Congressional Research Service

MEMORANDUM January 13, 2010

Subject: **Comparison of Division B Provisions of H.R. 3962 (as passed by the House) and Related Provisions in H.R. 3590 (as passed by the Senate)**

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This memorandum was prepared to enable distribution to more than one congressional office.

To assist Members of Congress, Committees and staff in comparing the House-passed and Senate-passed health reform bills, CRS has compiled 5 memorandums that together describe all of the health-related provisions in the bills. Each memorandum provides side-by-side comparisons of a subset of the provisions. The memorandums focus on Medicaid, Medicare, private health insurance, Indian health, and public health and workforce development. Each of the five memorandums compare current law to the proposed changes in the House-passed H.R. 3962 and the Senate-passed H.R. 3590. As H.R. 3962 was the first bill to pass the Congress, these memorandums describe provisions in order of the House bill's table of contents.

This memorandum includes all provisions in H.R. 3962 Division B-Medicare and Medicaid Improvements and related provisions in the Senate-passed H.R. 3590, with the exception of Title VII – Medicaid and CHIP (included in a separate CRS memo) and Title VIII – Revenue-Related Provisions.

All comparable Senate bill provisions are provided in the column next to the related House provision, with similarities and differences explained. Non-matching Senate provisions are provided at the bottom of the subject appropriate table.

To assist readers in interpreting unfamiliar abbreviations and acronyms, a glossary of abbreviations used in current law and/or the bill summaries is provided below.

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Glossary of Acronyms Used	
ACO	accountable care organization
AHRQ	Agency for Healthcare Research and Quality
APS	Ambulatory Payment Classification
ARRA	American Recovery and Reinvestment Act of 2009
ASC	ambulatory surgical centers
ASP	Average Sales Price
BBA	Balanced Budget Act of 1997
BIPA	Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000
BNAF	Budget Neutrality Adjustment Factor
CAH	critical access hospital
CBO	Congressional Budget Office
CCER	comparative clinical effectiveness research
CER	comparative effectiveness research
CERTF	comparative effectiveness research trust fund
CG	Comptroller General
CHIP	Children's Health Insurance Program
CMI	Center for Medicare and Medicaid Innovation
CMP	Civil Monetary Penalty
CMS	Centers for Medicare & Medicaid Services
CoPs	Conditions of Participation
CPI	Consumer Price Index
CPI-U	Consumer Price Index for Urban Consumers
DGME	direct graduate medical education
DME	durable medical equipment
DMEPOS	durable medical equipment, prosthetics, orthotics, and other medical supplies
DOD	Department of Defense
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005
DRG	Diagnosis Related Group
DSH	disproportionate share hospital
EHR	electronic health record
ESRD	end-stage renal disease
FCA	False Claims Act
FDA	Food and Drug Administration
FERA	Fraud Enforcement and Recovery Act of 2009
FFS	fee-for-service

Glossary of Acronyms Used	
FPL	Federal Poverty Level
FQHC	federally qualified health center
FTE	full time equivalent
GAO	Government Accountability Office
GME	graduate medical education
GPCI	geographic practice cost index
HAC	hospital acquired condition
HAI	health care associated infection
HCFAC	Health Care Fraud and Abuse Control
HCPCS	Health Care Procedure Coding System
HH	home health
HHA	Home Health Agency
HHS	Department of Health and Human Services
HIPB	Healthcare Integrity and Protection Databank
HIPPA	Health Insurance Portability and Accountability Act of 1996
HOPD	hospital outpatient department
HPSA	health professional shortage area
HRSA	Health Resources and Services Administration
HwH	hospital-within-hospital
IDR	Integrated Data Repository
IME	indirect medical education
IOM	Institute of Medicine
IPF	inpatient psychiatric facility
IPPS	inpatient prospective payment system
IRF	inpatient rehabilitation facility
LEI	List of Excluded Individuals
LEIE	List of Excluded Individuals/Entities
LEP	limited English proficiency
LIS	Low-Income subsidy
LTC	long-term care
LTCH	long-term care hospital
MA	Medicare Advantage
MA-PD	Medicare Advantage – Prescription Drug (Plan)
MB	market basket
MCH	Maternal and Child Health
MDH	Medicare dependent hospital
MedPAC	Medicare Payment Advisory Commission

Glossary of Acronyms Used	
MIF	Medicare Improvement Fund
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug Improvement and Modernization Act of 2003
MMSEA	Medicare, Medicaid and SCHIP Extension Act of 2007
MOCP	Maintenance of Certification Program
MSA	Metropolitan Statistical Area
MS-DRG	Medicare severity diagnosis related groups
MSP	Medicare Savings Program
NAIC	National Association of Insurance Commissioners
NIH	National Institutes of Health
NPI	National Provider Identifier
NTA	nontherapy ancillary services
OAA	Older Americans Act
OACT	Office of the Chief Actuary
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPPS	Outpatient Prospective Payment System
P4P	pay-for-performance
PAC	post-acute care
PACE	Program of All-Inclusive Care for the Elderly
PAQI	Physician Assistance and Quality Initiative
PBM	pharmacy benefit manager
PCOR	patient-centered outcomes research
PCORTF	patient-centered outcomes research trust fund
PDP	Prescription Drug Plan
PECOS	Provider Enrollment, Chain and Ownership System
PFFS	private fee-for-service
PHSA	Public Health Service Act
PPS	Prospective Payment System
PQRI	Physician Quality Reporting Initiative
RAC	Recovery Audit Contractor
RBRVS	Resource-Based Relative Value Scale
RHC	rural health clinic
RHQDAPU	Reporting Hospital Quality Data for Annual Payment Update
RRC	rural referral centers
RUG	Resource Utilization Group
RVU	Relative Value Unit

