection efforts collect a broad range of data for measuring disparities in the quality of and access to health care, there are no statutory requirements to ensure that the sample size is large enough to generate reliable, statistically significant estimates for various racial and ethnic groups. Some surveys oversample minorities (e.g., the National Health Interview Survey, the National Health and Nutrition Examination Survey, the Medical Expenditure Panel Survey) in an effort to produce reliable data for blacks, Hispanics, and Asians. But no federal surveys have large enough samples to examine smaller groups like Puerto Ricans, Cubans, or Filipinos.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPAA; P.L. 110-275) instructed the Secretary to evaluate approaches for collecting disparities data on Medicare beneficiaries and provide a report to Congress, including recommendations for reporting nationally recognized quality measures, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, on the basis of race, ethnicity, and gender. MIPAA further instructed the Secretary to implement the approaches identified in the initial report and, subsequently, report back to Congress with recommendations for improving the identification of health care disparities among Medicare beneficiaries based on an analysis of those efforts.

The Institute of Medicine in its 2002 health disparities report, *Unequal Treatment*, recommended that “accreditation bodies, such as the Joint Commission and National Committee for Quality Assurance (NCQA), should require the inclusion of data on patient race, ethnicity and highest level of education ... in performance reports of public and private providers as part of healthcare performance measurement.” Current statutorily mandated quality reporting programs for Medicare hospitals and physicians do not require the inclusion of data on race, ethnicity or primary language.

By making patient demographic data easier to collect and analyze, health information technology (HIT) systems have the potential to benefit health disparities research. To that end, the recently enacted Health Information Technology for Economic and Clinical Health (HITECH) Act (ARRA; P.L. 111-5) instructed the new HIT Policy Committee to recommend standards ensuring that HIT systems collect patient demographic data, including at a minimum, race, ethnicity, primary language, and gender.

Proposed Option

The proposal would require that federally funded population surveys collect sufficient data on racial/ethnic subgroups to generate statistically reliable estimates in studies comparing health disparities populations. It would ensure that quality reporting requirements include proposals to collect data on patients by race, ethnicity, and primary language, and it would extend the MIPAA provisions regarding the collection of health disparities data to the Medicaid and CHIP populations.

Standardized Categories for Data

Current Law

The Office of Management and Budget (OMB) Directive 15 (Standards for the Classification of Federal Data on Race and Ethnicity) outlines standards for the collection of race and ethnicity data on federally-sponsored surveys, administrative forms, and other records (*e.g.*, school applications or mortgage lending applications). OMB Directive 15 does not mandate collection of such data. However, when race data are collected Directive 15 requires a minimum of five racial categories (White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander). When ethnicity information is gathered, a dichotomous identification question with the choices “Hispanic or Latino” or “not Hispanic or Latino” must be used. Data collection instruments may include additional categories such as Mexican-American, Chicano, Puerto Rican, Cuban, or Filipino, as long as these categories can be aggregated to the standard categories. When individuals are asked to self-identify (which is OMB’s “preferred method”), Directive 15 also requires that respondents be given the opportunity to report multiple races in response to a single question. Including “multiracial” as an option is not acceptable.

In addition, when self-identification is used, race and ethnicity should be determined by first asking about ethnicity (“Hispanic or Latino” vs. “not Hispanic or Latino”) and, second, asking individuals to choose one of the aforementioned five racial categories. When the data is not based on self-identification, a single item race/ethnicity question inviting people to choose “all that apply” is acceptable. Finally, persons who identify as Alaska Native should also be asked for their tribal affiliation.

Generally, all federal agencies and federally sponsored entities must use the Directive 15 categories when collecting race and ethnicity data; however, the requirements may be waived if an organization can demonstrate that it is either unreasonable to use the categories in a particular situation, or if it can be shown that race and ethnicity data are not critical to the administration of the program seeking this information. OMB standards do not apply to state and municipal public health departments or to Medicaid. While the standards do apply to the Children’s Health Insurance Program (CHIP), they are not binding on states which opt to use CHIP funding to finance a Medicaid expansion or which employ a combination approach.

