

July 16, 2009

SUMMARY OF HOUSE TRI-COMMITTEE
HEALTH CARE REFORM BILL:
AMERICA'S AFFORDABLE HEALTH CHOICES ACT OF 2009
(H.R. 3200)

AT A GLANCE

The Issue:

On Tuesday, July 14, House leaders introduced the *America's Affordable Health Choices Act of 2009* (H.R. 3200). The "tri-committee" health care reform bill is the product of the chairmen of three key House committees: Ways & Means, Energy & Commerce and Education & Labor. The 1018-page bill is available at http://energycommerce.house.gov/Press_111/20090714/aahca.pdf.

Key proposals in the health care reform bill include:

- An expansive new public plan that – in addition to other insurance market reforms, Medicaid expansions and the creation of an insurance “exchange” – would expand coverage to an estimated 97 percent of Americans;
- Hospital payment cuts of \$119 billion in market basket update reductions, \$16 billion in payment reductions related to hospital readmissions and \$20 billion in Medicare and Medicaid disproportionate share hospital (DSH) payments; and
- Elimination of the exception for physician-owned hospitals under the whole hospital and rural provider exceptions under the Stark law.

The attached summary is based on the bill language introduced on July 14 at 12:51 p.m. However, today the three committees released additional provisions and changes that will be included in a new version of the legislation. As they begin marking up the legislation today, it is possible that additional amendments will be adopted. The AHA will update our summary once final language from the mark-ups is determined and before the bill goes to the House floor for a vote.

What You Can Do:

We urge you to review this advisory carefully and contact your members of Congress to express your concern. H.R. 3200 would result in significant cuts to Medicare hospital payments, and raises significant concerns that individuals would shift from private insurance coverage to the expansive public insurance option that would pay hospitals at Medicare rates, which are well below cost for most hospitals.

Further Questions:

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**SUMMARY OF HOUSE TRI-COMMITTEE
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BACKGROUND

On Tuesday, July 14, House leaders introduced the [*America's Affordable Health Choices Act of 2009*](#) (H.R. 3200). The "tri-committee" health care reform bill is the product of the chairmen of three key House committees: Ways & Means, Energy & Commerce and Education & Labor. The bill follows a previous draft that was released on June 19 and summarized by the AHA in a June 26 [*Legislative Advisory*](#). H.R. 3200 includes key coverage and financing proposals that were not included in the draft.

This *Legislative Advisory* is based on the bill language introduced on July 14 at 12:51 p.m. However, today the three committees released additional provisions and changes that will be included in a new version of the legislation. As they begin marking up the legislation today, it is possible that additional amendments will be adopted. The AHA will update our summary once final language from the mark-ups is determined and before the bill goes to the House floor for a vote.

At Issue

The House health care reform legislation would expand coverage by enacting an individual mandate and an employer "play or pay" policy. Additionally, it would create a health insurance exchange with a public insurance plan option, expand Medicaid to 133 percent of the federal poverty limit, and enact a number of insurance market reforms and administrative simplification. The Congressional Budget Office (CBO) has scored the coverage provisions at a cost of \$1.042 trillion over the 10-year period (FY 2010-FY 2019). Financing for the legislation includes revenues from the employer "play or pay," new surtaxes on individuals with incomes greater than \$350,000 and reductions to provider payments.

Among the key provisions affecting hospitals, the Tri-Committee bill:

- Permanently reduces the annual market basket updates for inpatient, outpatient, long term care, inpatient rehabilitation facility, and inpatient psychiatric hospitals to account for

“productivity gains” in FY 2010 and beyond. The CBO estimates cuts to hospitals of approximately \$119 billion over 10 years.

- Reduces both Medicare and Medicaid disproportionate share hospital (DSH) payments by \$10 billion each and redistributes remaining dollars based in part on levels of uncompensated care beginning in FY 2017. Hospitals with higher amounts of uncompensated care would have smaller reductions in their DSH payments.
- Pays hospitals Medicare payment rates for individuals enrolled in a new public health insurance plan (as part of a national health insurance exchange) for the first three years, after which the Secretary would set payment rates. Over time the public plan would be open to all.
- Implements a readmissions policy that would reduce payments to hospitals with higher-than-expected patient readmission rates and reduces post-acute payment for cases readmitted to a general acute hospital within 30 days, with total reductions to hospitals totaling \$16 billion over 10 years.
- Reforms the physician payment formula by eliminating the accumulated deficits under the existing sustainable growth rate formula and by directing higher payments to primary care providers.
- Directs the Secretary to develop a *plan* to bundle Medicare payments for post-acute care, and to determine whether hospital inpatient services and/or physician services should be included.
- Does not reduce indirect medical education (IME) payments or direct graduate medical education (DGME) payments. Includes a redistribution of unused residency training positions.
- Directs the Institute of Medicine to report on the validity and effects of the geographic adjusters used for physician and hospital payments, and to make recommendations for improvements. In response, the Secretary of Health and Human Services (HHS) may spend up to \$4 billion a year for two years.
- Eliminates the exception for physician-owned hospitals under the whole hospital and rural provider exceptions under the Stark law, but grandfathers those with a Medicare provider agreement in place by January 1, 2009.

Attached is a detailed summary of key proposals affecting hospitals.

**AHA SUMMARY OF HOUSE TRI-COMMITTEE
HEALTH CARE REFORM BILL:
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(H.R. 3200)**

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COVERAGE AND INSURANCE REFORMS

Insurance Market Reforms (Sec. 101-152, 1234)

The bill establishes insurance market reforms and standards for qualified plans offered inside and outside a national health insurance exchange (exchange). All plans offered, including plans offered through the insurance exchange, as well as the public plan option, would be required to meet set requirements. The most significant provisions include guaranteed issue and renewal of policies, a prohibition on pre-existing condition exclusions, nondiscrimination in benefits, adequacy of provider networks, rating restrictions, and minimum medical loss ratios. Other provisions address fair marketing practices, benefit package offerings, timely payment of claims, fair grievance and appeals mechanisms and transparency. Also included are changes in the guaranteed issue requirements for Medigap plans that guarantee access to affordable coverage for Medicare beneficiaries.

Early Investments (Subtitle G)

The Secretary of HHS, before implementing comprehensive health insurance reform, must undertake the following investments to improve the efficiency and value of health care:

- *Ensuring Value and Lower Premiums* (Sec. 161)
All health insurance issuers would be required to meet a medical loss ratio set by the HHS Secretary beginning in plan years after January 1, 2011. Failure to do so would require rebates to enrollees.
- *Ending Health Insurance Rescission Abuse* (Sec. 162)
All health insurance companies would be prohibited from rescinding coverage except in instances of clear fraud and would be required to conduct independent review beginning October 1, 2010. This provision eliminates the practice of rescinding coverage when an enrollee becomes ill.
- *Administrative Simplification* (Sec. 163)
Major advances in standardizing insurance administrative requirements would be made for all health plans whether in or out of the Health Insurance Exchange and whether claims are processed on paper or electronically. Health insurance administrative simplification must include: standardizing language, forms, claims attachments and coordination of benefits; establishing operating rules and companion guides for processing health transactions; increasing electronic exchange of clinical and administrative data; timely and transparent claims processing; improved enforcement; and standardized electronic provider enrollment in health plans. Also included is implementation assistance for providers, especially those in rural and underserved areas.

- **Reinsurance Program for Early Retirees (Sec. 164)**

The Secretary would establish a temporary reinsurance program for early retirees within 90 days of enactment. The program would provide reimbursement to participating employment-based plans for part of the cost of providing coverage to retirees ages 55-64 and their families. The program would reimburse participating employment-based plans for 80 percent of the cost of benefits provided enrollees in excess of \$15,000 and below \$90,000. The bill provides \$10 billion for the program, and the funds are available until expended.

Additional Reforms (Sec 153- 155)

Whistleblower protections are established for employees that report violations of this act made by their employer. These protections are in accordance with current law *Consumer Product Safety Act* protections. Current law statutory obligations of employers to collectively bargain with employees regarding matters related to health care are preserved. The act also provides severability so that if any part of this act is found unconstitutional it will not affect other parts of this act.

Health Choices Administration (Sec. 141-152)

An independent agency, known as the Health Choices Administration, would be established. The Health Choices Administration commissioner (commissioner) would be appointed by the President and confirmed by the Senate. The duties of the commissioner include administering the new insurance market standards, the Health Insurance Exchange, and the affordability credits (low-income subsidies). The commissioner would consult with the National Association of Insurance Commissioners, state agencies and other federal agencies to establish a Health Insurance Ombudsman. The commissioner would have the authority to collect data and administer sanctions.

Health Insurance Exchange (Sec. 141, 201-208, 1701-1702)

The commissioner would establish the exchange to facilitate access to qualified health insurance coverage for individuals and employers. The commissioner would certify entities offering qualifying health plans, solicit and negotiate bids and establish standards for certification that include licensure, enrollment process and data reporting. The scope of the commissioner would include managing Medicaid wrap-around benefits for certain exchange-eligible individuals, contracting with essential community providers, managing subsidies for low-income individuals and assuring that services are culturally and linguistically appropriate. The commissioner also would establish a risk-pooling mechanism minimizing the impact of adverse selection of enrollees among the plans offered. Additionally, the commissioner would conduct outreach and education, timely eligibility determinations and a process for open enrollment. The Secretary has oversight and enforcement responsibilities. The exchange would be up and running by year one, which is defined as 2013 or any earlier year so determined by the President.