Glossary of Acronyms Used	
SCH	sole community hospital
SEP	Special Election Period
SNF	skilled nursing facility
SNP	Special Needs Plan
SSA	Social Security Act
SSI	Supplemental Security Income
TRHCA	Tax Relief and Health Care Act of 2006
USC	United States Code
USPSTF	United States Preventative Services Task Force
VBP	value-based purchasing

Division B: Medicare and Medicaid Improvements[1]

Contents

[1] Title VII - Medicaid and CHIP is discussed in a separate memo. Title VIII – Revenue Related Provisions is not included.

Title I – Improving Health Care Value

Subtitle A – Provisions Relating to Medicare Part A

Part 1 – Market Basket Updates

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Skilled nursing facility payment update. Current Law: SNFs are paid through a PPS which is composed of a daily ("per-diem") urban or rural base payment amount that is then adjusted for case mix and area wages. Each year, the SNF payment rate is increased by an update factor that is determined, in part, by the projected increase in the SNF market basket (MB) index. Without changes to current law, the SNF MB update for FY2010 is 2.2%.	*H. §1101.* The provision would eliminate the MB update for SNFs between January 1, 2010 and September 30, 2010. Subject to another provision regarding a productivity adjustment, the rate would be increased by the skilled nursing facility MB percentage change for the fiscal year involved for each subsequent fiscal year.	No provision.
Inpatient rehabilitation facility payment update. Current Law: Starting January 1, 2002, payments to inpatient rehabilitation facilities (IRFs) are made under a discharge-based prospective payment system where one payment covers capital and operating costs. Typically, the per discharge payment amount is increased each fiscal year by an update factor based on the increase in the market basket index. However, for fiscal years 2008 and 2009, the update factor has been set at zero %, starting for discharges as of April 1, 2008.	*H. §1102.* This bill would extend the zero update factor until September 30, 2010 (through the end of fiscal year 2010) but would not apply to payment units occurring before January 1, 2010.	*S. §3401 as modified by S. §10319.* See description of *S §3401* in following cell.
Incorporating adjustments for productivity improvements into market basket updates for certain providers. Current Law: Most providers in fee-for-service (or traditional) Medicare, including acute care hospitals (or IPPS hospitals), skilled nursing facilities (SNFs), long term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and hospice care providers receive predetermined payment amounts	*H. §1103.* This bill would include a productivity adjustment in the update factors for certain providers. The productivity offset would equal the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity. The estimate used would be that published before the promulgation of the regulation establishing the Medicare rates for the year or period. The productivity adjustment would be included	*S. §3401 as modified by S. §10319.* Generally, the provision would provide for updates based on the MB or CPI minus full productivity estimates for all Parts A and B providers and suppliers who are subject to a MB or CPI update. The productivity offset would be identical to that in HR. 3962. This section of the H.R. 3590 includes update adjustments for dialysis, outpatient, ambulance, ASC, and DMEPOS services discussed in other parts of this side-