While OMB Directive 15 does not address data on language, CMS requires that this information be reported for Medicaid beneficiaries. CMS does not require the collection of primary language data for CHIP enrollees and their parents. No one is required to collect data regarding disability.

Proposed Option

The proposal would establish uniform categories for collecting data on race and ethnicity, requiring the use of OMB Directive 15 standards and the OMB policy for aggregation and allocation of subgroups. Funding would be provided to states for technology upgrades needed to adopt OMB categories. The OMB standards would apply to Medicaid. CMS would be required to collect primary language data on CHIP enrollees and their parents.

Additionally, this proposal would require the collection of access and treatment data for people with disabilities. The Centers for Medicare and Medicaid Services (CMS) would be required to determine where people with disabilities access primary care and the number of providers with accessible facilities and equipment to meet the needs of the disabled. Access to intensive care units would also be evaluated. Quality reporting requirements would include provisions to collect data on patients with disabilities by type of disability.

Public Reporting, Transparency, and Education

Current Law

Medicare section 1886(b)(3)(B)(viii)(VII) requires the Secretary to establish procedures for making reported hospital quality data available to the public. Section 1886(b)(3)(B)(viii)(VIII) further requires the Secretary to post on the CMS website (1) quality measures of process, structure, outcome, and (2) patients' perspectives on care, efficiency, and costs of care that relate to inpatient care. Currently, individual hospital performance on specific quality measures and on certain conditions is available on the Hospital Compare website. However, this information is not stratified by race, ethnicity or gender.

The NCQA's online tool for comparing health plans, *Quality Compass*, does not stratify data from the Healthcare Effectiveness Data and Information Set (HEDIS) by race; NCQA only provides plan-level performance data on the HEDIS measures. The Joint Commission also reports quality data for its accredited entities at www.qualitycheck.org, but this information is also not stratified by race or ethnicity.

The Healthcare Research and Quality Act of 1999 (P.L. 106-129) instructed the Agency for Healthcare Research and Quality (AHRQ) to issue an annual National Healthcare Disparities Report. The annual report, which is based on an analysis of numerous existing data sources, tracks "prevailing disparities in health care delivery" as they relate to "racial factors and socioeconomic factors" in the United States.

Proposed Option

The proposal would require health care quality data to be published by race, ethnicity and gender.

Language Access

Current Law

Federal and state governments share in the cost of Medicaid based on a statutory formula defining the federal contribution (*i.e.*, federal medical assistance percentage, FMAP). The federal match for administrative expenditures does not vary by state and is generally 50 percent, but certain administrative functions have a higher federal matching rate. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA; P.L. 111-3) permits states to receive a 75 percent FMAP for translation or interpretation services in connection with the enrollment and retention of, and use of services under Medicaid by, children of families for whom English is not the primary language.

The HHS Office of Minority Health issued national standards for the delivery of culturally and linguistically appropriate health care services (CLAS). Federally funded health care programs must meet the Language Access Services standards established under CLAS. For example, staff must receive education and training in culturally and linguistically appropriate service delivery, and health care organizations must provide language assistance services.

Proposed Option

The proposal would extend the 75 percent matching rate for translation services to all Medicaid beneficiaries for whom English is not the primary language, and would establish CLAS standards for private insurers in the Health Insurance Exchange. The proposal would also establish grants for outreach and enrollment efforts to fund, for example, multi-lingual help lines and for data collection efforts.

Elimination of Five-year Waiting Period for Non-Pregnant Adults

Current Law

Under prior law, legal immigrants arriving in the United States after August 22, 1996, were ineligible for Medicaid or CHIP benefits for their first five years in the U.S. Coverage of such persons after the five-year bar was permitted at state option if they met other eligibility requirements for that program. For legal immigrants (but not refugees and asylees), the law requires that their sponsor's income and resources be taken into account in determining eligibility for those who have signed a legally binding affidavit of support. Generally speaking, for federal means-tested programs (*e.g.*, Medicaid, TANF), the affidavit of support required the sponsor to ensure that the new immigrant will not become a public charge and makes the sponsor financially responsible for the individual.

