

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
MedPAC on steroids	Don't include	Not included	Included (pp. 188-191),	<p><b>SENATE:</b> The Chairman's Mark would establish an independent Medicare Commission (hereafter the Commission) that would develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries. The Commission would be composed of 15 members, who would be appointed by the President and confirmed by the Senate. The Senate Majority Leader, the Speaker of the House, the Senate Minority Leader, and the House Minority Leader would each present three recommendations for appointees to the President; however, these recommendations in no way would limit the President's ultimate responsibility to present Congress with qualified nominees. Qualifications for members of the Commission would be similar to the qualifications required for members of the Medicare Payment Advisory Commission (MedPAC). In addition to these qualifications, members of the Commission would be required to be free of any conflicts of interest and would be held to certain disclosure and accountability requirements. Members of the Commission would serve six-year, staggered terms and would continue to serve until replaced. After serving on the Commission, former members would be barred from lobbying the Commission and other relevant executive branch departments and agencies and relevant congressional committees for one year. In addition to the 15 members of the commission, the Secretary of Health and Human Services (HHS), the Administrator of the Center for Medicare and Medicaid Services (CMS), and the Administrator of the Health Resources and Services Administration (HRSA) would serve as ex-officio, non-voting members of the Commission. MedPAC would continue to exist in its current form as an advisory body to Congress.</p> <p>The Commission would be tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts compared to the trajectory of Medicare spending under current law. The scope of proposals presented to Congress should (1) to the extent feasible, target reductions to sources of excess cost growth; (2) to the extent feasible, improve the health care delivery system, including the promotion of integrated care, care coordination, prevention and wellness and quality improvement; (3) to the extent feasible, protect beneficiary access to care, including in rural and frontier areas; (4) to the extent feasible, consider the effects of provider payment beneficiary changes on beneficiaries; (5) to the extent feasible, consider the effects of proposals on any provider who has, or is projected to have, negative profit margins or payment updates; and (6) to the extent feasible, improve the quality of care delivered to Medicare beneficiaries; (7) to the extent feasible, consider the unique needs of individuals dually eligible for Medicare and Medicaid; and (8) prior to December 31, 2019 not impact providers scheduled to receive a reduction to their inflationary payment updates in excess of a reduction due to productivity in a year in which the Commission's proposals would take effect. The Commission would be prohibited from presenting proposals that would ration care, increase revenues, or otherwise change Medicare beneficiary cost-sharing (including premiums under sections 1818, 1818A, and 1839 of the Social Security Act), benefits, or eligibility standards.</p> <p>As appropriate, the Commission shall include recommendations to reduce expenditures under Part C and Part D, such as through reductions in federal premium subsidies to MA-PD and PDP plans and performance bonuses to MA plans. In the case of a recommendation related to payments to plans under Parts C or D, such recommendations shall apply to plan years beginning January 1st of the year following the submission of such recommendations.</p> <p>In its proposals to Congress prior to December 31, 2019, the Commission may include supplemental, non-binding recommendations regarding improvements to payment systems for providers who are otherwise not subject to the scope of the Commission's proposals. These supplemental recommendations shall not be included in the Commission's proposals to reduce excess cost growth in a given year.</p> <p>The Secretary shall begin the rulemaking process to implement the Commission's proposal upon delivery of such proposals to Congress on January 1. The Secretary may use interim final rulemaking to implement the changes proposed by the Commission.</p> <p>Beginning with the 2013 report of the Medicare Trustees, the Chairman's Mark would require the CMS Office of the Actuary (OACT) to project whether the Medicare per-capita growth rate in 2015 will exceed the average of the growth rates in the Consumer Price Index (CPI) and the Consumer Price Index for medical care (CPI-M) projected for 2015. The Medicare per-capita growth rate would be calculated as the five-year moving average of Medicare spending (Parts A, B, and D) per unduplicated enrollee, ending with the projection for the year in which the Commission's proposals would apply. This projection would be made without regard to the physician fee schedule update, and would take into account any delivery system reforms or other payment changes that have been enacted, are scheduled to be enacted, or published as a final rule but have not been implemented at the time of the analysis.</p> <p>If the projected excess cost growth is estimated to be greater than the average of CPI and CPI-M, the Commission would be required to submit a</p>

<sup>1</sup> Keyed to the TriCommittee text that was released on July 14, 2009.

<sup>2</sup> Changes from initial mark highlighted with new additions in blue and deletions in red.