Exchange-Eligible Individuals and Employers

Eligibility for enrollment through the exchange would be phased in over a three-year period.

- **Year one:** Individuals who are *not* already enrolled in a qualifying health plan or other acceptable coverage would be eligible for the exchange (*Acceptable coverage would include employer-based coverage, Medicare, Medicaid, DOD/Tricare, VA or*

“grandfathered” health insurance coverage). Employers with 10 or fewer employees and the self-employed also would be eligible for the exchange.

- Year two: All individuals and employers eligible in year one would continue to be eligible along with an additional group of employers – those with 20 or fewer employees.
- Year three: All individuals and employers eligible in years one and two would continue to be eligible along with large employers. The commissioner would determine the definition and eligibility requirements for large employers and establish a phased-in schedule for entry into the exchange.

Medicaid, Children’s Health Insurance Program (CHIP) and the Exchange

Non-traditional Medicaid beneficiaries, which include those newly eligible for Medicaid up to 133.33 percent of the federal poverty level (FPL) (e.g., \$14,400 per year for an individual in 2009; \$29,300 per year for a family of four in 2009) – such as childless-adults and uninsured newborns – would be eligible for the exchange if they were enrolled in a qualified health plan, group health coverage or grandfathered coverage during the six months prior to becoming Medicaid eligible. The federal government would pay 100 percent of the costs of Medicaid coverage, effective in 2013.

State governments and the exchange must coordinate enrollment for the traditional and non-traditional Medicaid populations through a memorandum of understanding.

All children born in the U.S. who are not covered under an acceptable coverage plan would be considered non-traditional Medicaid. State Medicaid programs would be required to cover newborns up to the first 60 days of life.

CHIP enrollees would be required to obtain coverage through the exchange and the program is terminated by 2013.

Essential Benefits Package

The Health Benefits Advisory Council, which would be a public-private advisory committee, comprised of medical and other experts, would be charged with recommending covered benefits and the essential benefits package. The essential benefit package must include a full range of services such as inpatient and outpatient hospital services, emergency services, mental health services, prescription drug, maternity services, well baby, and well child services. The essential benefits package can have no cost-sharing for preventive benefits including well baby and well child care, and there are limits to out-of-pocket spending. Those limits are \$5,000 for individuals and \$10,000 for a family indexed to the Consumer Price Index (CPI). The essential benefit package is 70 percent of the actuarial equivalent of the package designed as if there were no cost-sharing.

Benefits Package

There are four benefit tiers that participating plans can offer. Each participating plan must provide one basic plan in each service area and can at their option offer enhanced or premium levels benefit categories. The cost sharing variation cannot exceed plus or minus 10 percent with regard to each benefit category of services.

- The basic plan would be the essential benefit package defined by the Health Benefits Advisory Committee. For individuals receiving affordability credits or subsidies, cost sharing would be modified for the basic benefit plan.

- The enhanced benefit plan would be the basic plan with a lower level of cost sharing, set at 15 percent of the actuarial equivalent of the plan.
- The premium plan would include all the basic benefits with an even lower level of cost-sharing, set at 5 percent of the actuarial equivalent of the plan.
- The premium-plus plan would add benefits such as adult oral health and vision care, or other non-covered benefits. Plans may offer multiple premium-plus options.

The differences between the three main plans (basic, enhanced and premium) are the levels of cost sharing required, not the benefits covered. Plans can offer benefit packages outside the exchange.

Health Insurance Exchange Trust Fund

A trust fund would be established to pay the operating expenses of the exchange. The revenue to support the trust fund would come from taxes and excise taxes on individuals and employers who fail to obtain coverage, provide acceptable coverage, or fail to meet certain coverage requirements.

State-Based Health Insurance Exchanges

A state or a group of states could apply to the commissioner to operate an insurance exchange if it met specified criteria.

Public Health Insurance Plan (Sec. 221-226)

To offer greater choice and affordability of health plans, the Secretary would establish a public health insurance plan. This public plan would be available only through the exchange. The Secretary would enter into administrative contracts with entities similar to Medicare fiscal intermediaries to administer the public plan option. The public plan would be available in year one of the exchange and would have to meet all the requirements of the exchange. Individuals and employers with access to the exchange would have access to the public plan. The benefit levels of basic, enhanced, premium and premium-plus would be the same for the public plan as for the exchange.

Premiums and Financing

Start-up funds of \$2 billion would be provided for the public plan as well as enough funds to cover 90 days worth of claims reserves based on projected enrollment. However, going forward, the Secretary would be required to establish geographically adjusted premium rates that allow the cost of the health benefits and their administrative costs to be fully financed.

Provider Payments

In the first three years of the exchange, the public plan would pay hospitals and other providers based on Medicare Part A and Part B. Hospitals would receive the Medicare rates for the first three years of the exchange.

Medicare practitioners' rates, for this time period, would apply without regard to the sustainable growth rate (SGR) with an update of not less than 1 percent. The public plan would pay physicians and other practitioners the Medicare fee schedule rate plus an incentive bonus payment of 5 percent if they participate in both Medicare and the public plan. Pediatricians and other practitioners, as determined by the Secretary, who typically do not participate in Medicare, would be eligible for the incentive bonus. This additional incentive

payment of 5 percent would not be available to hospitals participating in the public plan. Hospitals would receive Medicare rates.

Rate-setting Process

Beginning in year four of the exchange, the Secretary would be required to establish a provider rate-setting system that would conform to the current federal rule making process. Such rates shall not exceed the initial Medicare payments levels from the first three years of the public plan.

Modernizing Hospital and Other Provider Payment

Beginning in year one of the exchange, the Secretary could utilize innovative payment methods. Such payment methods could include payments for medical home; care coordination; accountable care organizations; value-based purchasing; bundling; and capitation, including the full range of risk from partial to full capitation. These innovative payment methods must seek to improve outcomes, reduce health disparities, address geographic variation, manage chronic illness and promote integrated delivery. Cost sharing could be modified to encourage the use of services that promote health and value.

Provider Opt-out Option

Providers participating under Medicare are participating providers in the public plan unless they opt out in a process established by the Secretary. Hospitals are eligible for the opt-out option.

Provider Conditions of Participation (COP)

The Secretary would establish COPs for providers including licensure, provider exclusion and prohibition of balance billing. For physicians, there are two types of COP: 1) preferred physicians are those who agree to accept the public plan payment rate as payment in full; and 2) participating non-preferred physicians are those who will not balance bill in excess of Medicare limitations. Non-physician providers who participate in the public plan must accept public plan rates as payment in full.

Individual Affordability Credits/Subsidies (Sec. 241-246)

Subsidies for the purchase of health coverage for low-income individuals and families would be available in the form of affordability credits through the exchange. Individuals and families with incomes up to 400 percent of the FPL (e.g., \$57,600 for an individual in 2009; \$117,200 for a family of 4 in 2009) would be eligible for affordability credits to be used toward the premium and cost sharing. Individuals who are offered employer coverage are, generally, not eligible for affordability credits within the exchange. But, beginning in year 2 of the exchange, employees will be eligible for affordability credits if their premiums from their employer-based plan exceed 11 percent of their income. Affordability credits would be managed by the commissioner of the exchange or entities approved by the commissioner, including state Medicaid programs through a memorandum of understanding.

Premium credits would be based on the average cost of the three lowest-cost, basic health plans in the area. The credit would be set using a sliding scale so that individuals and families with incomes at or below 133.33 percent of FPL would pay no more than 1.5 percent of their income toward a premium contribution, with the credit phasing out at 11 percent of income for those with incomes at 400 percent FPL.

The cost-sharing credits will result in cost-sharing reductions and are to be based on a sliding scale for individuals and families at or below 133.33 percent FPL up to 400 percent of FPL. The cost-sharing credit is based on a calculation of the annual-cost sharing limit and a reduction in the cost-sharing amount based on a percentage of the full actuarial value if no cost sharing were imposed. Undocumented immigrants would not be eligible for the affordability credits.

Shared Responsibility (Sec. 301-314)

Individual Responsibility

All individuals would be required to obtain “acceptable health coverage” either through the exchange or through employer-based coverage, Medicare, Medicaid, DOD/Tricare, VA or “grandfathered” health insurance coverage. Individual health insurance policies would not be acceptable unless they qualify under the “grandfathered” insurance option. The individual mandate is enforced through a 2.5 percent tax on adjusted gross income up to the cost of the average national premium for the basic health plan offered in the exchange. The Secretary, in coordination with the commissioner, would determine the national average premium. The tax is prorated by the portion of the year the individual is without coverage. Exceptions to the mandate would apply for dependents, non-resident aliens, individuals residing outside of the U.S., those with religious objections and those facing financial hardships.

Employer Responsibility – Play or Pay

Employers would be required to offer and pay a portion of their employees’ health coverage or, in lieu of coverage, pay into the Health Insurance Exchange Trust Fund. This approach works as follows:

- Employers would be required to offer coverage to their employees and their families, contributing financially toward that coverage. If their employees seek coverage through the exchange, they must contribute to the exchange. For full-time employees, employers must contribute for individuals 72.5 percent of the cost of the lowest-cost plans for individuals and 65 percent for families. The Secretary of HHS, with the exchange commissioner and the secretaries of Labor and Treasury, would set the employer contribution for part-time employees.
- Employers would have the option to pay in lieu of providing coverage. That payment would be equal to 8 percent of the employees’ wages and would be paid into the exchange trust fund. There is a total exemption of the 8 percent tax for small employers with annual payrolls not exceeding \$250,000. Small employers with annual payrolls above \$250,000 but not exceeding \$400,000 would be subject to a graduated tax from 2 percent to 6 percent if they choose not to provide coverage.