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established under different, unique prospective payment systems. Each year, the base payment amounts in the different Medicare payment systems are increased by an update factor to reflect the increase in the unit costs associated with providing health care services. Generally, Medicare's annual updates are linked to projected changes in specific market basket (MB) indices which are designed to measure the change in the price of goods and services purchased by the provider. Starting in FY2007, acute care hospitals paid under Medicare's inpatient prospective payment system (IPPS) that do not submit required quality data will have the applicable MB percentage reduced by two percentage points. The reduction would apply for that year and would not be taken into account in subsequent years. Beginning in FY2015, one quarter of the applicable MB percentage will be reduced if the required quality data is not submitted. Unless significant hardship is demonstrated, the remainder of the MB update (or three-quarters of the MB update) is subject to reduction in IPPS hospitals that are not meaningful electronic health record (EHR) users by FY2015. This reduction will be increased over a three year period. These reductions would apply only to the fiscal year involved and would not be taken into account in subsequent fiscal years.	in annual updates for **IPPS hospitals** for fiscal years beginning in 2010, but would apply to discharges starting January 1, 2010. Starting in FY2015, the productivity adjustment would not apply to 75% of the otherwise applicable MB update that is subject to reduction if an IPPS hospital is not a meaningful EHR user. An IPPS hospital would not receive an annual increase for this component of the update that was less than zero. The productivity adjustment would apply to the annual updates for **SNFs** and **IRFs** starting FY2011. To the extent that the base rate for **LTCHs** would be subject to an annual update, the update factor would be subject to a productivity adjustment starting for discharges on January 1, 2010 during the rate year ending in 2010 and subsequent years. To the extent that the base rate for **IPFs** would be subject to an annual update, the update factor would be subject to a productivity adjustment for days occurring during the rate year ending in 2011 and in subsequent years. The productivity adjustment would apply to **hospice** care for fiscal years beginning FY2010 but only with respect to days starting January 1, 2010.	by-side comparison. This section would implement a full productivity adjustment for IPPS hospitals, IPFs, IRFs, LTCHs, and SNFs beginning in FY2012. It would implement a full productivity adjustment for hospice providers beginning in FY2013. In addition, it would implement a full productivity adjustment for home health providers beginning in FY2015. Except where noted below, the application of the update adjustments would be able to result in a negative factor and a basis of payment that would be lower than in the preceding year. The update factors for Medicare providers would be subject to the following adjustments*:* Aside from the productivity factor beginning in FY2012, the MB update for **IPPS hospitals, IRFs and IPFs** would be reduced 0.25 percentage point in FY2010 and FY2011. In FY2012 and FY2013, the MB update would be reduced 0.1 percentage point. For each of the fiscal years from FY2014 through FY2019, the 0.2 percentage point reduction to the MB would be contingent upon the level of the insured nonelderly population relative to the projection of insured population for the year preceding enactment (CBO's fiscal year estimate at time of enrollment of the bill in either House). Specifically, only if the level of non-elderly insured population is 5 or fewer percentage points above the projections, would the MB update be reduced by 0.2 percentage point. As described subsequently the **IPF update** would also be subject to a reduction on 0.2 percentage point for the failure to submit required quality data starting in RY2014. The MB update for **LTCHs** would be reduced 0.25 percentage point in RY2010 and 0.5 percentage point in RY2011. In RY2012 and RY2013, the MB update would be reduced 0.1 percentage point. For each of the fiscal years from RY2014 through RY2019, the 0.2 percentage point reduction to the MB would be contingent upon the level of the insured nonelderly population relative to the projection of insured

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		population as is the IPPS update. **SNFs**: The SNF MB update would be subject to the productivity factor adjustment beginning in FY2012. **Home health agencies**: Aside from the productivity factor adjustment beginning in 2015, the MB update for home health services would be reduced by 1.0 percentage point in 2011, 2012, and 2013. **Hospice care:** The hospice MB update would be subject to the productivity factor adjustment beginning in FY2013. Aside from the productivity factor adjustment, the MB update would be reduced by 0.3 percentage point in FY2013. For each of the fiscal years from FY2014 through FY2019, a 0.3 percentage point reduction to the MB would be contingent upon the level of the insured population relative to the projection of insured population the year preceding enactment.

Part 2 – Other Medicare Part A Provisions

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Payments to skilled nursing facilities – Changes in recalibration factor. Current Law: Skilled nursing facilities (SNFs) are paid through a PPS which is composed of a daily ("per-diem") urban or rural base payment amount that is then adjusted for case mix and area wages. The base payment is adjusted for treatment type and care needs of the beneficiary based on 53 payment-adjusted resource utilization groups (RUGs). In January 2006, CMS implemented a refined SNF PPS (using FY2001 claims data), including a parity adjustment to ensure that estimated total payments under the 53-group RUG model would maintain parity to the formerly used 44-group RUG model in a budget neutral manner. In the final rule published on August 11, 2009, CMS describes how it will establish a revised case-mix	*H. §1111(a).* The provision would require the Secretary to adjust the case mix indexes for FY2010, using CY2006 claims data, by the appropriate recalibration factor, as described in the SNF final rule issued by the Secretary on August 11, 2009.	*S. §10325.* The Secretary would be prohibited from implementing the RUG-IV system described in the final rule prior to October 1, 2011. Beginning on October 1, 2010, the Secretary would be required to implement the change specified to therapy furnished on a concurrent basis that is a component of RUG-IV and changes to the lookback period to ensure that only those services furnished after admission to a SNF are used as factors in determining a SNF case mix classification.

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classification methodology (RUG-IV) and implementation schedule for FY2011, reflecting updated staff time measurement data derived from the recently completed Staff Time and Resource Intensity Verification (STRIVE) project, among other things. According to CMS, the rule is intended to correct for changes made for FY2006 in which changes that were intended to better account for the resources used in the care of medically complex patients resulted in payments exceeding budget neutrality estimates. Among the changes described in the final rule are changes to the billing method for concurrent therapy. According to CMS, concurrent therapy is defined as the practice of one professional therapist treating multiple patients at the same time, each of whom can be receiving different therapy treatments. There are currently no MDS coding restrictions regarding the number of patients that may be treated concurrently, among other things. The final rule specifies that concurrent therapy time provided in a Part A SNF setting would no longer be counted as individual therapy time for each of the patients involved; rather, for each discipline, CMS would require allocating concurrent therapy minutes among the individual patients receiving it before reporting total therapy minutes on the MDS 3.0. According to CMS, the total impact of the recalibration for FY2010, as described in the final rule and accounting for a MB increase of 2.2 percentage points, would be a decrease in Medicare payments to SNFs of 1.1% (or $360 million) below FY2009 payments. Some individual providers could experience larger decreases in payments than others due to case-mix utilization.		
Payments to skilled nursing facilities – Change in payment for nontherapy ancilary (NTA) services and therapy services. Current Law: CMS also applied an adjustment to account for the variability in the use of nontherapy	*H. §1111(b) and (c).* The provision would require the Secretary to increase payments for non-therapy ancillary services by 10% and decrease payments for the therapy case mix component of such rates by 5.5%. Such payment changes would be	No provision.