CHIPRA permits states that meet certain requirements to waive the five-year ban for Medicaid or CHIP coverage to pregnant women and children who are lawfully residing in the United States, and are otherwise eligible for such coverage. For states that elect to extend such coverage, the provision assures that the cost of care will not be deemed under an affidavit of support against an individual's sponsor. In addition, as a part of states' redetermination processes (*i.e.*, to redetermine eligibility at least every 12 months with respect to circumstances that may change and affect eligibility), individuals made eligible under this provision whose initial documentation showing legal residence is no longer valid will be required to show "further documentation or other evidence" that the individual continues to lawfully reside in the U.S.

Proposed Option

The proposal would add non-pregnant adults to the list of Medicaid beneficiaries for whom states would be permitted to waive the five-year bar to extend Medicaid coverage.

Reduction in Infant Mortality and Improved Maternal Well-Being

Current law

Title V of the Social Security Act is administered by the Maternal and Child Health Bureau, which is part of the Department of Health and Human Services' (HHS) Health Resources and Services Administration. Title V authorizes \$850 million each fiscal year in order to improve the health of children and mothers. These funds are authorized to increase access to services; coordinate services; provide prevention, diagnostic and treatment services for pregnant women, mothers, and children, including those with disabilities.

Proposed Option

Provide funding to states, tribes, and territories to develop and implement targeted approaches to reducing infant mortality. Grant funding would be authorized through the Title V – Maternal and Child Health Services Block Grant and may require coordination with other operating divisions of HHS. Awards will be based on the applicants' ability to demonstrate the capacity to engage in one or more types of evidence-based approaches to reduce infant mortality and its related causes, and consequences, such as preterm births, infant and child disability, reduced health status of women during their childbearing years, and maternal mortality. The Secretary would undertake and publish an evaluation of funded projects including a formal assessment of the funded projects for their potential, if scaled broadly, to improve health care practice, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

Prepared by the National Governor's Association

SUMMARY OF SELECTED POLICY OPTIONS PRESENTED IN

SENATE FINANCE COMMITTEE, "EXPANDING HEALTH CARE COVERAGE:
PROPOSAL TO PROVIDE AFFORDABLE COVERAGE TO ALL AMERICANS," MAY 14, 2009

INSURANCE MARKET REFORMS AND EXCHANGE PROPOSALS	
<p>New Federal Risk Rating Rules: Individual and Small-Group Health Insurance Markets</p>	<ul style="list-style-type: none"> • Guaranteed issue (all applicants accepted) and guaranteed renewability • No exclusions for pre-existing conditions • Insurers can vary premiums based on only age (by a ratio of up to 5:1), geography, tobacco use, and family size • Highest rate cannot be more than 7.5 times the lowest rate for all factors combined • Risk adjustments: insurers with large share of low-risk enrollees would be required to transfer money to those with large share of high-risk enrollees to establish level playing field and reduce "cherry picking"
<p>A New Insurance Exchange</p>	<ul style="list-style-type: none"> • Would serve as clearinghouse for sale of insurance for at least individuals and small business (could be organized at federal and state level) <ul style="list-style-type: none"> ◦ Enroll people in plan ◦ Provide marketing standards ◦ Determine who is eligible for subsidies (tax credits) • States would provide seal of approval for health benefit plans (but there would be a federal benefits floor) • All insurers selling individual and small-group insurance would be required to participate, but could offer coverage outside • Insurers selling both within and outside the exchange would have to charge the same price in both places for the same coverage and be subject to same rating rules
<p>Benefit Packages</p>	<ul style="list-style-type: none"> • All plans have to offer four tiers of benefit options covering a comprehensive set of services • Benefits within a tier could vary somewhat (as long as "actuarially equivalent") and would probably vary primarily by the level of cost sharing
<p>Subsidies to Make Coverage Affordable</p>	<ul style="list-style-type: none"> • In the form of refundable tax credit payable in advance • Available only to people who purchase coverage through the Exchange • Available for people between 100% and 400% of the federal poverty level (FPL) • Required premium would be capped as a percentage of income, with the percentage rising with income and with percentage tied to less comprehensive benefit levels (tiers) as income rises • The credit would be tied to the cost of the second least costly plan offered within a geographic area • Some small, lower-wage employers (meeting both standards below) would get a tax credit for each full-time worker (not refundable or payable in advance) <ul style="list-style-type: none"> ◦ Employers with 10 to 25 workers, with phase out beginning after 10 workers, and ◦ With average annual wage from \$20,000 to \$40,000, with phase out after \$20,000