ERISA Plans

Employers would be allowed to meet the health coverage participation requirements by establishing and maintaining a group health plan that meets certain criteria. Employers would be subject to compliance audits and could face civil penalties for failure to comply. Tax penalties also would apply to these ERISA plans.

Avoiding Adverse Selection

The Health Choices Commission would have the authority to set standards to prevent an employer from steering high-risk employees into the exchange in order to avert adverse selection.

Subsidy/Credit for Small Business Employee Health Coverage

A subsidy for small business employers would be a credit equal to 50 percent of the expenses for an employee's qualified health plan. The tax credit is phased out in the case of an employer with 10 to 25 employees, and also is phased out in the case of an employer with average wages of \$20,000 to \$40,000 per year.

Medicaid Expansion (Sec. 1701-1702)

Medicaid would be expanded to individuals under age 65, both traditional and non-traditional categories, with incomes at or below 133.33 percent of FPL. (Non-traditional Medicaid eligibles could go into the exchange beginning year one and include non-disabled, childless adults.) Children would be covered under Medicaid at birth for the first 60 days of life as non-traditional Medicaid beneficiaries, if they did not have "acceptable" coverage at the time of birth. These new populations would be 100 percent federally financed through the Medicaid Federal Medical Assistance Percentage (FMAP).

Medicare Advantage (Sec. 1161-1177)

There are significant changes to Medicare Advantage (MA) plan payments, specifically the gradual reduction in MA plan benchmarks for bids to align more closely with average Medicare fee-for-service (FFS) costs; the elimination of the MA Regional Plan Stabilization Fund; extension of the Secretary's authority to apply coding intensity adjustments to reduce plan rates; the inclusion of quality bonuses for high quality plans; and improvements to risk adjustment for MA payments. The overall effect of these changes would significantly reduce plan payment levels from the current average of 114 percent per-beneficiary FFS costs. Additional changes would limit beneficiary out-of-pocket costs for individual health services, modify enrollment periods, increase transparency on administrative costs and address other operational aspects.

Medicare Advantage Plans for Special Needs Individuals

These reforms to the MA plans for special needs individuals include placing limits on enrollment periods and extending the authority to restrict enrollment to special populations. The enrollment limits would no longer permit an MA special needs plan (SNP) to enroll outside of the enrollment period. The SNPs would be able to continue limiting enrollment to their target population through 2012 and, in the case of certain dual eligible SNPs, through 2015.

KEY DELIVERY SYSTEM REFORMS

Hospital Readmissions (Sec. 1151)

Beginning in FY 2012, inpatient prospective payment system (PPS) hospitals with higher-than-expected readmissions rates would experience decreased Medicare payments for all Medicare discharges. Performance evaluation would be based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program and are reported on *Hospital Compare* in summer 2009. The base

inpatient payment for hospitals with *actual* readmission rates higher than their Medicare-calculated *expected* readmission rates would be reduced by an adjustment factor that is the greater of:

- A hospital-specific readmissions adjustment factor based on the number of readmitted patients in excess of the hospital's calculated expected readmission rate; or
- 0.99 in FY 2012; 0.98 in FY 2013; 0.97 in FY 2014; and 0.95 in FY 2015 and beyond.

This means the largest potential reduction for a hospital would be 1 percent in FY 2012; 2 percent in FY 2013; 3 percent in FY 2014; and 5 percent in FY 2015 and beyond. This reduction would apply to *all* Medicare discharges.

Beginning in FY 2013, the Secretary would be able to expand the list of conditions to include chronic obstructive pulmonary disorder and several cardiac and vascular surgical procedures, as well as any other condition the Secretary chooses, including an “all-cause” readmission rate measure. The Secretary would be directed to seek endorsement from the National Quality Forum (NQF) for all measures used to assess readmissions performance. However, the Secretary would have the discretion to proceed without receiving endorsement.

Up to 5 percent of the readmissions payment reductions taken from inpatient PPS hospitals would be available to assist hospitals receiving or eligible to receive at least \$10 million per year in Medicare DSH payments. Such hospitals would receive funds up to the amount of their readmissions payment reduction. These funds would be used to support transitional care activities designed to address patient noncompliance issues that result in higher-than-normal readmissions rates, such as providing care coordination services to assist in transitions from the hospital to other settings, or increasing the services offered by discharge planners.

Critical access hospitals (CAHs) also would be evaluated for their performance on readmissions.

- CAHs would be evaluated in the same manner as inpatient PPS hospitals.
- The adjustment factor would be applied to CAHs' cost-based payments for cost reports beginning in FY 2012 and beyond.

Post-acute providers also would experience reduced payments for readmissions.

- Payments for skilled-nursing facilities, inpatient rehabilitation facilities, home health agencies and long-term care hospitals (LTCHs) would be reduced when patients are readmitted to an inpatient PPS or critical access hospital from a post-acute provider within 30 days of the initial discharge.
- Payments would be reduced by 0.4 percent in 2012; 0.7 percent in 2013; and 1.0 percent in 2014.
- The readmissions adjustment would not apply to LTCH cases that qualify as interrupted stays. Interrupted stays are LTCH patients who are temporarily discharged to a general acute hospital or other setting on a planned basis and subsequently return to the LTCH for the conclusion of their care. Existing regulations require that Medicare make no additional payment for services provided while the LTCH patient is temporarily discharged to another setting during an interrupted stay.

- The Secretary would be charged with developing measures to assess post-acute care providers' readmission rates and, for FY 2015 or later, applying a policy to post-acute care providers that is similar to the proposed hospital policy.

Post-Acute Care Payment Reform Plan for Bundled Payment (Sec. 1152)

No later than three years after the health reform law is enacted, the Secretary will develop a *plan* to reform Medicare payment for post-acute care services, including skilled-nursing facility, inpatient rehabilitation facility, long-term care hospital, hospital-based outpatient rehabilitation facility and home health agency services. The plan should include detailed specifications for bundling payment for post-acute care services and also could include other approaches. The Secretary would need to consider:

- To whom the payment would be made, the activities and services included in the bundle, the time frame of the bundle and whether the bundle should include physician services;
- Whether inpatient hospital services should be included in the bundle and, if so, which inpatient services;
- Whether critical access hospitals should be included in the bundle;
- The extent to which savings could be achieved due to increased efficiencies;
- Whether rates should be determined on a national basis or should differ by area, severity, outliers and other factors;
- Protections needed to ensure beneficiaries receive appropriate, high-quality care and have a choice of provider;
- The extent to which transitional care services would improve the quality of care and functioning of a bundled post-acute payment system;
- Legal and regulatory barriers to bundling;
- Quality measures that would be appropriate for reporting by hospitals and post-acute providers;
- Whether and how cost-sharing requirements should be modified;
- Other regulations that may need to be modified or eliminated, such as the post-acute care transfer policy; and
- Other issues the Secretary deems appropriate.

The legislation would convert the current Acute Care Episode (ACE) demonstration to a pilot program by January 1, 2011. This pilot program may include additional geographic areas and high-cost conditions. If the services provided in the ACE demonstration and pilot program maintain or increase quality and reduce expenditures, the Secretary would expand the pilot program to include post-acute care and other services. Participation in the pilot would be voluntary.

Value-Based Purchasing

The legislation does not propose a Medicare value-based purchasing program. However, the Secretary could adopt such a payment system for the public plan.

Accountable Care Organizations (Sec. 1301)

The legislation would permit pilot projects to test the success of accountable care organizations (ACOs) in coordinating and improving care provided to patient populations. Physician groups, working with hospitals and other providers of care, would be permitted to form an ACO, and the physician groups would be rewarded for providing high-quality, efficient care. The physician group must have a legal structure, include sufficient primary

care physicians, report on quality measures selected by the Secretary and use patient-centered processes. The legislation also allows “other physician organizational models” to participate in the pilot program. “Other physician organizational models” are defined as “any model of organization under which physicians enter into agreements with other providers for the purposes of participation in the ACO pilot program...and share in any incentive payments under such program.”

The total payment to the ACO would be determined by the Secretary, but would be based on prior history of payment for Medicare patients in that area adjusted for estimated savings to create a target performance amount. ACOs with high scores and with costs below the targeted amount would be eligible for incentive payments. The pilot projects also could test a partial capitation model or other payment models. CMS may allow ACOs to continue operating so long as they are reducing costs while maintaining quality or improving quality while maintaining costs.

Extension of Gainsharing Demonstration (Sec. 1903)

The gainsharing demonstration project enacted in the *Deficit Reduction Act of 2005* would be extended from December 31, 2009 to September 30, 2011. Since the awarding of those projects was significantly delayed, this extension would provide the projects with approximately the same amount of time as would have been available if they had been awarded on a timely basis.