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
MedPAC on steroids (con.)				<p>proposal to Congress by January 1, 2014 that would reduce excess cost growth by 0.5 percentage points in 2015, as estimated by OACT. If excess cost growth is projected to be less than 0.5 percentage points (or the equivalent reduction in future years), then the Commission would be required to submit a proposal that eliminates excess cost growth, as certified by OACT. The Chairman's Mark would also require that the Commission's proposals are certified by OACT to not increase spending within the following ten-year budget window.</p> <p>If the Commission fails to submit a proposal by the January 1st deadline that meets the requirements described above, the Secretary of HHS would be required to submit a proposal to Congress that would achieve the same reduction in excess cost growth (as certified by OACT) by no later than January 5, 2014. The Secretary's proposal would be subject to the same scope and requirements as the Commission.</p> <p>The Commission would be required to submit a draft of its proposal to MedPAC and CBO by September 1, 2013. Once the proposal is submitted to Congress, MedPAC would be required to review and present its analysis of the Commission's (or Secretary's) proposal no later than February 1, 2014. By April 1, 2014, the Senate Finance Committee, along with the relevant House Committees, would be required to report out either the Commission's (or Secretary's) proposal or an amended proposal that achieves the same level of reductions in excess cost growth. Policy changes extraneous to Medicare would be prohibited and would be stricken from the proposal. If a committee fails to report a legislative package achieving the targeted level of Medicare savings by April 1st, the Commission's (or Secretary's) package would be automatically discharged from that committee.</p> <p>The Chairman's Mark would require the package be brought to the floor within 15 days of being reported or discharged from a committee. In the Senate, the package would be subject to 30 hours of debate. Only budget-neutral and germane amendments would be considered in order. Once passed by both chambers, the conference report would be subject to 10 hours of debate in the Senate. If a package that meets the level of Medicare savings described above is not enacted into law by August 15, 2014, the Chairman's Mark would require the Commission's (or Secretary's) original proposal to go into effect automatically.</p> <p>The Chairman's Mark would require the Commission to make additional proposals on January 1st of 2015, 2016 and 2017, based on the procedures described above. However, the targeted level of Medicare savings would increase each year. The proposal delivered to Congress in 2015, would be required to reduce excess cost growth by 1.0 percentage point in 2016. The proposal delivered to Congress in 2016 would be required to reduce excess cost growth by 1.25 percentage points in 2017. The proposal delivered to Congress in 2017 would be required to reduce excess cost growth by 1.5 percentage points in 2018. <b>The growth target in 2019 and beyond would be GDP per capita plus one percent.</b></p> <p>In any year where excess cost growth is not projected, the Commission would not be required to submit a proposal to Congress with a specific savings target, nor would such proposals be eligible for fast-track consideration in Congress. However, the Commission would submit purely advisory proposals that fall under the Commission's purview. This advisory proposal would not go into effect automatically absent Congressional action.</p> <p><b>In 2019, Congress would be required to hold a vote under fast-track procedures on whether the Commission should extend beyond 2019, but the Commission would continue unless Congress affirmatively votes to terminate it. In 2019, the Chairman's Mark would require Congress to pass a joint resolution to continue further proposals and subsequent action by the Commission. This resolution would be placed on a fast-track procedure in order to ensure a vote occurs.</b></p> <p>Changes implemented as a result of this provision would not be subject to administrative or judicial review.</p> <p>The Chairman's Mark would grant the Commission immediate authority to advise the Secretary of HHS on priorities for health services research, particularly as they pertain to payment reforms under Medicare. In addition, the Commission would have the same level of access to federal data and research as MedPAC and CBO, and would be required to regularly consult with the Medicaid and CHIP Payment and Access Commission (MACPAC). The Chairman's Mark would establish the Consumer Advisory Commission (CAC), which would be composed of ten consumer representatives that would advise the Medicare Commission on the impact of Medicare payment policies on consumers. Members of the CAC would be appointed by the GAO and serve three-year, staggered terms.</p> <p>The Chairman's Mark would require, by July 1, 2015, the GAO to conduct a study on the effect of the Commission's proposals. Specifically, the study would provide an assessment of the effect of the Commission's proposal on Medicare beneficiary's access to providers, affordability of premiums and cost-sharing, and quality of care provided. GAO would be required to conduct similar subsequent studies.</p> <p><b>No reductions in Medicare outlays may be utilized to offset any non-Medicare outlays.</b></p>
SGR	(1) Rebase the SGR (2) Provide a	Provided all of the key aspects requested, also	(1) No rebasing (2) Update for 2010 of 0.5%	<p><b>SENATE:</b> The annual update to the conversion factor used in the determination of the Medicare fee schedule would be a 0.5 percent increase in 2010. The conversion factor for 2011 and subsequent years would be computed as if the increase in 2010 had never applied.</p> <p>The Chairman's Mark would establish a new ten percent bonus on select evaluation &amp; management codes under the Medicare fee schedule for five years, beginning January 1, 2011. The groups of codes to which this bonus would apply would be office visits, home visits, nursing facility visits, and</p>

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
SGR (con.)	small update (3) Don't penalize specialty care at the expense of primary care	recharacterized the E&M bucket (section 1121, starting on p. 238)	(3) Additional funds for primary care (at the expense of specialty care) (p. 136, 125)	<p>domiciliary, rest home (e.g. boarding home), or custodial care services.</p> <p>The bonus would be available to <b>primary care practitioners</b> who: (1) have a specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine (or are an advanced practice nurse or physician assistant); and (2) furnish 60 percent of their services in the select codes. Services provided to both established patients and new patients would qualify. Qualifying practitioners providing care in a HPSA would also receive the 10 percent bonus on hospital visit codes that are typical of primary care medicine (as determined by the Secretary), though only ten percent of these visits would count toward the 60 percent threshold.</p> <p>In addition, <b>general surgeons providing care in a HPSA</b> would also be eligible for a ten percent bonus on major procedure codes for five years, beginning January 1, 2011.</p> <p><b>Half (50 percent) of the cost of the bonuses would be offset through an across-the-board reduction to all other codes, except for physicians who primarily provide services in a HPSA zip code.</b></p>
PQRI	(1) Ensure PQRI is not punitive (2) Ensure more timely feedback (3) Establish a Public-private partnership to establish registries (4) Reward docs who report to registries	Included (1) and (2) but not (3) and (4) (section 1124, starting on p. 258)	Included (2) but not (1), (3), or (4) (Note: MOC and value-based modifier provision)(pp. 100-103)	<p><b>SENATE:</b> The Chairman's Mark would establish a new PQRI option in addition to the options within the current program detailed above. The Chairman's Mark would extend PQRI incentive payments beyond 2010. <b>Eligible professionals who successfully report in 2010 would receive a two percent bonus in 2011. Eligible professionals who successfully report in 2010 would receive a one percent bonus in 2011. Eligible professionals who successfully report in 2011 would receive a 0.5 percent bonus in 2011. Eligible professionals who failed to participate successfully in the program would face a 1 percent payment penalty in 2012, based on their 2011 reporting period. Eligible professionals who failed to participate successfully in the program would face a 1.5 percent payment penalty in 2013, based on their 2012 reporting period.</b> The incentive payments and adjustments in payment would be based on the allowed charges for all covered services furnished 102 by the eligible professional, based on the applicable percent of the fee schedule amount. <b>For 2012, the applicable percent would be calculated as 99 percent of their total allowed charges. For reporting periods 2012 and in subsequent years, the penalties for non-reporting would be two percent, calculated as 98 percent of their total allowed charges. For 2013, the applicable percent would be calculated as 98.5 percent of their total allowed charges. For 2014 and in subsequent years, the penalties for non-reporting would be two percent, calculated as 98 percent of their total allowed charges.</b> The penalty would be assessed on an annual basis and would not be cumulative. The Chairman's Mark would further improve the PQRI program by requiring CMS to make two additional enhancements to the program. <b>First, CMS would be required to provide timely feedback to eligible professionals on their performance with respect to satisfactorily submitting data on quality measures.</b> Second, CMS would be required to establish an appeals process for providers who participate in the PQRI program but do not qualify for incentive payments during their performance period.</p> <p><b>The Chairman's Mark would extend PQRI incentive payments beyond 2010.</b> Eligible professionals who successfully report in 2010 would receive a two percent bonus in 2011. Eligible professionals who failed to participate successfully in the program would face a 1 percent payment penalty in 2012, based on their 2011 reporting period. The incentive payments and adjustments in payment would be based on the allowed charges for all covered services furnished by the eligible professional, based on the applicable percent of the fee schedule amount. <b>For 2012, the applicable percent would be calculated as 99 percent of their total allowed charges. For reporting periods 2012 and in subsequent years, the penalties for non-reporting would be two percent, calculated as 98 percent of their total allowed charges. The penalty would be assessed on an annual basis and would not be cumulative.</b></p> <p><b>Finally, the Mark would require CMS to develop a plan to integrate the PQRI program with the standards for meaningful use of certified electronic health records as created in the American Recovery and Reinvestment Act of 2009.</b></p> <p>Expansion of Physician Feedback Program. The Chairman's Mark would require the Secretary, beginning in 2012, to provide reports to physicians that compare their resource use with that of other physicians or groups of physicians caring for patients with similar conditions. Resource use would be measured based on the items and services furnished or ordered by physicians or groups of physicians. Feedback reports would be based on an episode-grouper methodology established by the Secretary that would combine separate but clinically-related services into an episode of care for which the physician is accountable. The episode-grouper would be required to be developed by January 1, 2012. The Secretary would be required to make the methodology available to the public, and the Secretary would be required to seek endorsement of the episode-grouper by the entity with a contract with the Secretary under section 1890(a) of the Social Security Act.</p> <p>In preparing feedback reports, the Secretary would be required to make appropriate data adjustments, including adjustments to (1) account for differences in the demographic characteristics and health status of individuals so as not to penalize those physicians who tend to serve less healthy individual who may require more intensive interventions, and (2) eliminate the effect of geographic adjustments in payment rates.</p>