<p>A "Public" Health Insurance Plan to be Offered Through the Exchange</p>	<p>Four options are offered:</p> <ol style="list-style-type: none"> 1. Medicare-Like public plan, operated by HHS <ul style="list-style-type: none"> • Eligibility, market rules, tax credits same as for other insurers in the Exchange • Providers paid Medicare rates plus 0% to 10% • Risk adjustment would apply to the public plan in same way as to others 2. Third Party Administrator – similar to #1 except: <ul style="list-style-type: none"> • Operated outside of HHS by multiple regional administrators/TPAs • TPAs would organize network of providers and negotiate payment rates • Would have to have reserve funds 3. States would establish a public plan, perhaps letting people purchase through state employees' plan 4. No public plan of any kind; just private plans in a reformed market
<p>Individual Responsibility Mandate</p>	<ul style="list-style-type: none"> • Everyone required to have coverage at least equal to lowest-cost option • If people did not enroll initially, they might be subject to preexisting condition exclusions for a period of 9 months and pay a higher premium • People could change plans annually or upon life-changing event (marriage, divorce, etc.) • Enforcement: <ul style="list-style-type: none"> ○ Have to report months covered on income tax form (insurers also report) ○ Non compliers pay tax equal to percentage of lowest-cost plan for months not covered: 25% first year, 50% second years, 75% thereafter • Exemptions possible if: <ul style="list-style-type: none"> ○ Lowest cost option exceeds 10 percent of income ○ Individual is below 100 percent of poverty ○ Hardship
<p>Employer Responsibility ("Play or Pay" Mandate)</p>	<ul style="list-style-type: none"> • Employers with \$500,000 or more annual payroll required to either offer coverage to all full-time employees or pay an assessment <ul style="list-style-type: none"> ○ "Playing" employers must contribute at least 50% of the premium of the least costly plan ○ For "Paying" employers, assessment would vary between \$100 to \$500 per employee per month depending on size of total payroll (between \$500,000 and \$1.5 million) ○ Alternatively, assessment would be a percent of payroll, varying from 2% to 6% based on total payroll amount • A worker who accepts employer coverage is eligible for the current tax exclusion (employer contribution not taxed as employee income) but not eligible for the tax credit • A worker who does not accept employer-offered coverage may be eligible for tax credit; the employer pays what would have been paid for the employee coverage to the Exchange. • Medicaid Interaction: states would be required to offer current-law Medicaid premium assistance to individuals eligible for Medicaid who are offered employer-sponsored coverage. <p>Under a different option, employers would not be required to play or pay, but individual mandate would be in force</p>