Physician-Owned Hospitals and Self-Referral (Sec. 1156)

The legislation would eliminate the exception for physician-owned hospitals under the whole hospital and rural provider exceptions under the Stark law, but would grandfather those physician-owned hospitals with a Medicare provider agreement in place by January 1, 2009 and would limit the percentage of physician ownership to no more than the level on the date of enactment. These provisions incorporate long-sought AHA policies. Grandfathered facilities would be required to meet several types of requirements to maintain their grandfathered status. Those include:

- A variety of disclosures to patients about physician ownership and reports to HHS and public availability of physician ownership information on the HHS Web site and physician-owned hospitals’ Web sites.
- Patient safety requirements related to emergencies and patient disclosures regarding onsite physician availability.
- Adherence to a set of rules that ensure bona fide ownership and investment, including:
 - Aggregate physician ownership or investment could not exceed the level in place on the date of enactment.
 - Ownership or investment could not be conditioned, directly or indirectly, on physicians making or influencing referrals to the hospital.
 - 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.
 - The hospital could not provide loans or financing for physician investments in the hospital.

- The hospital could not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan to any individual or group of physician owners or investors related to acquiring an ownership interest in the hospital.
 - Ownership or investment returns to physician owners or investors would be distributed to them in an amount directly proportional to the interest they hold in the hospital.
 - Compensation of and returns to physician owners or investors could 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.
 - The hospital could 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.
- No expansion of the number of operating rooms, procedure rooms or beds on or after the date of enactment could be made unless the hospital obtained HHS approval to do so. Any approved increase 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. An opportunity for public input on an expansion application would be required and applications could not be submitted more often than once every two years. The qualification requirements for growth exceptions would be that the hospital must:
 - Be located in a county with high population growth (i.e., 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);
 - Have a Medicaid inpatient admission percentage equal to or greater than the average percentage for all hospitals located in the county;
 - Not discriminate against beneficiaries of federal health care programs and not permit physicians practicing at the hospital to discriminate against such beneficiaries;
 - Be located in a state with a state average bed capacity less than the national average; and
 - Have an average bed occupancy rate that is greater than the state average bed occupancy rate.

Medical Home Pilot Program (Sec. 1302)

The legislation would establish a medical home pilot program in Medicare to evaluate the feasibility and advisability of reimbursing qualified, patient-centered medical homes that provide service to high-need beneficiaries. Two models of medical homes would be evaluated – the independent, patient-centered medical home model and the community-based, medical home model.

The independent, patient-centered medical home must be a physician-, nurse practitioner-, or physician assistant-directed practice that would be certified by the Secretary. It must provide targeted, high-need beneficiaries with direct and ongoing access to a primary care or principal care physician or nurse practitioner, coordinate care for the beneficiary across care settings, integrate clinically-relevant patient data into patient care and apply evidence-based guidelines. A prospectively paid monthly fee would be paid for medical home services on a per-beneficiary basis.

The community-based, medical home model must be a nonprofit, community-based or state-based organization that is certified by the Secretary. The organization must provide high-need beneficiaries with medical home services under the supervision of a primary care or principal care physician or nurse practitioner. The organization must employ community health workers who assist in chronic care management activities. Two separate monthly payments would be made on a prospective basis for each high-need beneficiary, including one payment to the community-based organization and one payment to the primary or principal care practice.

The Secretary would evaluate the pilot program to determine the extent to which medical homes result in the following:

- Improved quality and coordination of care;
- Reductions in health disparities;
- Reductions in preventable hospitalizations;
- Prevention of readmissions;
- Reductions in emergency department visits;
- Improved health outcomes;
- Improved patient satisfaction; and
- Improved efficiency of care and reductions in health care expenditures.

A report to Congress on the findings of the evaluation must be submitted and, depending on these findings, the Secretary could expand the program on a permanent basis. In order to expand the program, the chief actuary of CMS must certify that expansion would not result in additional spending under Medicare.

The legislation provides \$6 million annually for FYs 2010-2014 for the administration of the program; \$200 million annually for FYs 2010-2014 for medical home services provided in the independent, patient-centered medical home model; and \$125 million annually for FYs 2012-2016 for medical home services provided in the community-based medical home model. An additional \$2.5 million for FYs 2010-2012 is provided for initial implementation activities.

Improved Coordination and Protection for Dual Eligibles (Sec. 1905)

The legislation requires the Secretary to provide, through an identifiable office or program within CMS, a focused effort to improve coordination between Medicare and Medicaid and protection in the case of all dual eligibles. The office must review all policies under Parts A and B of Title XVIII, under the Part C Medicare Advantage program, and under Title XIX. The review must evaluate where policy changes should be made to simplify access, improve care continuity, harmonize regulatory conflicts between Medicare and Medicaid, and improve total cost and quality performance for dual eligibles.

MEDICARE AND MEDICAID PAYMENT CHANGES

Disproportionate Share Hospitals (Sec. 1112, 1704)

The legislation, by January 1, 2016, would require the Secretary to submit a report to Congress on the continued role of Medicare disproportionate share hospital (DSH) payments, taking into account the impact of health care reform on reducing the number of uninsured individuals. The Secretary would be required to recommend the appropriate amount of Medicare DSH payments (taking into account the empirical justification for DSH payments

for different hospital types), the eligible hospitals and the distribution of payments given hospitals' uncompensated care costs, if any, and costs associated with serving low-income beneficiaries.

In addition, the legislation proposes reductions to Medicare DSH payments. Specifically, if there is a significant decrease in the number of uninsured individuals, beginning in FY 2017, the Secretary would adjust DSH payments in two ways.

- First, the Secretary would make adjustments to Medicare DSH payments based on the report issued by January 1, 2016, and take into account the empirical justification for DSH payments.
- Second, the Secretary would increase Medicare DSH payments for a hospital by an amount based on the amount of uncompensated care the hospital provides, excluding bad debt. The Secretary would establish the formula for determining this increase, but a hospital would not receive more than half of the decrease in DSH payments they lost as a result of the first provision above. Hospitals that provide more uncompensated care would receive a greater increase than hospitals providing relatively less uncompensated care.

The legislation defines a significant decrease in the number of uninsured individuals as a decrease of more than 8 percentage points in the national rate of uninsurance for the under-65 population from 2012 to 2014.

The Secretary also is mandated to report to Congress by January 1, 2016 on the continuing role of Medicaid DSH as health reform is implemented and is required to coordinate this report with the mandated Medicare DSH report. The Secretary is specifically required to make recommendations on the appropriate targeting of Medicaid DSH payments within a state and the distribution of Medicaid DSH funds among the states. The Secretary must also specify, in the report, the DSH Health Reform methodology to be used to implement the Federal DSH funding cuts. The Secretary is directed to reduce Medicaid DSH payments to states by a total of \$10 billion (\$1.5 billion in FY 2017, \$2.5 billion in FY 2018, and \$6.0 billion in FY 2019). In developing the DSH Health Reform methodology, the Secretary is directed to consider a state's percentage of uninsured individuals (determined on the basis of audited hospital cost reports) and/or how well a state targets DSH payments to hospitals with high Medicaid inpatient volumes and high levels of uncompensated care (excluding bad debt).

340B Drugs (Sec. 2501-2503)

The legislation would expand eligibility for the 340B program to include freestanding children's hospitals, critical access hospitals, Medicare-dependent hospitals, sole community hospitals, rural referral centers, and certain maternal and child health, comprehensive mental health, and substance abuse treatment providers. Currently, eligible entities include community health centers, certain children's hospitals, hemophilia treatment centers and public and nonprofit disproportionate share hospitals that serve low-income and indigent populations. The legislation also would expand the 340B program discounts to inpatient drugs and require participating hospitals to credit State Medicaid programs with a portion of the savings resulting from the 340B discounts. These changes would be effective July 1, 2010.

MEDICARE

Market Basket Updates (Sec. 1103, 1131, 1155)

For 2010 and beyond, the legislation would reduce the annual inpatient, outpatient, inpatient rehabilitation facility, long-term care hospital, psychiatric hospital, skilled-nursing facility, hospice, home health agency, ambulance and ambulatory surgical center market basket updates by the full estimate of “productivity growth” (currently estimated at 1.3 percent for FY 2010). Also for 2010 and beyond, the legislation would reduce the annual market basket update by productivity growth for durable medical equipment that is not subject to competitive bidding. The legislation also would replace the existing laboratory service update of the consumer price index minus 0.5 percent with an update of the consumer price index minus productivity.

The legislation describes the productivity adjustment as the change in the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity. For inpatient acute hospitals, this productivity adjustment is in addition to, and would interact with, the existing market basket incentives/penalties tied to hospital quality reporting and requirements for becoming a “meaningful user” of health information technology.

For FY 2010 through FY 2014, the inpatient and outpatient market basket update for hospitals would be reduced by the productivity adjustment.

- During these years, if a hospital does not report data on the required quality measures, the market basket remaining after the productivity adjustment would be reduced by an additional 2.0 percentage points, but not below zero.

In FY 2015 and 2016, the market basket would continue to be reduced by the productivity adjustment.

- During these years, if a hospital does not report data on the required quality measures, the market basket remaining after the productivity adjustment would be reduced by 25 percent, but not below zero.
- Also during these years, if a hospital is not a “meaningful user” of health information technology, the market basket would be reduced by 25 percent and 50 percent, but not below zero. This adjustment would be calculated without regard to the productivity adjustment.

In FY 2017 and beyond, the market basket would continue to be reduced by the productivity adjustment.

- If a hospital does not report data on the required quality measures, the market basket remaining after the productivity adjustment would be reduced by 25 percent, but not below zero.
- Also during these years, if a hospital is not a “meaningful user” of health information technology, the market basket would be reduced by 75 percent, but not below zero. This adjustment would be calculated without regard to the productivity adjustment.