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ancillary (NTA) services (e.g., prescription drugs, medical equipment and supplies, IV therapy). After noting that actual utilization patterns differed from CMS projections, CMS used actual CY2006 claims data to update its calibrations and its parity adjustment so as to re-establish budget neutrality and its NTA adjustment component.	required to apply for days on or after April 1, 2010, and until the Secretary implements an alternative case mix classification system for the SNF PPS. Under a future SNF case mix classification system, the Secretary would also be required to conduct an analysis of payments for NTA so as to ensure their accuracy for services furnished during a fiscal year beginning with FY2011, within certain specifications. Such analysis would be required to consider the use of appropriate predictors which may include age, physical and mental status, ability to perform activities of daily living, prior nursing home stay, diagnoses, broad RUG category and a proxy for length of stay. In conducting the analysis, the Secretary would also be required to consult with interested parties, including MedPAC and other stakeholders, to identify appropriate predictors of nontherapy ancillary costs. The Secretary would be required to include the results of the analysis in the FY2011 rulemaking cycle for purposes of implementation beginning with FY2011. In addition, the Secretary would be required to implement changes to payments for non-therapy ancillary services and may include use of a model that predicts payment amounts applicable to NTA services under such future SNF classification system as the Secretary determines appropriate. These changes would be required to be budget neutral for estimated expenditures that would otherwise occur without such changes under such future SNF services classification system. Beginning with October 1, 2010, the Secretary would be required to provide for an addition or adjustment to the outlier payment amounts with respect to NTA and may provide for amounts with respect to therapy services. Such outlier adjustments or additional payments would be required to be based on aggregate costs during a SNF stay and not on the number of days in such stay. The Secretary would be required to reduce estimated payments that would otherwise be made under the PPS with respect to a FY by 2 percent. The total amount of	

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	additional payments or payment adjustments for these outliers with respect to a FY could not exceed 2% of total payments projected or estimated based on the SNF PPS.	
Medicare DSH report and payment adjustments in response to coverage expansion. Current Law: Since 1986, an increasing number of acute care hospitals have received additional Medicare payments because they serve a disproportionate share of low-income patients. The policy justification for Medicare's disproportionate share hospital (DSH) spending has changed over time. Originally, the DSH adjustment was intended to compensate hospitals that treat a large proportion of low-income patients for higher Medicare costs associated with their treatment. Now, the adjustment is considered as a way to protect access to care for vulnerable populations. Most DSH hospitals receive the additional payments based on a formula calculated using the proportion of the hospital's Medicare inpatient days provided to poor Medicare beneficiaries (those who receive Supplemental Security Income or SSI) added to the proportion of total hospital days provided to Medicaid recipients.	*H. §1112.* No later than July 1, 2016, the Secretary would be required to submit a report on Medicare DSH that would take into account the impact of health reform in reducing the number of uninsured individuals. The report would include the following recommendations concerning the appropriate amount, targeting, and distribution of Medicare DSH payments to hospitals given their continued uncompensated care costs and their higher Medicare costs associated with serving low-income beneficiaries. The Secretary would coordinate the issuance of this report with this legislation's required report on Medicaid DSH. If there is a significant decrease in the national rate of uninsurance as a result of this legislation, starting in FY2017 Medicare DSH adjustments would be implemented based on the recommendations of the required report and would take into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size. An additional hospital payment would be made based on the estimated amount of uncompensated care provided by the hospital based on criteria for uncompensated care, excluding bad debt. A significant decrease in the national rate of uninsurance would be established if there is a decrease in the uninsured under 65-population from 2012 to 2014 that exceeds 8 percentage points. This rate for a year would be determined by the Bureau of Census in its Current Population Survey that is published in or about September of the succeeding year. For each fiscal year (starting in FY2017) the Secretary would estimate the aggregate reduction in the amount of the Medicare DSH payments by implementing the empirically justified DSH adjustment. The Secretary would compute the	*S. §3133 as modified by S. §10316.* Starting in FY2015 and for subsequent fiscal years, the Secretary would make DSH payments equal to 25% of what otherwise would be made, a payment that represents the empirically justified amount as determined by MedPAC in its March 2007 Report to Congress. In addition to this amount, starting in FY2015, the Secretary would pay to such acute care hospitals an additional amount using a formula that is the product of 3 factors: **factor (1)** the difference in the hospital's DSH payments because of this legislation; **factor (2)** for FY2015, FY2016 and FY2017, the difference in the percentage change in the uninsured under-65 population from 2013 (as calculated from current estimates from CBO data before the vote to enroll the Act in the House) and those who are uninsured in the most recent period for which data is available minus 1.5 percentage points; and in FY2018 and subsequently, the same calculation based on data from the Census Bureau or other appropriate sources as certified by the Chief Actuary of CMS. The 1.5 percentage point subtraction would occur in FY2018 and FY2019; and **factor (3)** the percentage of uncompensated care provided by the hospital (relative to all acute care hospitals) for a selected period based on appropriate data. There would be no administrative or judicial review of any estimate used to determine the factors or any periods used to establish the factors.