MEDICAID COVERAGE AND FUNDING PROPOSALS

	<p>Income Standards/Methodologies</p> <p>State mandate to raise income eligibility for pregnant women, children and parents (up to 150% FPL "for example")</p> <ul style="list-style-type: none"> Income disregards eliminated (to better align with Exchange) Income measured based on modified adjusted gross income (MAGI) Maintenance of effort requirement for all previously eligible populations until Exchange fully operational (Silent as to whether eligibility may be retained thereafter) <p><i>Comment: Childless adults not included in this proposal</i></p>
	<p>Payments for Newly Eligible Individuals</p> <ul style="list-style-type: none"> Full federal funding through 2015 followed by a 5-year phase down; thereafter, regular FMAP rates would apply. <ul style="list-style-type: none"> Alternative: Increase FMAP for all populations for a certain duration Provider payments may not fall below "X" percent (e.g., 80%) of Medicare reimbursement rates (Silent regarding rates for non-Medicare services)
<p>Coverage Expansion</p>	<p>Options for Medicaid Coverage</p> <p><i>Approach 1: Increased Coverage through the Current Medicaid Structure</i></p> <p>Medicaid eligibles deemed ineligible for tax credits in the exchange. States could choose to provide premium assistance to those with employer-sponsored insurance (ESI) or states could be required to provide premium assistance (to mitigate crowd-out)</p> <p><i>Approach 2: Increased Coverage Through the Exchange</i></p> <p>Duals, disabled and other special needs groups covered through existing Medicaid program while children, pregnant women, parents and childless adults are covered through Exchange insurance plans. States would subsidize premiums, reimburse insurers for cost-sharing and provide wrap-around coverage for Medicaid services exceeding Exchange plan coverage (e.g., EPSDT). Other variations on this approach noted that would include allowing states to create Medicaid-only plans to participate in Exchange.</p> <p><i>Approach 3: Increased Coverage Through Both the Current Medicaid Structure and the Exchange</i></p> <p>Childless adults below 115% of the FPL would not become eligible for Medicaid, but would instead be eligible for federal tax credits to purchase private coverage through the Exchange or coverage through a Medicaid buy-in (with coverage equal to parent benefit package). Credit would be treated as a "voucher" for the buy-in option with reimbursement to state (from the Exchange) when costs exceed voucher amount.</p> <p>Treatment of Territories</p> <p>Remove caps and apply FMAP formula (with possibility of phasing in over time) or keep existing structure, but raise caps.</p>
<p>Changes to FMAP Formula</p>	<p>Potentially Budget Neutral Changes</p> <ul style="list-style-type: none"> Add a state poverty rate factor (to existing state per capita income factor) Limit year-to-year changes to +/- two percentage points Change per capita income data from a 3-year average to a 2-year average. <p>Automatic Countercyclical Stabilizer (after January 1, 2012)</p> <ul style="list-style-type: none"> Applicable when at least 23 states show a 10% increase in rolling average quarterly unemployment rate compared to

	<p>corresponding quarter two years prior.</p> <ul style="list-style-type: none"> Once applicable, any state with an increase in its quarterly unemployment rate (on a rolling 6 month average basis) compared to corresponding quarter two years prior is eligible for temporary FMAP increase. Formula factors include (a) increase in number of unemployed, (b) the national average amount of federal Medicaid spending attributable to the unemployed and (c) adjusted by the state's relative Medicaid costs of nondisabled, nonelderly adults and children. <p>State DSH allotments and the definition of a DSH hospital would remain unchanged. State allotments would be designated as a pool that would be dispersed directly to qualified hospitals in the state by the Secretary of HHS.</p> <ul style="list-style-type: none"> Hospitals would submit uncompensated care claims to CMS (in addition to the Medicaid claims data that CMS already receives from states) The Secretary, by regulation, would specify DSH reimbursable services. <p>A variation on this option would reallocate DSH funds among the states.</p>
<p>Medicaid Disproportionate Share Hospital Payments – Direct Distribution by HHS</p>	
<p>PROPOSALS TO IMPROVE LTC AND SERVICES FOR DUALS</p>	
<p>Dual Eligible Proposals</p>	<ul style="list-style-type: none"> Establish a new 5 year Medicaid demonstration authority for exploration of alternative approaches to coordinating care for duals. Permit states to count Medicare savings for purposes of the Section 1915(b) waiver authority cost-effectiveness test. Would allow increased contracting with MCOs (including Medicare dual eligible SNPs) to coordinate care for duals. Establish a new Office of Coordination for Dually Eligible Beneficiaries (OCDEB) within CMS that would be responsible for identifying and leading agency efforts to align Medicare and Medicaid financing, administration, oversight rules, and policies for dual eligibles. Would allow states to seek approval to offer additional services (beyond DRA list). Individuals would be allowed to simultaneously enroll in more than one Medicaid waiver. Would increase the income cap (currently 150% FPL) to persons with income up to 300% of the maximum SSI payment (who meet the needs based criteria).
<p>Changes to DRA HCBS State Plan Option (Section 1915(i))</p>	<p>Would eliminate the existing institutional level-of-care requirement for eligibility for section 1915(c) waivers and <i>require</i> states to replace it with less stringent criteria.</p>
<p>Changes to Section 1915(c) HCBS Waivers</p>	<p>Approach 1: Increase the number of persons that states would be <i>required</i> to enroll in either or both of the 1915(i) and 1915(c) authorities.</p> <p>Approach 2: Prohibit states from using waiting lists to prevent eligible beneficiaries from accessing HCBS.</p>
<p>Increase Access to Medicaid HCBS</p>	<p>Increase the federal match for Medicaid HCBS by 1%.</p>
<p>Increase Federal Match for Medicaid HCBS</p>	<p>Require states to apply spousal impoverishment rules in all HCBS waivers and under the 1915(i) HCBS State Plan Option.</p>
<p>Medicaid Spousal Impoverishment Rules</p>	<p>Allow states to treat those applying to Medicaid for HCBS differently by allowing them to retain higher levels of assets.</p>
<p>Medicaid Resources / Asset Test</p>	