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
PQRI (con.)				<p>The Secretary would have the authority to exclude certain information regarding an item or service from feedback reports if the Secretary determines that there is insufficient information relating to such item or service to provide a valid assessment of utilization. The Secretary would be required to provide for education and outreach activities to physicians on the operation of, and methodologies used, under the Feedback Program.</p> <p><b>Beginning in 2015 2014, payment would be reduced by five percent if an aggregation of the physician's resource use is at or above the 90th percentile of national utilization. After five years, the Secretary would have the authority to convert the 90th percentile threshold for payment reductions to a standard measure of utilization, such as deviations from the national mean.</b></p> <p><i>Value-Based Modifier for Physician Payment Formula.</i> The Secretary of Health and Human Services would be required to apply a separate, budget-neutral payment modifier to the fee-for-service physician payment formula. This separate modifier will not be used to replace any portion of the Geographic Adjustment Factor. The separate payment modifier will, in a budget-neutral manner, pay physicians or groups of physicians differentially based upon the relative quality of care they achieve for Medicare beneficiaries relative to cost. Costs shall be based upon a composite of appropriate measures of cost that take into account justifiable differences in input practice costs, as well as the demographic characteristics and baseline health status of the Medicare beneficiaries served by physicians or groups of physicians. Quality shall be based upon a composite of appropriate, risk-based measures of quality that reflect the health outcomes and health status of Medicare beneficiaries served by physicians or groups of physicians. In establishing appropriate quality measures the Secretary would be required to seek the endorsement of the entity with a contract with the Secretary under section 1890(a) of the Social Security Act. The Secretary would also be required to take into account the special conditions of providers in rural and other underserved communities.</p> <p>The Secretary would be required to publish, by January 1, 2012, the specific measures of quality and cost, the specific dates for implementation of the payment adjustment, and the proposed prospective performance period. The Secretary would be required to begin implementing the value-based payment adjustment in the 2013 rulemaking process. During the performance period, which will begin in 2014, the Secretary will provide, to the extent feasible, information to physicians about the value of care they provide. The Secretary will implement payment consequences beginning in 2015 based on the value of care delivered during the performance period. The payment modifier should be applied in a way that promotes systems-based care. By 2017, all physician payments must be subject to this payment modifier.</p>
HIT	Adjust timelines	Not included (section 1124, starting on p. 258) but does require the integration of PQRI and "meaningful user" within ARRA	No timeline adjustment but has similar language to House re: "meaningful user," (under PQRI) and free clinics added to HITECH for bonus (p. 110)	<p>HOUSE: Section 1124 adds the following provision: Key portion of Wu's amdt: (1) <b>IN GENERAL.</b>—Not later than one year after the date the report is submitted to the Congress under subsection (b), if, under subsection(b)(2), the Commissioner recommends increased reimbursement rates, the Commissioner shall require that qualifying health benefits plans increase reimbursement rates for health care providers that show meaningful use of electronic health records. (2) <b>COST LIMITATION.</b>—An increase in rates under paragraph (1) shall not result in any increase in affordability premium or cost-sharing credits under subtitle C of title II of this division.</p>
CER	(1) Separate entity (2) liability protections for following guidelines	Not included (section 1401, starting on p. 501 and section 1802, starting on p. 824) but	Included as a separate entity with no liability protections and some "patient safeguards" to	<p>HOUSE: Gingrey amdt: "(i) APPLICATION OF FEDERALLY FUNDED CLINICAL COMPARATIVE EFFECTIVENESS RESEARCH.—The Centers for Medicare &amp; Medicaid Services may not use Federally funded clinical comparative effectiveness research data under this section to make coverage determinations for medical treatments, services, or items under . title XVIII on the basis of cost." Rogers amdt: "(<input type="checkbox"/>) RESEARCH NOT TO BE USED TO DENY OR RATION CARE.—In no case may any research conducted, supported, or developed by the Center for Comparative Effectiveness Research, the Comparative Effectiveness Research Commission, or the Federal Coordinating Council for Comparative</p>