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	additional hospital payments for uncompensated care so that the estimated aggregate amounts for the fiscal year did not exceed 50% of the aggregate DSH reduction. Also, hospitals with higher levels of uncompensated care would receive higher uncompensated care payments. See also the **Special treatment for DSH hospitals** in Section 1151 of the bill.	
Extension of the hospice regulation moratorium. Current Law: The PPS for hospices attempts to adjust for geographic differences through a wage index adjustment. When the data source used to adjust payments for differences in the cost of labor across geographic area was changed in 1997 from the 1983 Bureau of Labor Statistics data to the hospital wage data, a budget neutrality adjustment factor (BNAF) was instituted by the Secretary to prevent participating hospices from experiencing reductions in total payments as a result of the change. This BNAF increases payments to certain hospices that would otherwise experience a payment reduction by boosting hospice payments to these providers by amounts that would make overall payments budget neutral to the levels that they would have received had the Secretary used the 1983 Bureau of Labor Statistics wage adjustment. The revised final rule for FY2010 specifies that the hospice wage index BNAF would be phased out over seven years, with a 10% reduction in FY2010, and a 15% reduction for each year from FY2011 through FY2016.	*H. §1113.* The provision would extend the delay on the implementation of the phase-out of the budget neutrality adjustment factor through October 1, 2010.	No provision.
Permitting physician assistants to order post-hospital extended care services. Current Law: In a skilled nursing facility (SNF), Medicare law allows physicians, as well as nurse practitioners and clinical nurse specialists who do not have a direct or indirect employment relationship with a SNF, but who are working in collaboration with a physician, to certify the need for post-hospital extended care services for purposes of Medicare payment. Section 20.2.1 of	*H. §1114(a).* The provision would allow a physician assistant [who is legally authorized by the state in which the services are being furnished] who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes.	*S. §3108.* On or after January 1, 2011, the provision would allow a physician assistant who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes.

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Chapter 8 of the Medicare Benefit Policy Manual defines post-hospital extended care services as services provided as an extension of care for a condition for which the individual received inpatient hospital services. Extended care services are considered "post-hospital" if they are initiated within 30 days after discharge from a hospital stay that included at least three consecutive days of medically necessary inpatient hospital care.		
Providing for recognition of attending physician assistants as attending physicians to serve hospice patients. Current Law: Under the Medicare program, hospice services may only be provided to terminally ill individuals under a written plan of care established and periodically reviewed by the individual's attending physician and the medical director (and by the interdisciplinary group of the hospice program). For an individual to be eligible for Medicare-covered hospice services, the individual's attending physician (not including a nurse practitioner) and the medical director (or physician member of the interdisciplinary group of the hospice program) must each certify in writing that the individual is terminally ill at the beginning of the first 90-day period of hospice.	*H. §1114(b).* For purposes of a hospice written plan of care, the provision would include a physician assistant (who is legally authorized by the state in which the care is being delivered and acting under the supervision of a physician) in the definition of an attending physician. The provision would continue to exclude physician assistants from the authority to certify an individual as terminally ill.	No provision.
Establish hospital value based purchasing program. Current Law: Since FY2005, acute care hospitals that submit required quality data have received higher payments than those hospitals that do not submit such information under Medicare's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program (often referred to as the hospital pay-for-reporting program or P4R program). There are 46 quality measures collected in the RHQDAPU program that impact the FY2011 payment update. Individual hospital performance on specific quality measures and on certain conditions is available on Hospital Compare on the CMS website. In November, 2007, CMS released a mandated report on the implementation of a Medicare hospital	No provision.	*S. §3001 as modified by S. §10335.* Starting for discharges on October 1, 2012, hospitals would receive value-based incentive payments from Medicare. The first year of the VBP program would be a data collection/performance year. Beginning in FY2013, hospital payments would be adjusted based on performance under the VBP program. Certain hospitals would be excluded in a fiscal year: those that are subject to payment reductions associated with reporting required quality data in that fiscal year; those that have been cited for deficiencies that pose immediate jeopardy to their patients, and those for which there are not sufficient number of measures or cases that apply to the hospital for a performance period. Acute care hospitals in Maryland paid under their state specific Medicare