OTHER IMPROVEMENTS TO MEDICAID	
Quality of Care	Apply similar quality measures established in CHIPRA to all Medicaid eligible populations
Enrollment and Retention Simplification	<ul style="list-style-type: none"> Eliminate face-to-face interview option and asset tests for acute care services Require states to (a) provide 12-month continuous eligibility (b) have Medicaid enrollment websites, (c) outstation eligibility function for all eligibility groups at DSH hospitals, FQHCs and state departments of motor vehicles, and (d) extend administrative automatic renewal and Express Lane renewal to all Medicaid beneficiaries. Require HHS Secretary to develop a model process for beneficiaries who change state of residency frequently.
Family Planning	Create a new optional categorically needy eligibility group for non-pregnant adults with benefits limited to family planning services and supplies and related medical diagnosis and treatment services. Income eligibility level would be equal to the highest level for pregnant women under Medicaid or CHIP.
Drug Policy Changes	<ul style="list-style-type: none"> Make prescription drugs a mandatory benefit for both categorically and medically needy eligibility groups. Remove smoking cessation drugs, barbiturates and benzodiazepines from Medicaid's excluded drug list. Increase the Federal Upper Payment Limit (FUL) for Multi-Source Drugs from 250% to 300% of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multi-source drugs.
Transparency in Section 1115 waivers and for State Plan Amendments that Limit Benefits	A variety of proposed options applicable to states and the HHS Secretary to make waiver and SPA information publicly available including notice and comment periods, public meeting requirements, and web-postings.
NEW MEDICARE COVERAGE PROPOSALS	
Reduce or Phase-Out the Medicare Disability Waiting Period	Four options presented with varying phase-in proposals. One option also excludes persons with access to certain private coverage (other than COBRA).
Temporary Medicare Buy-In (until Exchange becomes operational)	Voluntary buy-in for persons age 55 through 64 who do not have employer-sponsored insurance (ESI) or Medicaid coverage. Premiums would equal expected average cost of benefits for Medicare participants plus a 5% admin fee.
CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) PROPOSALS	
Coordination with Exchange Following Expiration of Reauthorization Period	<p>Following the later of (a) September 30, 2013 or (b) when the Exchange becomes operational,</p> <ul style="list-style-type: none"> Increase CHIP income eligibility to 275% FPL Eliminate income disregards; measure income by MAGI Retain EPSDT benefit Require CHIP enrollees to receive primary coverage through the Exchange with CHIP providing secondary coverage through a state wrap-around <p>Other variations on this option noted that would include allowing states to create Medicaid-only plans to participate in Exchange and limiting premium reimbursement to wrap-around services</p>