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
CER (con.)	(3) Don't use CER to establish coverage decisions	two amendments (Gingrey and Rogers limited its scope), also do NOT expect Christensen amendment to be adopted as part of next E&C mark up (per PIPC)	prohibit "the Secretary using the research to ration care" (pp. 192-202)	<p>Effectiveness Research be used by the federal government to deny or ration care."  <u>SENATE</u> (key excerpts)                      The Chairman's Mark would authorize the establishment of a private, non-profit corporation that would be known as the —Patient-Centered Outcomes Research Institute.  <b>Administration of the Institute.</b> The Chairman's Mark would establish a Board of Governors for the Institute. The Institute's Board would have 21 15 members, including the Secretary of Health and Human Services, the Director of AHRQ, and the Director of NIH (or their respective designees). The other 18 members would be appointed by the Comptroller General of the United States within six months after enactment and would include three members representing each of the following groups: patients and health care consumers; <b>physicians, including surgeons; agencies administering public health programs (including one member each representing the Centers for Medicare and Medicaid Services (CMS), a state health program (including Medicaid/CHIP or a state governor), and other Federal health programs);</b> private payers (including at least one health insurance plan and one self-insuring employer); pharmaceutical, device, and diagnostic manufacturers; and others (including one member representing each of non-profit health services research organization, quality improvement and decision support organizations, and independent health services researchers.)  <b>Research of the Institute.</b> The Chairman's Mark would charge the Institute with identifying national priorities for comparative clinical effectiveness research and establishing a research project agenda.                      Addressing Subpopulations. The Institute would design research to take into account potential differences in outcomes among different subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different comorbidities, genetic and molecular sub-types, or quality of life preferences. Members of such subpopulations would be included in the research as feasible and appropriate.                      When appropriate, the Institute would design research that takes into account different characteristics of treatment modalities that could affect research outcomes.                      Institute Contracts. The Chairman's Mark would allow the Institute to enter into contracts with Federal agencies as well as with appropriate private sector research or study-conducting entities for the management and conduct of research in accordance with the research agenda. Advisory Panels. The Chairman's Mark would require the Institute, as appropriate, to appoint expert advisory panels to assist in identifying research priorities and establishing the research project agenda. The Mark would require such panels to include <b>representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the relevant topic.</b> Methodology Committee. The Chairman's Mark would establish a standing methodology committee to serve the Institute.                      Dissemination of Information. The Chairman's Mark would require the Institute to disseminate the findings of research to clinicians, patients, and the public in a comprehensible manner and form so that they are useful to patients and providers in making health care decisions. <b>The Institute would be prohibited from disseminating research findings from a study or assessment that would include practice guidelines, coverage recommendations, or policy recommendations. Further, in any dissemination, the inclusion of data that would violate the privacy of research participants or violate any confidentiality agreements made with respect to use of the data would be prohibited.</b>                      Use of Institute Findings. <b>The Chairman's Mark would establish several limitations around the use of the Institute's comparative effectiveness research findings. First, the Institute would not mandate coverage, reimbursement, or other policies for any public or private payer. None of the reports or research findings would be construed as mandates, guidelines, or policy recommendations. (The Secretary would not be prevented from covering the routine costs of clinical care for Medicare beneficiaries participating in research provided for by the Institute for whom such costs would normally be covered under Medicare.)</b>  <b>Second, the Secretary of HHS would be prohibited from denying coverage based solely on a study conducted by the Institute. The Secretary would be required to use an iterative and transparent process when using research from the Institute in making coverage determinations.</b> The process would allow stakeholders and other individuals to provide informed and relevant information with respect to the determination, to review draft proposals of the determination and to submit public comments with respect to draft proposals. The Secretary would be required to consider other relevant evidence and studies, in addition to research findings from the Institute, as well as any evidence and research that demonstrates or suggests a benefit of coverage with respect to subpopulations, even if the research from the Institute demonstrates or suggests that, on average with respect to the general population, the benefits of coverage do not exceed the harm. The Chairman's Mark would not supersede or modify the statutory basis of the reasonable and necessary standard that is used to make coverage decisions under current law.  <b>Third, the Secretary would be prohibited from using the Institute's research in determining coverage, or creating reimbursement or incentive programs, for a treatment in ways that treat extending the life of an elderly, disabled, or terminally ill patient of lower value than extending the</b></p>

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
CER (con.)				<p>life of a person who is younger, non-disabled, or not terminally ill. The Secretary would also be prohibited from using the Institute's research in determining coverage, or creating reimbursement or incentive programs, for a treatment in a manner that precludes, or with intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability.</p> <p>These limitations would not be construed to limit the application of differential copayments based on factors such as cost or type of service. <b>Further, the limitations shall not be construed to prevent the Secretary from using comparative effectiveness evidence in determining coverage, reimbursement or incentive programs based upon comparing the difference in the effectiveness of alternative treatments in extending a patient's life due to the patient's age, disability, or terminal illness. Nothing in the Chairman's Mark would be construed to limit comparative effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a treatment will result in disability.</b></p> <p>Finally, the Chairman's Mark would prohibit the Institute from developing or employing a dollars per quality adjusted life year (or similar measure that discounts the value of a life because of a person's disability) as a threshold to establish what health care is cost-effective or recommended; and the Secretary shall not use such measure (or similar measure) as a threshold to determine coverage, reimbursement, or incentives programs.</p> <p>NCD Study. The Chairman's Mark would require the Comptroller General to submit a report to Congress within 18 months after the date of enactment on the process for making national coverage determinations under the Medicare program. The report would include a determination of whether the Secretary of HHS has complied with applicable law and regulations, including requirements for consultation with outside experts, providing appropriate public notice and comment opportunities, and making appropriate information and data available to the public and to non-voting members of advisory committees.</p>
Physician Sunshine	<p>(1) Model like the Senate bill (2) Physicians correct inaccuracies (3) Exclude CME (4) pre-empt State law</p>	<p>(1) No major changes (2) Clarifies that physicians aren't responsible for changes (3) Includes CME (4) Some pre-emption (section 1421, starting on p. 635)</p>	<p>(1) Base = Senate bill (2) Allows for corrections (3) Does not appear to include CME (4) Some pre-emption (pp.210-211)</p>	<p><u>HOUSE:</u> <u>Physicians not responsible:</u> (2) ACCURACY OF REPORTING- The accuracy of the information that is submitted under subsections (a) and (b) and made available under paragraph (1) shall be the responsibility of the applicable manufacturer or distributor of a covered drug, device, biological, or medical supply reporting under subsection (a) or hospital or other health care entity reporting physician ownership under subsection (b). The Secretary shall establish procedures to ensure that the covered recipient is provided with an opportunity to submit corrections to the manufacturer, distributor, hospital, or other entity reporting under subsection (a) or (b) with regard to information made public with respect to the covered recipient and, under such procedures, the corrections shall be transmitted to the Secretary.</p> <p><u>Limited pre-emption:</u> (h) Relation to State Laws- (1) IN GENERAL- Effective on January 1, 2011, subject to paragraph (2), the provisions of this section shall preempt any law or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer and applicable distributor (as such terms are defined in subsection (f)) to disclose or report, in any format, the type of information (described in subsection (a)) regarding a payment or other transfer of value provided by the manufacturer to a covered recipient (as so defined). (2) NO PREEMPTION OF ADDITIONAL REQUIREMENTS- Paragraph (1) shall not preempt any law or regulation of a State or of a political subdivision of a State that requires any of the following: (A) The disclosure or reporting of information not of the type required to be disclosed or reported under this section. (B) The disclosure or reporting, in any format, of the type of information required to be disclosed or reported under this section to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes. (C) The discovery or admissibility of information described in this section in a criminal, civil, or administrative proceeding'.</p> <p><u>SENATE:</u> The Chairman's Mark would amend 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 annual transparency reports, penalties for noncompliance, procedures for the submission of information and public availability of this information. The Chairman's Mark would require <b>any manufacturer of a covered drug, device, biological, or medical supply that makes a payment or another</b></p>