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value-based purchasing (VBP) program, which recommends expanding the RQHDAPU program in order to financially reward hospitals differentially for performance; public reporting of performance would be a key component as well.		system would be exempt if an annual report documents that a similar state program achieves at least comparable patient outcomes and cost savings. The Secretary would select measures other than measures of readmissions for the hospital VBP program from those used in the RHQDAPU program. In FY2013, the measures would cover at least five specified conditions. For discharges occurring during FY2014 and subsequently, the Secretary would ensure that measures would include appropriate efficiency measures, such as adjusted Medicare spending per beneficiary. The Secretary would establish VBP performance standards, including levels of achievement and improvement, and a methodology for assessing the total performance of each hospital. The performance standards would be announced no later than 60 days prior to the beginning of the period. Hospitals with the highest scores would receive the largest VBP payments. There would not be a minimum performance standard in determining the performance score for any hospital. Hospitals that meet or exceed the established standards for a performance period would receive an increased base operating diagnosis-related group (DRG) payment for each discharge in the fiscal year. Starting in FY2013, the Secretary would fund the VBP incentive payments by reducing the base operating DRG payments for each hospital's discharges in a fiscal year by an applicable percentage. These reductions would apply to all hospitals. The applicable percentage would be 1.0% in FY2013; 1.25% in FY2014; 1.5% in FY2015; 1.75% in FY2016; and 2.0% in FY2017 and in subsequent years. Certain adjustments within Medicare's inpatient hospital payment system, such as those for outliers, indirect medical education, disproportionate share hospital and low volume, would not be affected. Certain payments to sole community hospitals and Medicare dependent hospitals (for FY2012 and FY2013) would also not be affected.

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		Individual hospital performance on each specific quality measure, on each condition or procedure, and on total performance would all be publicly reported. A process would be established that allows hospitals to appeal their performance assessment and score; these appeals would be resolved in a timely manner. There would be no judicial or administrative review of certain aspects of the VBP program. The Secretary would consult with small rural and urban hospitals on the application of the VBP program to such hospitals. The RHQADPU program would be modified. The Secretary would be able to require hospitals to submit data on measures that are not used for the determination of VBP payments. Effective for FY2013 payments, the Secretary would be required to provide for appropriate risk adjustment for quality measures for outcomes of care. These measures would be validated appropriately. GAO would conduct a study of the VBP program with an interim report to Congress due by October 1, 2015 and a final report due by July 1, 2017. The Secretary would conduct a study of the VBP with a report to Congress due by January 1, 2016. No later than two years from enactment, three-year, budget neutral VBP demonstration projects would be established in critical access hospitals (CAHs) and in hospitals excluded from VBP because of an insufficient volume; reports on the demonstration projects would be due to Congress no later than 18 months after completion of the projects.
Establish quality reporting for LTCHs, IRFs, and hospice programs. Current Law: Under current law, IRFs, LTCHs, and hospices are not required to report quality data to the Centers for Medicare and Medicaid Services (CMS). Medicare pays for inpatient care provided by IRFs and LTCHs, and for hospices, using different prospective payment systems (PPS). Each PPS is updated annually using a market basket (MB) index which measures the	No provision.	*S. §3004.* The Secretary would be directed to establish quality reporting programs for LTCHs, IRFs, and hospices. Starting in rate year 2014, LTCHs would be required to submit data on specified quality measures. This requirement would start in FY2014 for IRFs and hospices. Entities that did not comply would have a reduction in their annual update of 2 percentage points. The reduction would be able to result in an annual

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estimated change in the price of goods and services purchased by the provider to produce a unit of output.		update that is less than 0.0 which would result in a basis of payment that is lower than in the preceding year. Any reduction would not affect payments in subsequent years. The required measures affecting these payments would be published no later than October 1, 2012. The providers would be able to review the data prior to being publically available.
Establish quality reporting for cancer hospitals. Current Law: Eleven cancer hospitals are exempt from the Medicare inpatient prospective payment system (IPPS) used to pay inpatient hospital services provided by acute care hospitals. As part of these exemptions, these facilities are paid on a reasonable cost basis for providing inpatient services, subject to certain payment limitations and incentives. Currently, there are no quality reporting requirements for these hospitals.	No provision.	*S. §3005.* The Secretary would be directed to establish quality reporting programs for IPPS-exempt cancer hospitals starting FY2014. These measures would be published no later than October 1, 2012. The providers would be able to review the data prior to being publically available.
Extend LTCH payment rule deferrals. Current Law: LTCHs are designed to provide extended medical and rehabilitative care for patients who are clinically complex and have multiple acute or chronic conditions. LTCHs that are distinct units of other hospitals are not explicitly permitted by the Medicare statute. Over time, however, the LTCH industry has evolved to include co-located hospitals-within-hospitals (HwHs) or satellite facilities in addition to traditional freestanding facilities. CMS has implemented additional organizational requirements on these LTCHs, in an attempt to ensure that these are separate entities. Certain LTCHs (grandfathered HwHs) have been exempted from the requirements. Starting October 1, 2004, CMS established limits on the number of discharged Medicare patients that HwHs and satellite LTCHs (except grandfathered LTCHs) can admit and be paid as independent LTCHs; after that threshold has been reached, generally, the LTCH will receive a substantially lower payment for subsequent patient admissions who have been discharged from the host hospital. Starting July 1, 2007, CMS extended this	No provision.	*S. §3106 as modified by S. §10312 .* The provisions would extend the existing three-year moratoriums for two years until December 29, 2012.