Inpatient Rehabilitation Facility Payment Update (Sec. 1102)

The legislation freezes rates for inpatient rehabilitation facilities (IRFs) for the final three quarters of FY 2010 at the FY 2009 level.

Payments to Skilled Nursing Facilities (Sec. 1101, 1111)

The legislation freezes the FY 2010 market basket update for skilled-nursing facilities (SNF) for the final three quarters of FY 2010 at the FY 2009 level. This cut would be in addition to CMS' proposal to cut SNF payments by \$1 billion in FY 2010 to adjust for greater-than-expected utilization of the new payment categories added in 2006.

The legislation would make several additions and modifications to skilled nursing facility (SNF) payments. The Secretary would be required to compare SNF payments under the prior RUG-44 model and the current RUG-53 model to assess budget neutrality of SNF payments for 2006. In 2006, CMS moved to the RUG-53 system, which added nine new payment categories for complex patients requiring rehabilitation. This analysis shall be used by the Secretary to determine the appropriate recalibration factor to adjust the SNF case mix indexes for FY 2010, using the method recommended in CMS' FY 2010 proposed rule for the SNF PPS.

Beginning in FY 2010, the Secretary would be required to implement a SNF outlier policy for non-therapy ancillary outlier costs, and could add an adjustment (increase or decrease) for the therapy services portion of outlier cases. SNF outlier cases would be determined based on aggregate costs per stay. Annual SNF payments would be reduced by two percent to provide for budget neutral implementation of SNF outlier payments.

Beginning January 1, 2010, the Secretary would be required to increase SNF payments for non-therapy ancillary services by 10 percent and would decrease payment for the therapy component of SNF payments by 5.5 percent. These changes would remain in effect until an alternative SNF case-mix system is implemented.

The legislation also directs the Secretary to analyze the accuracy of payments for non-therapy ancillary services under a future SNF classification system. In doing so, the Secretary must consult with MedPAC and other stakeholders. The Secretary must report its analysis in CMS' rulemaking for FY 2011, incorporate the findings in CMS' recommendations for that year, and ensure that any changes are budget neutral.

Payments to Home Health Agencies (Sec. 1153-1154)

The legislation would eliminate the home health market basket update for calendar year 2010, and directs the Secretary to reduce payments for FY 2011 by an additional 5.5 percent (but not below zero) to reflect coding changes identified by CMS. The legislation would require the Secretary to conduct an analysis to rebase the home health prospective payment system before 2011 or, if unable to do so, implement a 5 percent cut in 2011.

Payments to Physicians (Sec. 1121-1124, 1303-1304)

Sustainable Growth Rate (Sec. 1121)

Under current law, physician fees in Medicare are slated to be reduced by 21 percent in January 2010 and by about 5 percent for the subsequent four years. This legislation would reform fundamentally and permanently the SGR formula that updates reimbursement for physician services in Medicare.

The proposal would eliminate accumulated deficits under the existing SGR and rebase the system to 2009. It would provide a conversion factor update for 2010 based on the Medicare Economic Index (MEI) in order to allow a new system to be developed.

The SGR would be replaced with a new “target growth rate” formula that:

- Removes items, such as drugs and laboratory services, not paid under the Medicare physician fee schedule from the computation of the target growth rate;
- Retains limits on volume growth, but establishes two separate target growth rates – one for primary and preventive care services and one for other services;
- Provides a higher target growth rate for primary care and preventive care services than for other services. That is, the volume of primary and preventive care services is allowed to grow at the annual rate of Gross Domestic Product (GDP) plus 2 percent and other services are allowed to grow at GDP plus 1 percent; and
- Allows ACOs to have individual target growth rates and payment updates.

Mis-valued Codes under the Physician Fee Schedule (Sec. 1122)

The legislation would require the Secretary to identify periodically mis-valued codes under the physician fee schedule and review and make adjustments to the relative values for these codes, including consolidation of individual services into bundled codes for payment. It also would require the Secretary to establish a process to validate relative value units of codes identified as mis-valued. It would provide CMS with \$20 million annually to carry out this section. These provisions would not be subject to law related to federal information policy or to the requirements of the Federal Advisory Committee Act. They could be implemented through program instruction (meaning they would not be subject to public notice and comment). This section also would repeal the Practicing Physician’s Advisory Council.

Payments for Efficient Areas (Sec. 1123)

In 2011 and 2012, the legislation would provide a 5 percent increase in payments for physician fee schedule services furnished in areas identified by the Secretary as “efficient areas.” Efficient areas are defined as those counties in the lowest fifth percentile of utilization based on annual per-capita spending for services, standardized for geographic differences in payment rates.

Modifications to the Physician Quality Reporting Initiative (PQRI) (Sec. 1124)

The legislation would require the Secretary to establish a mechanism by 2011 that would provide timely feedback to physicians who report data under the PQRI and would establish an informal appeals process for physicians with PQRI payment disputes. The Secretary would need to develop a plan by 2012 that integrates clinical reporting on quality measures with reporting requirements related to the meaningful use of electronic health records. Quality reporting incentive payments would be extended for two years, through 2012.

Rate Increase for Selected Primary Care Services (Sec. 1303)

Starting in 2011, the legislation would provide a 5 percent payment incentive (or 10 percent if furnished in a health professional shortage area) to primary care practitioners for whom primary care services make up at least 50 percent of their total allowed charges. A primary care practitioner means a physician or other health care practitioner (including a nurse practitioner and a physician assistant) who specializes in family medicine, general internal medicine, general pediatrics, geriatrics, or obstetrics and gynecology. This payment incentive will not be taken into consideration in applying the existing 10 percent health professional shortage area bonus payment and the physician scarcity areas incentive payments, nor will it

be considered in calculating the payment rates for physician professional fees under the Method II critical access hospital payment methodology.

Increased Reimbursement Rate for Certified Nurse-midwives (Sec. 1304)

The legislation would increase reimbursement for certified nurse-midwives by removing the statutory language limiting their reimbursement to 65 percent of a physician's reimbursement for the same service.

Medicaid Primary Care Bonus Payment (Sec. 1721)

For physicians and other health care professionals who provide primary care services, Medicaid reimbursement would be increased to 80 percent of the Medicare rate in 2010, 90 percent in 2011 and 100 percent in 2012. The additional cost to the state Medicaid programs would be fully financed by the federal government through FMAP increases.

Payments to Ambulatory Surgery Centers (Sec. 1144)

The legislation would require CMS to develop a cost report for use by ambulatory surgery centers (ASCs) within three years of enactment and would require ASCs to begin to report their costs to CMS as a condition for coverage for cost-reporting periods beginning 18 months after the ASC cost report is developed. In 2012, it would require ASCs to report quality data such as data on health care-associated infections and other data as required by the Secretary.

Payments for Imaging Services (Sec. 1147)

Beginning January 1, 2011, the legislation would reduce payments for advanced diagnostic imaging services under the physician fee schedule by adjusting their practice expense relative value units to reflect higher presumed utilization of advanced diagnostic imaging equipment. Beginning January 1, 2011, the legislation would increase the discount applied to the technical component for multiple imaging procedures performed during the same encounter under the physician fee schedule from 25 to 50 percent. Savings generated from this change would not be budget neutral.

Geographic Variation (Sec. 1157, 1158, 1146)

The legislation calls for an Institute of Medicine (IOM) report within one year after enactment with recommended changes to improve the accuracy of the geographic adjustment factors for hospitals and physicians (area wage index and geographic practice cost index). The study would include an evaluation and assessment of:

- the validity of the adjustment factors;
- the methodology used to determine the adjustment factors;
- the measures used for the adjustment factors (taking into account the timeliness of data and frequency of revisions, the sources of data and the degree to which they are representative of costs, and the operational costs of providers);
- the effect of the adjustment factors on the level and distribution of the health care workforce (including the ability of hospitals and other facilities to maintain an adequate and skilled workforce);
- the effect of the adjustment factors on population health and quality care; and
- the effect on the ability of providers to furnish efficient, high quality care.

The Secretary is directed to propose changes to geographic adjustment factors through the rulemaking process, taking into account the IOM recommendations. In making these

changes, hospitals and physicians may not be paid less than they otherwise would have been paid under Medicare. The legislation places \$8 billion in the Medicare Improvement Fund to implement this provision.

Medical Equipment Program Improvements (Sec. 1148)

This section includes numerous changes for selected providers of durable medical equipment, orthotics, prosthetics and supplies (DMEPOS). Pharmacies issuing DMEPOS for at least 5 years and with no adverse action would no longer be required to obtain a surety bond. For pharmacies that applied for DMEPOS supplier accreditation before August 1, 2009, accreditation would not be required for diabetic testing supplies, canes, and crutches until an independent accreditation organization acts on such application. In addition, suppliers of oxygen equipment in the 27th month of the 36-month rental period would be required to continue furnishing such equipment for the remainder of its reasonable useful lifetime, regardless of the location of the individual, unless another supplier accepts this responsibility. And finally, if a supplier of oxygen equipment declares bankruptcy, beneficiaries with more than 24 months of rental payments to such a supplier would be eligible for a new 36-month rental period with another supplier.