PREVENTION AND WELLNESS PROPOSALS FOR MEDICARE

<p><i>Personalized Prevention and Wellness</i></p>	<ul style="list-style-type: none"> • Adds coverage for a personalized prevention plan once every 5 years (in addition to current one-time initial preventative exam) to include comprehensive health risk assessment (HRA) by phone, web or provider encounter and personalized prevention plan by provider. No co-payment or deductibles would apply. • Assessment and electronic tools to be designed by Secretary
<p><i>Incentives to Utilize Preventive Services and Engage in Healthy Behaviors</i></p>	<ul style="list-style-type: none"> • Would remove or limit beneficiary cost-sharing for preventive services covered by Medicare and rated "A" or "B" by US Preventive Services Task Force (USPSTF) (a process established by the Medicare Improvements for Patients and Providers Act of 2008, or "MIPPA") • Would encourage HHS Secretary to provide refunds or other incentives for successful completion of certain behavior modification programs (e.g. smoking cessation and weight loss) • Would explore ways to improve provider education and patient awareness of covered preventive services
<p><i>Coverage of Evidence-Based Preventive Services</i></p>	<ul style="list-style-type: none"> • Would provide authority to the HHS Secretary to withdraw coverage for preventive services rated "D" by USPSTF, unless deemed medically necessary by a prescribing physician. (A "D" rating means the evidence provided no benefit or harm outweighed benefit.)

PREVENTION AND WELLNESS PROPOSALS FOR MEDICAID

<p><i>Access to Preventive Services for Eligible Adults</i></p>	<p>State coverage of screening and preventive services for eligible adults is currently optional (other than certain family planning and pregnancy associated services). Proposal would:</p> <ul style="list-style-type: none"> • Clarify definition of "screening and preventive" services for adults to include services rated as "A" or "B" by USPSTF and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) • Provide a 1% FMAP increase for screening and preventive services that states opt to cover • Require states to cover comprehensive tobacco cessation services for pregnant women without cost-sharing
<p><i>Incentives to Utilize Preventive Services and Engage in Healthy Behaviors</i></p>	<ul style="list-style-type: none"> • Would remove or limit cost-sharing for clinical preventive services rated "A" or "B" by USPSTF • Would allow states to design proposals and apply for funds to explore refunds or incentives to Medicaid enrollees who complete certain behavior modification programs (e.g. smoking cessation and weight loss) <ul style="list-style-type: none"> ◦ Funding capped ◦ Programs must be comprehensive, evidence-based (Secretary determines), widely available and easily accessible ◦ State application must include plans for provider education and patient awareness of covered services

GRANTS AND CREDITS TO PROMOTE PREVENTION OF CHRONIC DISEASE AND ENCOURAGE HEALTHY LIFESTYLES

<p><i>"Right Choices" Grants</i></p>	<p>Annual capped grants to states for 3 to 5 years, or until insurance options are available through Exchange (whichever is sooner) to provide access to certain evidence-based primary preventive services to uninsured children and adults</p>
<p><i>Prevention and Wellness Innovation Grants</i></p>	<ul style="list-style-type: none"> • Competitive grant program for states to promote health and human service program integration; improve care coordination and access to preventive services/treatments; and integrate health care delivery services to improve outcomes. States would select 1 of 3 approaches: <ul style="list-style-type: none"> ◦ Promotion of local multidisciplinary team-based care ◦ Providing individualized plans for health and human service needs for low-income beneficiaries ◦ Other (state-defined) innovative approach