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payment policy to other types of LTCHs, including grandfathered entities. Congress provided for a three-year moratorium on the application of this payment policy for certain LTCHs starting December 29, 2007. Effective for the first cost reporting period beginning on or after October 1, 2002, LTCHs are paid according to a prospective payment system (PPS), subject to a five-year transition period. By statute, total payments under LTCH-PPS must be equal to the amount that would have been paid if the PPS had not been implemented in the initial year of implementation. CMS proposed to review LTCH payments and make a one-time prospective adjustment to the LTCH PPS to correct for any errors in the original budget neutrality calculations. Congress applied a 3-year moratorium to this policy. The LTCH-PPS includes certain case level adjustments for short stay and interrupted stay cases. CMS adopted a very short-stay outlier payment policy starting July 1, 2007 to reduce payments for patients who have lengths of stay that are less than or equal to one standard deviation from the geometric average length-of-stay of the same MS-DRG under the IPPS. Congress applied a 3-year moratorium to this policy. Finally, a three-year moratorium on new LTCHs, including HwHs and satellite facilities, and on the increase of hospital beds in existing LTCHs was established.		
Hospice Reform. Current Law: For a person to be considered terminally ill for eligibility purposes for Medicare's hospice benefit, the beneficiary's attending physician and the medical director of the hospice (or physician member of the hospice team) must certify that the individual has a life expectancy of six months or less. The medical director or physician member of the hospice team must recertify that the beneficiary is terminally ill at the beginning of each 90- or 60-day eligibility period. Medicare covers hospice care for terminally ill beneficiaries instead of most other Medicare services related to the curative	No provision.	*S. §3132.* The Secretary would be required to begin, by January 1, 2011, collecting additional data and information needed on cost reports, claims, or other mechanisms as the Secretary determines appropriate, to revise payments for hospice care, and for other purposes (as determined appropriate by the Secretary). Additional data and information collected could include (i) charges and payments; (ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, part A benefits; (iii) with respect to each type of service included in hospice care: the number of

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
treatment of their illness. Medicare payments to hospices are predetermined fixed daily amounts for each case, and are based on one of four prospectively determined units of payment, which correspond to four different levels of care (i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care).		days of hospice care attributable to the type of service; the cost of the type of services; and the amount of payment for the type of service; (iv) charitable contributions and other revenue of the hospice program; (v) the number of hospice visits; (vi) the type of practitioner providing the visit; and (vii) the length of the visit and other basic information with respect to the visit. Not earlier than October 1, 2013, the Secretary would be required to, by regulation, implement budget neutral revisions to the methodology for determining hospice payments for routine home care and other services. Such revisions could be based on an analysis of data with information described above. Such revisions could include adjustments to per diem payments that reflect changes in resources intensity in providing care and services during the entire episode of hospice care. The Secretary would be required to consult with hospice programs and MedPAC regarding the collection of information and the payment revisions. Starting on or after January 1, 2011, to recertify a beneficiary for hospice eligibility, a hospice physician or nurse practitioner would have a face-to-face encounter with the individual. This encounter would occur prior to the 180th-day recertification and with each subsequent recertification. The physician or nurse practitioner would attest that such hospice visits took place (in accordance with procedures established by the Secretary). In the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under Medicare, the hospice care provided to such individual would be medically reviewed (in accordance with procedures established by the Secretary).

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Medicare hospice concurrent care demonstration program. Current Law: Medicare covers hospice care for terminally ill beneficiaries instead of most other Medicare services related to the curative treatment of their illness.	No provision.	*S. §3140.* The provision would require the Secretary to conduct a three-year demonstration program, from Medicare funds that would otherwise be paid for hospice care, to allow patients who are receiving hospice care to also receive any other items or services covered under Medicare during the same period. The Secretary would be required to select not more than 15 hospice programs, in both urban and rural areas, at which sites the demonstration program would be conducted. The Secretary would be required to conduct an independent evaluation of the demonstration program to determine whether it has improved patient care, quality of life, and cost-effectiveness for Medicare participants. The Secretary would be required to submit to Congress a report containing the results of the evaluation, together with such recommendations as the Secretary determines appropriate. With respect to the 3-year period of the demonstration program, the Secretary would be required to ensure that the aggregate Medicare expenditures for such period do not exceed the aggregate expenditures that would have been expended under Medicare if the demonstration program had not been implemented.
Require quality reporting for IPFs. Current Law: IPFs are paid under a prospective payment system that was established under BBRA. IPFs are not required to submit quality data.	No provision.	*S. §3401 as modified by S. §10322.* A new Section 1886(s) would be added to the SSA to codify the establishment of a IPF-PPS. As mentioned earlier, the IPF update would also be subject to a reduction of 2.0 percentage points for the failure to submit required quality data starting in RY2014. The application of this penalty would be able to result in an annual update less than 0.0. However, any such reduction would apply only with respect to the