Medicare Part D (Sec. 1181-1185)

The legislation includes several changes to the Medicare Prescription Drug Program under Part D including:

- Fills in the Part D coverage gap – referred to as the “donut hole” – beginning in 2011 over a period of 15 years by progressively increasing the initial coverage limit and decreasing the annual out-of-pocket threshold.
- Helps pay for filling this gap by establishing a drug manufacturer rebate for any covered outpatient drug the manufacturer dispensed after December 31, 2010, to any full premium subsidy Medicare drug plan enrollee for which payment was made by a drug plan sponsor or a MA organization.
- Incorporates into the bill the voluntary agreement from the pharmaceutical industry to provide discounts of 50 percent for brand-name drugs used by Part D enrollees in the Part D donut hole. Treats the discounted amount as if it were incurred by the beneficiary for the purposes of calculating the true out-of-pocket costs.
- Eliminates deadlines for long-term care pharmacists to file Part D claims to allow more time for improved coordination with state Medicaid programs.
- Allows prescription drug costs incurred or paid under a state pharmaceutical assistance program, under an AIDS drug assistance program or by the Indian Health Service to count toward the annual out-of-pocket threshold under Part D.
- Permits individuals enrolled in a Part D drug plan or a MA organization to make mid-year changes in their enrollment for formulary changes that adversely impact them.

Medicare Part D Information Disclosure (Sec. 1801)

Authorizes the IRS to disclose to SSA certain taxpayer return information to assist SSA in its outreach program to identify individuals who are eligible for Medicare Part D assistance.

Telehealth Expansion and Enhancements (Sec. 1191)

The legislation expands Medicare’s telehealth benefit to beneficiaries who are receiving care at freestanding dialysis centers and establishes a Telehealth Advisory Committee to provide HHS with additional expertise on the telehealth program.

Medicare Extenders (Sec. 1142, 1192-1196, 1231)

The legislation would extend several Medicare provisions. They include:

- Extending cost-based payment for brachytherapy for two additional years.
- Extending for two additional years outpatient hold harmless payments for certain hospitals in rural areas with 100 or fewer beds and for certain sole community hospitals with 100 or fewer beds.
- Extending section 508 wage index reclassifications for the inpatient PPS through September 30, 2011.
- Under the physician fee schedule, extending by two years the provision increasing the work geographic index to 1.0 for localities in which the work geographic index is less than 1.0.
- Extending for two years grandfathering that allows independent laboratories to continue to directly bill, under the physician fee schedule, for anatomic pathology technical component services provided for certain hospitals' inpatients and outpatients.
- Extending the existing add-on payment for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas – through December 31, 2011.
- Extending the outpatient therapy caps exceptions process for an additional two years.
- Extending for two years the 5 percent increase in physician payment for certain psychiatric therapeutic procedures furnished in office or other outpatient facility settings or in inpatient hospital, partial hospital or residential care facility settings.

Repeal of the “45 Percent Medicare Trigger” (Sec. 1901)

Current law requires the annual Medicare Trustees’ report to include an estimate of the year in which general revenues will account for more than 45 percent of Medicare funding. If two consecutive trustees’ reports project that this portion will exceed 45 percent within the next six years, then the President must submit legislation to reduce the portion to less than 45 percent. The legislation would eliminate this requirement.

MEDICAID (Sec. 1703-1772)

Medicaid and CHIP Maintenance of Effort

A maintenance of effort (MOE) requirement for eligibility would be imposed on states for their CHIP programs. States could not fall below their CHIP eligibility standards as of June 16, 2009, to meet the MOE requirement. MOE ends with the opening of the Health Insurance Exchange in 2013 or, if later, the date on which the Health Choices Commissioner determines that the exchange has the capacity to support CHIP enrollees and the Secretary determines that procedures are in effect to ensure timely transition without interruption of coverage. In addition, a MOE requirement for eligibility would be imposed on states for their Medicaid programs. States could not fall below their Medicaid eligibility standards as of June 16, 2009, to meet the MOE requirement

Expanded Outstationing

The bill requires state Medicaid programs to allow adults to apply for Medicaid coverage at DSH hospitals, FQHCs, and locations other than welfare offices (requirement already applies to pregnant women and children). Effective July 1, 2010.

Medicaid Managed Care Organization (MCO) Minimum Loss Ratio

The legislation would establish a minimum loss ratio for Medicaid MCOs at a minimum of 85 percent. This requirement would be effective July 1, 2010.

Puerto Rico and Territories

The legislation would increase the Medicaid cap and the FMAP calculation for Puerto Rico and the Territories by amounts specified by the Secretary so that the total amount would not exceed \$10.35 billion between the years 2011 and 2019.

Healthcare-Acquired Conditions

State Medicaid programs would be required to adopt policies that would not result in higher payments to hospitals should a patient have a healthcare-acquired condition during the hospital stay (similar to the Medicare hospital-acquired conditions policy).

Access Improvements

Improvements in access to services would include a medical home pilot program, improvements in translation services and optional coverage for freestanding birth centers.

Coverage Improvements

The Transitional Medicaid Assistance program would be extended for those moving from welfare to work without health coverage. States could, at their option, cover low-income HIV-infected individuals and expand outstation eligibility enrollment sites. The Qualified Individual program, which extends Medicaid coverage to certain low-income elderly, would be made permanent.

Medicaid Integrity Program

The legislation would require evaluations and reports for state Medicaid Integrity programs intended to reduce overpayment, waste fraud and abuse. It extends the 60-day rule to one year. This policy, which governs the time period for repayment by the state to the federal government when an overpayment is discovered, would allow more time for review and appeals.

GRADUATE MEDICAL EDUCATION AND WORKFORCE

GRADUATE MEDICAL EDUCATION (Sec. 1501-1505, 1844)

Indirect Medical Education (IME)

The legislation does not propose any changes in Medicare IME payments to teaching hospitals.

Redistribution of Unused Residency Positions (Sec. 1501)

The legislation would redistribute “unused” residency training slots as a way to encourage increased training of primary care physicians. With limited exceptions, the *Balanced Budget Act of 1997* capped the number of residents that Medicare will recognize for direct graduate medical education (DGME) and IME at a teaching hospital’s 1996 level. *The Medicare Prescription Drug Improvement and Modernization Act of 2003* authorized a one-time redistribution of resident cap positions effective July 2005. This proposal would be the second time that residency positions are re-allocated.

Under the legislation, hospitals would lose 90 percent of their unfilled residency positions (based on cost reports over the past three years) and qualifying hospitals would be able to request up to 20 new slots. Priority for the new slots would be given to:

- Hospitals that had a reduction in resident training positions;
- Hospitals with three-year primary care residency training programs, such as family practice and general internal medicine;
- Hospitals that emphasize training in federally qualified health centers, rural health clinics, off-campus provider-based outpatient departments and other non-provider settings;
- Hospitals that are training residents over their current cap;
- Hospitals that emphasize training in health professional shortage areas; and
- Hospitals in states with low resident-to-population ratios.

Hospitals receiving additional slots would be required to maintain at least their current level of primary care residents in their training programs permanently. The redistributed slots would receive full IME (i.e., 5.5 percent) payments and DGME payments at the Medicare current law policy.

Counting Resident Time (Sec. 1502-1503)

Under certain conditions, hospitals have been allowed to count toward hospital DGME and IME payments the time residents spend training in sites that are not part of the hospital. Currently, hospitals may receive Medicare payments only if residents spend their time in patient care activities (as opposed to didactic conferences and seminars) and only if there is a written agreement between the hospital and the non-provider entity, and if the hospital incurs “all or substantially all” of the costs involved in the offsite training. Effective July 1, 2009, the legislation would allow all non-research time spent by a resident in an offsite setting to count toward DGME and IME payments if the hospital incurs the costs of the salary and benefits of the resident during this time. The legislation also calls for an Office of Inspector General (OIG) study to determine whether there is an increase in time spent by medical residents in non-provider settings due to this provision.

The legislation would require the Secretary to conduct a demonstration project to allow an approved “teaching health center” to receive directly DGME payments associated with training primary care residents and the DGME payment of its contracting hospitals for such residents. Approved teaching health centers would include federally qualified health centers or rural health clinics. They would be required to contract with teaching hospitals for the inpatient portion of the primary care residency program.

Resident Cap Positions from Closed Hospitals (Sec. 1504)

Currently, if a teaching hospital closes, the resident cap positions associated with it are eliminated. The legislation would allow the residency caps from closed hospitals to be distributed to other hospitals in the state according to a methodology determined by the Secretary. This provision would be retroactive to incorporate residency positions from hospitals that closed within the past two years.

Improving Accountability for Medical Residency Training (Sec. 1505)

The legislation would authorize a Government Accountability Office (GAO) study to evaluate residency training programs and determine whether certain educational goals are being met

and whether medical schools have the faculty and expertise necessary to achieve the goals for approved medical residency training programs. These goals include:

- Working effectively in various health care delivery settings (including non-provider settings);
- Coordinating patient care within and across settings;
- Understanding the relative costs and value of various diagnostic and treatment options;
- Working in inter-professional and multi-disciplinary team-based models to enhance safety and improve quality;
- Understanding and preventing errors; and
- Becoming meaningful users of electronic health records.

Medicaid Graduate Medical Education (GME) (Sec. 1744)

The Medicaid statute would be amended to explicitly include payments for the cost of GME, both inside and outside the hospital, as legitimate Medicaid payments. States would report GME expenditures to the Secretary. The Secretary would be directed to issue a rulemaking on the Medicaid program goals for Medicaid GME payments by December 31, 2011.