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
Physician Sunshine (con.)				<p><b>transfer of value to a physician, a physician medical practice, a physician group practice, or a hospital with an approved medical residency training program to report annually</b>, in electronic form, specified information on such transactions to the Secretary of HHS. The Chairman's Mark 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.</p> <p>The Chairman's Mark would require the Secretary to establish procedures no later than October 1, 2010 to ensure public availability of this information. Beginning September 30, 2012 and on June 30 of subsequent years, submitted information should be available on an Internet website that meets formatting, search, and usability requirements. In addition to the transfer information, the website should 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. <b>The Secretary should also allow recipients an opportunity to submit corrections to their information.</b> This reporting procedure should be established after consulting the Office of the Inspector General (HHS 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 to Congress and the states beginning April 1, 2012.</p> <p><b>Effective January 1, 2011 the Chairman's Mark would preempt any state (or political subdivision of a state) law or regulation that requires manufacturers to disclose the type of information required under this provision regarding payments or transfers to covered recipients. The Mark would not preempt any state (or political subdivision of a state) law or regulation that requires the disclosure or reporting of (1) any information not required under this provision; (2) the types of information excluded from reporting requirements under this provision, with the exception of the \$10 de minimis/\$100 aggregate reporting requirement; (3) information by any person or entity other than an applicable manufacturer or covered recipient described above; and (4) information reported to a Federal, state, or local government for public health purposes.</b></p> <p>The Secretary would be required to consult with the HHS OIG on the implementation of this section.</p>
ACOs	<p>(1) Explicitly include specialists (2) Thoroughly test before expanding</p>	<p>(1) Eshoo amendment included to clarify that primary care provider is "regardless of specialty." (2) Requires some study before expanding (E&amp;C manager's allows Secretary to broadly implement)</p>	<p>(1) Explicit mention of specialists, as well as Eschoo-like provision re: "regardless of specialty" (2) Current language does not discuss expansion of program (new pediatric provision on p. 75) (pp. 111-113)</p>	<p><b>SENATE:</b> The Medicare program would allow groups of providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicare program. Practitioners would be defined as physicians, <b>regardless of specialty</b>, nurse practitioners, physician assistants, clinical nurse specialists, and other practitioners or suppliers as the Secretary determines appropriate. Beginning on Jan. 1, 2012, eligible ACOs would have the opportunity to qualify for an incentive bonus. To qualify as an ACO, an organization would have to meet at least the following criteria: (1) agree to become accountable for the overall care of their Medicare fee-for-service beneficiaries; (2) agree to a minimum three-year participation; (3) have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers; (4) <b>include the primary care physicians for at least 5,000 Medicare fee-for-service beneficiaries;</b> (5) <b>provide CMS with information regarding primary care and specialist physicians participating in the ACO as the Secretary deems appropriate;</b> (6) have arrangements in place with a core group of specialist physicians; (7) have in place a leadership and management structure, including with regard to clinical and administrative systems; (8) define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care <b>such as through the use of telehealth, remote patient monitoring, and other such enabling technologies;</b> and (9) demonstrate to the Secretary that it meets patient-centeredness criteria determined by the Secretary, such as use of patient and caregiver assessments or the use of individualized care plans.</p>

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
Health Benefits Advisory Committee	(1) If included, a minimum of 3 physicians representing different specialties	Still just "at least one practicing physician or a health care professional" (section 123, starting on p. 30)	Not included	
Mis-valued physician services	(1) Don't add anything more than the current RUC process	Includes provisions (section 1122, starting on p. 149)	Included (p. 137-138)	<p><b>SENATE:</b> The Secretary would be required to periodically identify physician services as being potentially misvalued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. For purposes of identifying potentially misvalued services, the Secretary shall examine codes for which there has been the fastest growth; codes that have experienced substantial changes in practice expenses; codes for new technologies or services after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS; and such other codes determined to be appropriate by the Secretary. Adjustments to misvalued procedures would be subject to budget neutrality requirements.</p>
Physician-owned hospitals	(1) Don't make any further changes to physician-owned hospital restrictions	Includes further restrictions (section 1156, starting on p. 312)	Includes further restrictions (pp. 208-210)	<p><b>SENATE:</b> Beginning no later than 18 months after the date of enactment, only hospitals meeting certain requirements would be exempt from the prohibition on self-referral. Hospitals that have physician ownership and a provider agreement in operation on November 1, 2009 and that met other specified requirements would be exempt from this self-referral ban. These requirements would address conflict of interest, bona fide investments, and patient safety. In addition, the hospital could not have converted from an ambulatory surgical center to a hospital after the date of enactment.</p> <p>Specifically, to address conflicts of interest, an exempt hospital would (1) submit an annual report containing the identity of each physician owner and any other information on the nature and extent of all ownership interests in the hospital; (2) have procedures in place to require that any referring physician owner disclose to each patient (by a time that permits the patient to make a meaningful decision regarding the receipt of care) their ownership interest in the hospital and, if applicable, any such ownership interest of the treating physician; (3) not condition ownership, either directly or indirectly, on the physician owners making or influencing referrals to the hospital; and (4) disclose the fact that the hospital is owned in whole or in part 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 &amp; Medicaid Services. Exempt hospitals would ensure bona fide investments and proportional returns by meeting the following requirements: (1) physician owners could not own more than the percentage of the value of physician ownership determined on the date of enactment, or the investment interest in an entity whose assets include the hospital; (2) any ownership interest offered to a physician could not be offered on more favorable terms than those offered to an individual who is not a physician; (3) the hospital could not provide loans or financing for physician investments in the hospital; (4) the hospital could not guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan to any individual physician owner or group of physician owners that is related to acquiring ownership interest in the hospital; (5) investment returns must be distributed to investors in the hospital in an amount that is directly proportional to the capital investment by the hospital investor (as determined in accordance with procedures established by the Secretary); (6) compensation of and investment returns to physician owners must not include the guaranteed receipt of or exclusive right to purchase other business related interests in the hospital, including the purchase or lease of any commercial property under the control of other investors in the hospital or located near the premises of the hospital; and (7) the hospital does not offer a physician owner the opportunity to purchase or lease any property under hospital control on more favorable terms than others.</p> <p>To ensure patient safety, exempt hospitals would be required to disclose to all patients prior to admission that it does not have any physician available on the premises to provide services during all hours in which the hospital is providing services. Following such a disclosure, the hospital would receive a signed acknowledgement from the patient that no physician will be present. Also the hospital 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 needs of the patient involved. Exempt hospitals would not be permitted to increase the number of operating rooms, procedure rooms or beds for which the hospital is licensed after the date of enactment. A procedure room includes a room in which catheterizations, angiographies, angiograms, and endoscopies are performed. A process would be established to allow certain hospitals to expand. Hospitals eligible for expansion would include: (1) a hospital that is located in a county where the population</p>