	<ul style="list-style-type: none"> • HHS to conduct best practice study, and issue to states. Within 2 years, states are required to submit plan to integrate services for low-income • HHS would also be required to review and improve administration of its low-income programs • Would create a nonrefundable tax credit for 50% of employer costs for qualified wellness program (Secretary certified); maximum of 5 years <ul style="list-style-type: none"> ◦ Credit not to exceed \$200/employee up to 200 employees and \$100/employee in excess of 200 employees ◦ Another option includes above criteria and provides employers with 50 or fewer employees a credit limited to \$400/employee, without a sunset requirement • Components of qualified program outlined and dependent on number of employees
OPTIONS TO ADDRESS HEALTH DISPARITIES	
Required Data Collection	<ul style="list-style-type: none"> • Currently, Medicare enrollment database (EDB) obtains information from the SSA SS-5 data; racial category reporting is optional. Country of origin is reported, but primary language is not. Proposal would require SSA to collect race, ethnicity and language data on Medicare enrollees • Includes funding to upgrade SSA databases (ARRA included \$500 million to replace the SSA's National Computer Center and associated IT costs). • Requires federally funded population surveys to collect data on racial/ethnic subgroups to generate statistically reliable estimates in studies comparing health disparities populations • Extends MIPAA provision regarding collection of Medicare health disparities data to Medicaid and CHIP populations • Would establish uniform categories for collecting data on race and ethnicity by requiring the use of OMB Directive 15 standards and the OMB policy for aggregation and allocation of subgroups • Provides funding to states for tech upgrades to adopt OMB standards • Would apply OMB standards to Medicaid (already applicable to separate CHIP Programs) • Requires CMS to collect primary language data on CHIP enrollees and their parents (already collected for Medicaid beneficiaries) and requires CMS to collect access and treatment data for people with disabilities (not addressed by OMB Directive)
Data Collection Methods	<ul style="list-style-type: none"> • Requires federal funding to collect data on racial/ethnic subgroups to generate statistically reliable estimates • Extends MIPAA provision regarding collection of Medicare health disparities data to Medicaid and CHIP populations • Would establish uniform categories for collecting data on race and ethnicity by requiring the use of OMB Directive 15 standards and the OMB policy for aggregation and allocation of subgroups • Provides funding to states for tech upgrades to adopt OMB standards • Would apply OMB standards to Medicaid (already applicable to separate CHIP Programs) • Requires CMS to collect primary language data on CHIP enrollees and their parents (already collected for Medicaid beneficiaries) and requires CMS to collect access and treatment data for people with disabilities (not addressed by OMB Directive)
Standardized Categories for Data	<ul style="list-style-type: none"> • Would require healthcare quality data (e.g., Hospital Compare website data, AHRQ annual National Healthcare Disparities Report, etc.) to be published by race, ethnicity and gender • Extends the 75% CHIPRA administrative FMAP for translation services to all Medicaid beneficiaries • Extends the requirement for culturally and linguistically appropriate service delivery (i.e., "CLAS" standards) to insurers in the Exchange (currently applicable to federally funded health care programs) • Establishes grants for outreach and enrollment efforts
Public Reporting, Transparency and Education	<ul style="list-style-type: none"> • Would require healthcare quality data (e.g., Hospital Compare website data, AHRQ annual National Healthcare Disparities Report, etc.) to be published by race, ethnicity and gender • Extends the 75% CHIPRA administrative FMAP for translation services to all Medicaid beneficiaries • Extends the requirement for culturally and linguistically appropriate service delivery (i.e., "CLAS" standards) to insurers in the Exchange (currently applicable to federally funded health care programs) • Establishes grants for outreach and enrollment efforts
Language Access	<ul style="list-style-type: none"> • Would permit states to waive the 5-year ban on Medicaid coverage for non-pregnant, legal immigrant adults (CHIPRA waived ban on Medicaid and CHIP coverage for pregnant women and children) • Would provide funding to develop and implement targeted approaches to reducing infant mortality; grant funding would be authorized through the Title V – Maternal and Child Health Services Block Grant
Elimination of Five-year waiting Period for Non-Pregnant Adults	<ul style="list-style-type: none"> • Would permit states to waive the 5-year ban on Medicaid coverage for non-pregnant, legal immigrant adults (CHIPRA waived ban on Medicaid and CHIP coverage for pregnant women and children) • Would provide funding to develop and implement targeted approaches to reducing infant mortality; grant funding would be authorized through the Title V – Maternal and Child Health Services Block Grant
Reduction in Infant Mortality and Improved Maternal Well-Being	<ul style="list-style-type: none"> • Would provide funding to develop and implement targeted approaches to reducing infant mortality; grant funding would be authorized through the Title V – Maternal and Child Health Services Block Grant