WORKFORCE

Public Health Investment Fund (Sec. 2002)

The legislation would authorize \$79.3 billion over 10 years to establish a “Public Health Investment Fund” within the *Public Health Service Act*. This fund would be used to support community health centers, the National Health Service Corps program (including its scholarship and loan repayment programs), primary care loan funds, primary care education programs, nursing workforce development, the National Center for Health Statistics and the Agency for Healthcare Research and Quality (AHRQ).

Primary Care Workforce (Sec. 2201-2235)

The legislation proposes a number of policies to improve the primary care workforce.

National Health Service Corps

- Increases program funding to \$796 million over 10 years.
- Increases scholarship and loan repayment funding to \$3.2 billion over 10 years.
- Allows those in the National Health Service Corps to fulfill their obligated service requirement through half-time service.
- Allows the Secretary to count up to 20 percent of time spent in teaching activities to count as obligated service.
- Beginning in FY 2011, increases the amount of loans per individual from \$35,000 to \$50,000.

Promotion of Primary Care and Dentistry

- Provides \$3.0 billion in funding over 10 years to promote primary care and dentistry.
- Creates new “Health Professional Needs Areas,” defined as those geographic areas that have insufficient health professionals to deliver primary care services given the area’s population.
- Provides loan repayment programs to physicians and other health professionals who agree to practice in high-needs areas.

- Provides low-interest medical school loans to certain individuals who practice in primary care.
- Provides grants to medical schools, public and nonprofit entities (including hospitals) to develop and support primary care and dental training programs. Preference would be given to those entities training the greatest percentage of primary care health professions, who have the greatest increase in percentage of primary care health professions, who train individuals from underrepresented minority groups or disadvantaged backgrounds, who place a large number of graduates in underserved areas, or who help address the health care needs of vulnerable populations.
- Provides grants and contracts to entities that receive DGME payments (such as hospitals and “teaching health centers”) to support the development and operation of primary care residency training in community-based settings. Preference would be given to those who serve vulnerable populations, have a high or significantly improved percentage of primary care professionals, or who train individuals from underrepresented minority groups or disadvantaged backgrounds.

Nursing Workforce

- Provides \$1.45 billion over 10 years to train advanced education nurses who will practice in health professional shortage areas.

Public Health Workforce

- Provides \$642 million over 10 years of investment in the public health workforce.
- Establishes a new “Public Health Workforce Corps” to ensure an adequate supply of public health professionals and to eliminate critical public health workforce shortages.
- Provides scholarships (educational expenses plus a stipend) and a loan repayment program for individuals who enroll in programs of public health, health administration, management or policy, preventive medicine or other graduate school and who become commissioned officers and who agree to provide services in a workforce shortage area.
- Provides grants for eligible entities (including hospitals) to provide graduate medical training in preventive medicine specialties.

Grants to Provide Education to Nurses and Create a Pipeline to Nursing (Sec. 2531, 2541)

The legislation authorizes grants to address the projected shortage of nurses by implementing comprehensive programs to provide education to nurses and other ancillary health care workers who wish to advance their careers, and to create a pipeline to nursing. To be eligible to receive a grant, an entity must be: 1) a health care entity that is jointly administered by a health care employer and a labor union representing the health care employees of the employer; 2) an entity that operates a training program that is jointly administered by one or more health care providers or facilities or a trade association of health care providers, and one or more organizations which represent the interests of direct health care workers or staff nurses; 3) a State training partnership program consisting of equal participation from industry, private employers and labor organizations; or 4) a school of nursing.

Advisory Committee on Health Workforce Evaluation and Assessment (Sec. 2261, 2271)

The legislation would establish an Advisory Committee on Health Workforce Evaluation and Assessment that would make recommendations to the Secretary on the adequacy and appropriateness of the nation’s health workforce.

National Center for Health Workforce Analysis (Sec. 2281)

The legislation would establish a National Center for Health Workforce Analysis to evaluate the effectiveness of federal workforce programs.

QUALITY, DISPARITIES AND COMPARATIVE EFFECTIVENESS

Stand for Quality (Sec. 1441-1443)

The legislation provides for the development of national priorities for quality improvement and for measures to assess success in improving care. Two million dollars would be given to the Secretary from FY 2010 through FY 2014 to establish and update national priorities. The Secretary would be directed to solicit and consider recommendations from multiple outside stakeholders in setting the priorities. The Secretary also would be directed to contract with qualified entities to develop quality measures. The Secretary must solicit public comment on the measures and seek endorsement of the measures from a consensus organization. Twenty-five million dollars would be appropriated annually to the Secretary for these activities from FY 2010 through FY 2014. In addition, the GAO would be charged with conducting periodic evaluations of the quality measures data collection processes used by the Secretary.

This section requires the Secretary, with some discretion, to use measures endorsed by a consensus organization for the hospital inpatient, hospital outpatient, physician and renal dialysis services pay-for-reporting programs. The Secretary must seek NQF endorsement of new measures it develops for its pay-for-reporting programs. The Secretary is required to solicit input from a multi-stakeholder group, such as the Hospital Quality Alliance, on the selection of new quality measures prior to publishing any proposed rules containing measures for a pay-for-reporting program.

Public Reporting of Healthcare-associated Infections (Sec. 1461)

The provision would require all Medicare- and Medicaid-participating hospitals and ambulatory surgery centers (ASCs) to submit information on healthcare-associated infections by reporting them to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). This proposal would require the Secretary to validate the infection data and then publicly post it on the HHS Web site. The infection reporting program would be directed by CDC, and hospitals and ASCs would be required to begin reporting no later than two years after the date of enactment. This provision would not preempt state laws on infection reporting.

Quality and Surveillance / Implementing Best Practices (Sec. 2401)

The legislation would establish a Center for Quality Improvement within the AHRQ. The center would prioritize work on best practices for quality improvement, taking into account the national priorities for quality improvement established by the Secretary and relevant key health indicators. The center also would work to identify, develop, evaluate and implement best practices based on the priorities, either by acting directly or awarding contracts and grants to qualifying entities. In conducting these activities, the center and its contractors must work directly with provider organizations to implement successful improvement strategies. The center shall provide for the public dissemination of information on best practices. To jump start the work of the center, the legislation mandates that the initial work focus on healthcare-associated infections, safe surgery, and improving emergency room, obstetrics and neonatal care.

Assistant Secretary for Health Information (Sec. 2402)

This section would amend title XVII of the *Public Health Service Act* to establish an Assistant Secretary for Health Information within HHS, who would have a duty to ensure the collection, collation, reporting and publishing of information on key health indicators on the nation's performance in delivering health care, and who would set national standards for the collection of such information.

Comparative Effectiveness Research (Sec. 1401)

The legislation would create a center within AHRQ to conduct, support and synthesize comparative effectiveness research. It also would establish an independent comparative effectiveness research commission to oversee and evaluate the activities carried out by the center, and determine national priorities for comparative effectiveness research. The commission would consist of 17 members serving four-year terms, including the director of AHRQ and the chief medical officer of CMS, as well as 15 other members representing a broad constituency of stakeholders. Of these 15, at least nine must be practicing physicians, health care practitioners, consumers or patients. One member must have expertise in health disparities. No more than three members may be representatives of pharmaceutical or device manufacturers.

The commission would:

- appoint a clinical perspective advisory panel for each research priority;
- contract with the IOM to determine standards of evidence;
- employ an executive director and staff;
- ensure transparency, stakeholder input and public access to information; and
- ensure that the research takes into account potential differences for subpopulations.

The commission and the center would not be permitted to “mandate coverage, reimbursement or other policies for any public or private payer.”

The legislation would create a Comparative Effectiveness Research Trust Fund (CERTF). This fund would allocate \$300 million for comparative effectiveness research through 2012. It also would allocate funds to the commission to conduct its activities through 2012. For 2013 and beyond, the CERTF would be financed in a public/private manner based on a per-capita tax. HHS would pay an amount per Medicare beneficiary and private insurers would pay an amount per number of lives covered in the plan.

Additionally, the legislation includes a demonstration program that uses decision aids and other technologies to help patients and consumers improve their understanding of the risks and benefits of their treatment options and make informed decisions about their medical care.

Reducing Health Disparities (Sec. 1221-1224, 2241-2252)

The bill includes a variety of provisions that would reduce health disparities, including:

- A one-year HHS study on provider use of language services, potential Medicare payment for language services for all Medicare service providers and the extent to which state Medicaid programs are paying for such services.

- An HHS demonstration program for no fewer than 24 three-year grants to Medicare providers to improve effective communication with limited English proficiency (LEP) beneficiaries and test different payment methodologies for language services.
- An IOM study and report on the impact of language access services on the health and health care of LEP populations.
- A variety of provisions regarding workforce expansion, increased National Health Service Corps funding, increased scholarships and loan repayment for individuals from disadvantaged backgrounds as well as improved diversity and cultural competency in training health professionals.
- Emphasis in targeting a significant portion of new wellness and prevention initiatives to reduce disparities.
- Emphasis on better information to assess and address health disparities by a new Bureau of Health Information charged with collecting, collating, reporting and publishing a broad range of health indicators.

National Medical Device Registry (Sec. 2521)

The legislation establishes on enactment a national directory for class III devices and class II devices that are permanently implantable, life-supporting, or life-sustaining devices. Device information in the publicly available registry would be linked to patient safety and outcomes data from various public and private databases to facilitate analyses of post-market device safety and effectiveness.