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
Physician-owned hospitals (con.)				<p>increased during the most recent five year period at a rate that is at least 150 percent of the State's population increase; (2) a hospital whose Medicare inpatient admission percentage is equal to or greater than average percentage for all hospitals located in the county; (3) a hospital that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries; (4) a hospital that is located in a state with a state average bed capacity less than the national average ; and (5) a hospital that has an average bed occupancy rate that is greater than the state average bed occupancy rate. This capacity increase 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 and beds for which the hospital is licensed at the time of enactment. The process for expansion would allow the opportunity for community input and should permit an applicable hospital to apply for the expansion exception up to once every two years. The Secretary would publish final decisions on an expansion no later than 60 days after receiving a complete application. The Secretary would implement this process on May 1, 2011 and would promulgate regulations to carry out this process no later than April 1, 2011. There would 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 enforcement efforts would be able to include unannounced site reviews of hospitals. These audits should begin no later than August 1, 2011.</p>
GME/Workforce Strategy	<p>(1) Okay to reallocate unused GME slots (2) Don't include a GAO study</p>	<p>Adds reallocation and GAO study (section 1505, starting on p. 683)</p> <p>Sections 2261 (starting on p. 920) and 2271 (starting on p. 926)(Advisory Committee and Workforce Evaluation and Assessment)</p>	<p>(1) Reallocation (2) Workforce Advisory Cmte (No mention of GAO study)</p> <p>Also includes addnl changes to GME/IME (see text) and demo grants for training in areas with health labor shortages</p> <p>(Note: Additional reallocation changes as part of the technical corrections.)</p> <p>(pp. 126-134)</p>	<p><b>SENATE:</b> In order to promote training in outpatient settings and to ensure the availability of residency programs in rural and underserved areas, this policy would provide increased flexibility in laws and regulations governing graduate medical education funding in the Medicare program. Specifically, effective for cost reporting periods beginning on or after July 1, 2010, all time spent by a resident would count toward Medicare direct graduate education payment, without regard to the setting where the activities are performed, if the hospital continues, or in the case of a jointly operated residency program, the involved entities continue to incur the costs of the stipends and the fringe benefits of the resident during the time the resident spends in the setting. Effective for discharges on or after July 1, 2010, all the time spent by a resident in patient care activities in a nonhospital setting would be counted towards Medicare indirect medical education payment if the hospital continues, or in the case of a jointly operating residency training program, the entities continue to incur the costs of the stipends and fringe benefits of the resident during the time spent in that setting.</p> <p>An eligible training site would be an ambulatory or outpatient training site. A jointly operated residency training program means an approved medical residency training program that is jointly operated by one or more hospitals or by one or more eligible training sites under a written agreement which specifies a method for an equitable distribution of time spent by the resident in activities relating to patient care.</p> <p>Each hospital or eligible training site participating in the operation of a jointly operated residency training program would submit the written agreement to the Secretary. In the case of a jointly operated residency training program, the direct graduate medical education and the indirect medical education payments would not exceed the aggregate payments that would have been made to the hospitals and the eligible training sites if the training program had been independently operated.</p> <p>When calculating DGME payments, Medicare would count the time that residents in approved training programs spend in certain non-patient care activities in a nonhospital setting that is primarily engaged in furnishing patient care. Reimbursable non-patient care activities would include didactic conferences and seminars but would not include research that is not associated with the treatment or diagnosis of a particular patient. In addition, Medicare would count all the vacation, sick leave and other approved leave spent by resident in an approved training program as long as the leave time does not extend the program's duration.</p> <p>When calculating IME payments, Medicare would adopt the same rules about counting residents' leave time. Medicare would also include all the time spent by residents in approved training programs on certain non-patient care activities (including didactic conferences but not certain research) that occurs in an acute care hospital or in a provider-based hospital outpatient department.</p> <p>These provisions would be effective as of dates determined appropriate by the Secretary.</p> <p>system, the implications for the health care workforce as a result of greater utilization of health information technology, nursing workforce capacity, mental and behavioral health care workforce capacity, and the geographic distribution of health care providers.</p>

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
Imaging	Carve out X-Ray and other small \$	Limited to advanced as defined in section 1834(e)(1)(B) (section 1147, starting on p. 273)	Limited to "advanced" imaging equipment (undefined) Also adds (1) changes to the technical component of sequential imaging services and (2) changes to IOAE exception (pp. 183-184)	<p><b>HOUSE:</b>            C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION- In computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to <b>advanced diagnostic imaging services (as defined in section 1834(e)(1)(B))</b>, the Secretary shall adjust such number of units so it reflects a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.; and</p> <p><b>SENATE:</b> The Chairman's Mark would increase the utilization rate assumption for calculating the payment for <b>advanced imaging equipment</b> from 50 percent to 65 percent for 2010 through 2013. The rate would be further increased to 75 percent beginning in 2014. The Secretary of HHS would be required to conduct a study by January 1, 2013 on the estimated impact of the utilization rate change on the following: (1) beneficiary access, including in rural areas; (2) utilization of advanced diagnostic imaging services; and (3) the estimated savings to the Medicare program over the period of 2010 through 2019.</p> <p><b>In addition, the Chairman's Mark would increase the technical component payment reduction for sequential imaging services on contiguous body parts during the same visit from 25 percent to 50 percent.</b></p> <p><b>The in-office ancillary exception would include a requirement that with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services as determined by the Secretary, the referring physician must inform the individual at the time of the referral that the individual may obtain the services from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice.</b> The individual must be provided with a written list of suppliers who furnish services in the area in which the individual resides. This new requirement would apply to services furnished after January 1, 2010.</p>
Quality	Don't rely solely on NQF	Some softening to allow for the adoption of other measures (search for 1890(a) within the text to find references to NQF)(section 1442, starting on p. 622)	Mentions NQF as a partner several times (pp. 107-110)	<p><b>SENATE:</b> (key excerpts) Additional resources would be provided to HHS to strengthen the quality measure development processes for purposes of improving quality, informing patients and purchasers, and updating payments under federal health programs. Specifically, the Secretary would be directed to develop a national quality strategy; establish an interagency working group on health care quality; provide additional resources for quality measure development and endorsement; and establish a process for HHS to work with external stakeholders, <b>such as the National Quality Forum</b>, to select quality measures to be included in Medicare value-based purchasing and pay-for-reporting programs.</p> <p>In developing the national strategy and priorities, the Secretary would take into consideration <b>recommendations submitted by a qualified consensus-based entity as set forth in MIPPA</b>. To develop these recommendations, the qualified consensus based entity would convene a multi-stakeholder group. Stakeholders would include, but would not be limited to representatives of hospitals, physicians, post-acute providers, quality alliances, nurses and other health care practitioners, health plans, consumer representatives, life sciences industry, employers and public purchasers, labor organizations, licensing, credentialing and accrediting bodies, relevant government agency representatives, and others deemed appropriate by the Secretary. This multi-stakeholder group would operate in an open and transparent process.</p> <p>The Secretary would identify, not less than triennially, gaps where no quality measures exist, or where existing quality measures need improvement, updating or expansion consistent with the national strategy and priorities. <b>The qualified consensus-based entity set forth in MIPPA would be required to submit an annual report to the Secretary describing areas where gaps in quality measures exist and areas in which evidence is insufficient to support endorsement of quality measures related to the priority areas identified by the Secretary in the national strategy.</b> This report would also include information on the economic and quality impact of the use of endorsed measures, where available. In identifying gaps, the Secretary would take into consideration the gaps identified by the consensus based entity.</p> <p>The Secretary would then be required to develop measures that would fill identified gaps. <b>To fulfill the section, the Secretary would contract with an entity that has demonstrated expertise and capacity in the development and evaluation of quality measures; that have procedures in place to take into the account the view of payers or providers whose performance will be assessed by the measures and the views of other parties, such as consumers and health care purchasers; have transparent policies regarding governance and conflicts of interest; and have processes in place to collaborate with the qualified consensus-based entity involved with measure endorsement as identified in MIPPA.</b></p>