WELLNESS AND PREVENTION

Coverage and Waiver of Cost-sharing for Preventive Services (Sec. 1305)

The legislation would codify a comprehensive list of all Medicare-covered preventive services as of January 1, 2011. This provision would eliminate the application of cost-sharing and deductibles for all preventive services. Covered preventive services furnished in the hospital outpatient department would not be paid through the outpatient PPS but would be paid at 100 percent of the applicable physician fee schedule rate.

Medicaid Prevention (Sec. 1711-1812)

States would be required to provide Medicaid coverage for preventive services recommended by the United States Preventive Services Task Force and vaccines recommended by the CDC. States, at their option, could cover tobacco cessation programs, nurse home visiting services, family planning services and certain school-based clinic services.

Expanding Access to Vaccines (Sec. 1310)

As of January 1, 2011, the legislation would expand coverage under Medicare to all federally recommended vaccines and their administration. Federally recommended vaccines are those that are recommended by the CDC's Advisory Committee on Immunization Practices.

Prevention and Wellness Trust (Sec. 3111)

The House legislation would provide \$35.3 billion over 10 years for a new "Prevention and Wellness Trust." Specifically, it would allocate:

- \$350 million for prevention task forces;
- \$2.7 billion for prevention and wellness research;
- \$17.2 billion for delivery of community-based prevention and wellness services;

- \$13.6 billion for core public health infrastructure and activities for state and local health departments; and
- \$4 billion for core public health infrastructure and activities for CDC.

National Prevention and Wellness Strategy (Sec. 3121)

Within one year of enactment, the legislation requires the Secretary to submit to Congress a national strategy to improve the nation’s health through evidence-based clinical and community-based prevention and wellness activities, including core public health infrastructure improvements. This strategy would identify specific national goals and objectives, establish national priorities, identify health disparities, as well as develop a plan for addressing and implementing them.

Prevention Task Forces (Sec. 3101-3102)

The legislation creates a 30-member task force on clinical preventive services and a 30-member task force on community preventive services.

Prevention and Wellness Research (Sec. 3141)

The legislation provides grants to eligible entities (including hospitals) to conduct research in the priority areas identified in the national prevention and wellness strategy or by the task force on community preventive services.

Delivery of Community and Prevention Wellness Services (Sec. 3151)

The legislation provides grants to eligible entities (including hospitals) to provide evidence-based, community preventive and wellness services in the priority areas identified in the national prevention and wellness strategy.

REGULATORY OVERSIGHT AND REFORM

Increased Funding to Fight Waste, Fraud, Abuse (Sec. 1601-1653)

The legislation would add a number of new prohibitions and penalty provisions that would allow the OIG and CMS greater discretion to impose penalties and significant penalty amounts on providers. Most of these provisions would be enforced by the OIG under its authority to impose civil money penalties (CMPs). New provisions of particular interest for hospitals include:

- Making a false statement or misrepresenting a material fact in an application to participate in a federal health program or in any data submitted to support a claim. A \$50,000 penalty could be imposed for each false statement or misrepresentation. For violations related to an application, damages also could be assessed of not more than three times the amount claimed as a result of the false statement or misrepresentation. This conduct is already prohibited and subject to penalties under other laws.
- Failure to grant the OIG timely access for purposes of audits, investigations, evaluations or other statutory functions. A penalty of \$15,000 per day could be imposed. The OIG already can enforce compliance through a process involving oversight by the court. This legislation would enable OIG to enforce compliance independently under threat of a penalty.

- Failure to have a compliance program that meets certain specifications could receive a \$50,000 penalty per violation. The Secretary would be directed to establish core elements of a program in consultation with the OIG. Corrective action plans also could be imposed as well as monitoring. This legislation identifies elements of a compliance plan for the Secretary to consider. Significantly, the bill adds a new core element requiring procedures to return overpayments. It also adds another penalty for an insufficient compliance plan – disenrollment from the program.

Overpayments

The legislation creates a heightened focus on overpayments. In addition to the compliance plan requirement, the legislation would create a duty to report overpayments and a deadline for repaying them. Repayment would be required no later than 60 days from the date the overpayment is identified except for those subject to the normal reconciliation process. A known overpayment held longer than the time frame would be subject to enforcement under the *False Claims Act* (FCA). A recent amendment to the FCA created liability for the improper retention of an overpayment. This provision would define the time frames for determining when an overpayment is improperly retained. In addition, the bill reduces the time period allowed for submitting Medicare claims from three years to 12 months from the date of service.

Other Provisions

- The maximum time period for submitting claims would be shortened to 12 months instead of the current 36 months. The rationale is to minimize the opportunity for fraud schemes based on observing and exploiting processing patterns of CMS.
- Any person (e.g., a physician) excluded from a federal health care program that orders or prescribes an item or service while excluded, who knows or should know that a claim for such item or service will be presented to the program, could be subject to a \$50,000 penalty for each violation.

Transparency of Information on Skilled Nursing Facilities and Nursing Facilities (Sec. 1411-1416, 1421-1423, 1431-1432)

These sections of the legislation would require SNFs and nursing homes to disclose the following ownership information: 1) the governing board; 2) each officer, director, member, partner, trustee or managing employee; and 3) other “disclosable entities.” Such information must be shared upon request and its availability posted in each facility’s lobby. The Secretary would issue regulations within two years of enactment.

Within three years of enactment, SNFs and nursing homes would implement compliance and ethics programs to prevent and detect criminal, civil and administrative violations and promote quality of care. By December 31, 2011, the Secretary would implement the Quality Assurance Program Improvement (QAPI) program, which includes standards and technical assistance on implementing best practices. Within the following year, SNFs and nursing homes would submit to the Secretary a plan to meet the QAPI standards; and the *Nursing Home Compare* Web site would include related data.

Within two years of enactment, SNF cost reports would be modified to separately report expenditures for wages and benefits for direct care staff, including registered and licensed professional nurses, certified nurse assistants and other medical and therapy staff. Within two

years of enactment, SNFs and nursing homes would be required to electronically submit staffing information.

Within one year of enactment, SNFs and nursing homes would be required to use a common resident complaint form and states would establish a complaint resolution process. A whistleblower protection program for employees also would be established.

Targeting Enforcement (Sec. 1421-1423)

The legislation would allow CMPs to be applied to SNFs and nursing homes in certain circumstances and with limits. For SNFs, the penalties would be: for any case where the deficiency is a direct cause of death, from \$3,050 to \$100,000; for a deficiency causing harm or immediate jeopardy, between \$3,050 and \$25,000; and for any other deficiency, between \$250 and \$3,050.

The Secretary, in consultation with the OIG, would establish a pilot program to implement an independent monitor to oversee interstate and large intrastate chains of SNFs and nursing facilities. Within one year of enactment, the Secretary would require SNFs and nursing homes to report a facility closure within 60 days of closure, and to include a plan for relocating patients.

Improving Staff Training (Sec. 1431-1432)

If deemed appropriate by the Secretary, training on dementia and abuse prevention could be required of a SNF or nursing home. Within two years of enactment, the Secretary would report to Congress on the findings of a study on training for certified nurse aides and supervisory staff for SNFs and nursing homes. The report would include recommendations on whether the quantity and content of such training should be increased.

Physician Payments Sunshine Provision (Sec. 1451)

Beginning in 2011, the legislation would require manufacturers and distributors of drugs, devices, biologicals or supplies that provide payment or other “transfers of value” (such as gifts, trips to research findings, and consulting fees) either directly or indirectly to physicians and other providers to report these payments annually to the Secretary or face civil monetary penalties.

REVENUE PROVISIONS

Surcharge on High Income Individuals (Sec. 441)

In 2011, individuals with modified adjusted gross incomes of more than \$350,000 will face incremental, additional taxes. These taxes will equal: 1 percent of any income over \$350,000 but not exceeding \$500,000; 1.5 percent of any income greater than \$500,000 but not exceeding \$1,000,000; and 5.4 percent of any income exceeding \$1,000,000 per year. The income thresholds will be adjusted for inflation beginning in 2012 and for taxpayers not filing a joint return. The percentages will become 2, 3, and 5.4 percent, respectively, in 2012 unless the federal government accrues “excess” savings from health reform.

Federal health reform savings are defined as the federal savings associated with the Medicare and Medicaid improvements required by the legislation. “Excess” savings are any above \$525 billion. Savings will be calculated by the director of the Office of Management and Budget (OMB) by 2012, and will include actual and estimated savings from 2009 through

2019. While the director of OMB would determine the excess federal health reform savings (which determine whether the taxes will be increased or not) in 2012, the increases would not actually take effect until 2013.

If excess health reform savings exceed \$150 billion but are not more than \$175 billion, the scheduled percentage increase for 2012 will not occur. If excess savings exceed \$175 billion the tax surcharge for income between \$350,000 and \$1,000,000 will be eliminated beginning in 2013.

Other Revenue Provisions: Allocating interest expenses; Foreign Multinational Corporations, Clarification of Economic Substance Doctrine. (Sec. 451-453)

The legislation also delays the effective date of a liberalized rule for allocating interest expense; prevents foreign multinational corporations incorporated in tax haven countries from avoiding tax on income earned in the United States; and clarifies when the economic substance doctrine should be applied by courts when deciding tax cases.