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
Geo variation	Don't include	Included (along with a new IoM study)(sections 1157 and 1158, starting on p. 328)	Includes an extension fo the geographic index (p. 137)	<p><u>SENATE:</u> The Chairman's Mark would extend the 1.00 floor for the geographic index for physician work for an additional two years through December, 2012.</p> <p>The Chairman's Mark would also direct the Secretary to adjust the practice expense GPCI for 2010 to reflect 3/4 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (i.e. a blend of 3/4 local and 1/4 national) instead of the full difference under current law. For 2011, the adjustment would reflect 1/2 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (i.e. a blend of 1/2 local and 1/2 national). Relief would apply only to areas with a practice expense GPCI less than 1.0. The Mark would hold-harmless any areas negatively impacted by the adjustment.</p> <p>The proposal would direct the Secretary to analyze current methods of establishing practice expense geographic adjustments under the physician fee schedule (PE GPCI) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different Medicare payment localities. Such analysis shall include an evaluation of: 1) the feasibility of using actual data or reliable survey data developed by recognized medical organizations such as the American Medical Association on the costs of operating a medical practice, including office rents and non-physician staff wages, in the different Medicare payment localities; 2) the office expense portion of the PE GPCI, including the extent to which types of office expenses are determined in local markets versus national markets, and 3) the weights assigned to each of the categories within the practice expense GPCI.</p> <p>Based on the analysis and evaluation, the Secretary shall, no later than January 1, 2012, make appropriate adjustments to the PE GPCI to ensure accurate geographic adjustments across payment areas, including adjustments to 1) base the —office rents   category and its weight on occupancy costs only and make weighting changes in other categories as appropriate; 2) ensure that office expenses that do not vary from region to region be included in the "other" office expense category; and 3) consider a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey (ACS) data or other reliable data for wage adjustments. Adjustments made in 2012 would be made without regard to the adjustments made in 2010 and 2011. If the Secretary has not completed the required analysis and evaluation and made appropriate adjustments in the Medicare Physician Fee Schedule rule for 2012 (or subsequent year), the 2011 payment rule under paragraph (1) shall remain in effect.</p>
Medical Liability reform	Include	Not included except for Gordon/Deal/M atheson amendment providing funds for state alternatives	SoS only (p. 207-208), despite numerous GOP attempts to add something more	<p><u>SENATE:</u> The Chairman's Mark would express the Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. The Mark would further express the Sense of the Senate that states should be encouraged to develop and test alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court. The Mark would express the Sense of the Senate that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system.</p>
Public plan/ CO-OP	(1) No mandatory participation of providers (rule of construction) (2) No linkage of payment to	Additional language regarding participation but providers must "opt out" of participation, payment linkage to MCare only	CO-OP proposal (not public plan) in which there is no discussion about payment of providers or provider participation	

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
Public plan/CO-OP (con.)	Medicare	for first 3 years (section 223 - 225, starting on p. 121) (Note: Blue Dog compromise affected this.)	(pp. 43-45)	
RAC program	??	Not included	Extended to Medicare Parts C and D and Medicaid (p. 193)	<p><u>SENATE:</u> The Chairman's Mark would extend the RAC program to Medicare Parts C and D and Medicaid. <a href="#">This expansion would require three items:</a></p> <ol style="list-style-type: none"> <li><a href="#">1. The CMS implement the RAC programs in Medicare Parts C and D and in Medicaid by the end of 2010.</a></li> <li><a href="#">2. That CMS coordinate the Medicaid RAC program with states, several of whom have already entered into contracts with RACs at the state level.</a></li> <li><a href="#">3. That CMS submit an annual report to Congress concerning the effectiveness of these programs and any recommendations for expanding or improving the programs.</a></li> </ol>
CMS Innovation Center	??	Not included	Included (pp. 113 -	<p><u>SENATE:</u> The Chairman's Mark would require the Secretary to create an Innovation Center within the Centers for Medicaid and Medicare Services (CMS). The Innovation Center will be a new office established within CMS that is authorized to test, evaluate, and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. The Mark would also make permanent the authority granted to the Secretary under Section 646 of the MMA (section 1866C of the Social Security Act).</p> <p>The Center would be required to conduct an evaluation of each model tested, including an analysis of the extent to which the model results in: (1) coordination of health care services across treatment settings; (2) reduction of preventable hospitalizations; (3) prevention of hospital readmissions; (4) reduction of emergency room visits; (5) improvement in quality and health outcomes; (6) improvement in the efficiency of care; (7) reduction in the cost of health care services covered under this title; and (8) achievement of beneficiary and family-caregiver satisfaction.</p> <p>In order to facilitate the timely design, implementation, and evaluation of payment models by the Center, the Mark exempts the Center from budget-neutrality requirements for an initial testing period. The Center would be given the authority to terminate or modify the design of models at any time during a testing period.</p> <p>To support its work, including the Center's evaluation component, the Center would be required to consult regularly with outside experts and stakeholders, including the Medicare Payment Advisory Commission (MedPAC), health professionals with demonstrated expertise in chronic care management of older adults, and representatives of patients and caregivers.</p> <p>The Secretary would be given the authority to expand the duration or the scope of any project undertaken by the Center if the Secretary determines that doing so would improve the quality of patient care and reduce the rate of growth of Medicare fee-for-service expenditures. The expected reduction in future Medicare expenditures must be certified by the CMS Office of the Actuary before an expansion could occur.</p> <p>The Center would be required to test and evaluate patient-centered delivery and payment models. The Center would review models that have shown evidence of success in the Medicare population. The Center would consider models that target beneficiaries who are dually-eligible for both Medicare and Medicaid, and beneficiaries with multiple chronic conditions and at least one of the following: (1) an inability to perform 2 or more activities of daily living; and (2) a cognitive impairment, including dementia.</p> <p>In addition, the Center would be required to consider for testing, at a minimum, models that achieve at least one of the following criteria:</p> <ol style="list-style-type: none"> <li><a href="#">1. Promote broad payment and practice reform in primary care, including patient-centered medical home models for high-need beneficiaries, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment;</a></li> <li><a href="#">2. Contract directly with groups of providers and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payments or through salary-based payment;</a></li> </ol>

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
CMS Innovation Center (con.)				<p>3. Promote care coordination between health care providers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payments.</p> <p>4. Support care coordination for chronically-ill Medicare beneficiaries at high risk of hospitalization through a health IT-enabled network that includes a chronic disease registry, home tele-health technology, and care oversight by the beneficiary's treating physician;</p> <p>5. Vary payment to physicians ordering advanced diagnostic imaging services according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders;</p> <p>6. Utilize medication therapy management services;</p> <p>7. Establish community-based health teams to support small-practice medical homes by assisting the principal primary care practitioner in chronic care management activities;</p> <p>8. Fund physician, nurse practitioner, or physician assistant-led home-based primary care programs with demonstrated experience in serving high-cost beneficiaries with multiple chronic illnesses and functional disabilities;</p> <p>9. Establish a program to assist beneficiaries in making informed health care choices by paying providers for using patient decision-support tools that improve beneficiary and caregiver understanding of their medical treatment options;</p> <p>10. Allow states to test and evaluate fully integrating care for dually eligible members, including the management and oversight of all Medicare and Medicaid funds for this population;</p> <p>11. Allow states to test and evaluate systems of all-payer payment reform for medical care of residents in each participating State, including individuals dually eligible for Medicare and Medicaid;</p> <p>12. Align nationally-recognized, evidence-based guidelines of cancer care with Medicare payment incentives in the areas of treatment planning and follow-up care planning for Medicare beneficiaries with cancer, including the identification of gaps in current quality measures;</p> <p>13. Improve post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospital, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge;</p> <p>14. Fund home health providers who offer chronic care management services to Medicare beneficiaries in cooperation with interdisciplinary teams.</p> <p>15. Promote improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions charged with: (1) developing, documenting and disseminating best practices and proven care methods; (2) implementing these techniques within their own institutions to demonstrate further improvements in quality and efficiency; and (3) providing assistance to other institutions on how best to employ these techniques to improve health care quality and lower costs.</p> <p>16. Facilitate inpatient care, including intensive care, of hospitalized Medicare beneficiaries at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.</p> <p>17. Promote greater efficiencies and timely access to outpatient services (such as physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care, when such service is provided by a health professional who has such authority under existing state law.</p> <p>The list of potential opportunities for improving quality and reducing costs are intended to be illustrative not binding; the Secretary would have authority to focus on identifying, designing, testing, and evaluating models that would be expected to reduce program costs while preserving or enhancing the quality of care received by individuals receiving benefits.</p> <p>In selecting models for testing, the Secretary shall also consider the extent to which models meet the following criteria:</p> <ol style="list-style-type: none"> <li>1. Foster care coordination for high-cost, chronically ill Medicare beneficiaries who are at highest risk for hospitalization or readmission;</li> <li>2. Place the patient, including family members and other informal caregivers, at the center of the care team;</li> <li>3. Include, but are not limited to, in-person contact with beneficiaries;</li> <li>4. Utilize technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time;</li> <li>5. Maintain a close relationship between care coordinators, primary care practitioners, specialist physicians, and other health care providers; Maintain a close relationship between care coordinators and primary care practitioners;</li> <li>6. Rely on a team-based approach to interventions such as comprehensive care assessments, care planning, and self-management coaching.</li> </ol> <p>To be approved for expansion, models would be required to demonstrate that they meet patient-centered criteria as determined by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.</p> <p>The scope of the Innovation Center would include the Medicaid and CHIP programs, with the same requirements for testing and evaluation of patient-</p>

Issue	Requested Outcome	House response (Bill reference section) <sup>1</sup>	Senate response (Chairman's mark released 10/2/09, including technical changes) <sup>2</sup>	Legislative text/summary information
CMS Innovation Center (con.)				<p>centered delivery and payment models that have shown evidence of success in Medicaid and CHIP populations as proposed for Medicare.</p> <p>Within 18 months of enactment, the Center would be required to post on the CMS website a report on the Center's initial consideration of the models listed above, as well as a detailed plan for the continuing work of the Center.</p> <p>The Chairman's Mark would appropriate \$10 billion from the Part A and Part B Trust Funds to the Center over 10 years. The costs of otherwise uncovered benefits delivered under this authority would be counted against the Center's overall funding level. In addition, the Center would be required to directly allocate a portion of such funding for the Center's evaluation activities.</p> <p><i>Effective Date</i></p> <p>The Innovation Center would be established by January 1, 2011.</p> <p>(p. 75)</p> <p>The Chairman's Mark would establish a Medicaid Global Payments demonstration project available to in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment system from a fee-for-service structure to a capitated, global payment structure. The CMS Innovation Center would conduct an evaluation of each demonstration project examining any changes in health care quality outcomes and spending. The Chairman's Mark would exempt the Innovation Center from the budget-neutrality requirements for an initial testing period. The Innovation Center would also be given the authority to terminate or modify the demonstration project during the testing period. The Secretary would be required to conduct and analysis of the demonstration project and report her findings to Congress.</p>