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		rate year involved and would not be taken into account in subsequent years. Starting in RY2014, IPFs would be required to submit data on quality measures as specified. These measures would be published no later than October 1, 2012. These measures would be required to be endorsed by an entity with a contract to establish quality and efficiency measures under 1890(a) of the SSA. In specified areas or medical topics where a feasible or practical measure has not been endorsed, another measure would be established as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization. Procedures would be established for making this data publically available, including reported on the CMS website, after appropriate review.
Conduct pilot test of pay-for-performance programs for certain providers. Current Law: No provision.	No provision.	*S. §10326.* No later than January 1, 2016, a pilot pay-for-performance program would be established for IPFs, LTCHs, IRFs, IPPS-exempt cancer hospitals, and hospice programs. Medicare requirements and those in Title XI and Title XVIII of the SSA would be waived as necessary. Payments under this section for each provider type would be established so that spending would not be increased. The Secretary would be able to expand the duration and scope of the pilot project at any point after January 1, 2018 if the Secretary determines that such expansion would reduce Medicare spending without reducing quality of care or improve the quality of care and reduce spending. The Chief Actuary of CMS would certify that an expansion would reduce Medicare spending. Finally, the Secretary would determine that an expansion would not deny or limit the coverage or provision of Medicare benefits.

Subtitle B – Provisions Relating to Medicare Part B

Part 1 – Physicians' Services

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Resource-based feedback program for physicians in Medicare. Current Law: Both MedPAC and GAO have suggested that CMS provide information to physicians on their resource use with the expectation that physicians who are outliers would alter their practice patterns as a result. Providing this information to physicians would enable them to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (if available) recommends, and to revise practice styles as appropriate. Section 131(c) of MIPPA established such a physician feedback program, which CMS implemented by January 1, 2009. CMS initially called this effort the Physician Resource Use Feedback Program, but has renamed this initiative the "Physician Resource Use Measurement and Reporting Program." MIPPA also requires the GAO to conduct a study of the Physician Feedback Program as described above, including the implementation of the Program, and to submit a report to Congress by March 1, 2011 containing the results of the study, together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.	*H. § 1121.* The bill would modify the existing physician feedback program and establish a feedback implementation plan for providing information to providers about their practice patterns. The Secretary would develop and specify the nature of the reports, based on results and findings from the Medicare program as in existence before the date of the enactment of this act. These reports could be based on a per capita basis, an episode basis that combines separate but clinically related physicians' services and other items and services furnished or ordered by a physician into an episode of care, as appropriate, or both. The nature of the reports would be developed by January 1, 2012. During 2011, the Secretary would establish methodologies as appropriate to (i) attribute items and services to physicians, (ii) identify appropriate physicians for purposes of comparison, and (iii) aggregate items and services attributed to a physician into a composite measure per individual. The Secretary would evaluate the methods with regard to their efficacy in changing practice patterns to improve quality and decrease costs. The Secretary would develop a plan to disseminate these reports in a significant manner in the regions and cities of the country with the highest utilization of Medicare services. To the extent practicable, the reports would be disseminated to increasing numbers of physicians each year; during 2014 and in subsequent years, the reports would be disseminated at least to physicians with utilization rates among the highest 5% of the nation. The Secretary could disseminate the reports via: direct meetings between contracted physicians, though contracts with local, non-profit entities engaged in quality improvement efforts at the community level, in	*S. § 3003.* The proposal would require new types of reports and data analysis under the physician feedback program. Not later than January 1, 2012, the Secretary would develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate. Beginning with 2012, the Secretary would provide reports to physicians that compare patterns of resource use of the individual physician to such patterns of other physicians. In preparing these reports, the Secretary would establish methodologies as appropriate to (i) attribute episodes of care, in whole or in part, to physicians, (ii) identify appropriate physicians for purposes of comparison, and (iii) aggregate episodes of care attributed to a physician into a composite measure per individual. In preparing these reports, the Secretary would make appropriate adjustments, including adjustments (i) to account for differences in socioeconomic and demographic characteristics, ethnicity, and health status of individuals, and (ii) to eliminate the effect of geographic adjustments in payment rates.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	mailings or other methods of communication that facilitate large-scale dissemination, or by other methods specified by the Secretary.	
Misvalued codes under the physician fee schedule. Current Law: The Medicare physician fee schedule is based on assigning relative weights to each of more than 7,000 physician service codes used to bill Medicare. The relative value for a service compares the relative work involved in performing one service with the work involved in providing other physicians' services. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS). CMS, which is responsible for maintaining and updating the fee schedule, continually modifies and refines the methodology for estimating relative value units (RVUs). CMS relies on advice and recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in its assessments. In general, as currently implemented, increases in RVUs for a service or number of services lowers the resultant fees for other physician services. One consequence has been that the payments for evaluation and management codes, whose RVUs typically are not increased over time, have fallen relative to other codes whose RVUs have increased and as a consequence of new technologies that have been introduced into coverage with relatively high RVUs. CMS is required to review the RVUs no less than every five years.	*H. § 1122.* Under this proposal, the Secretary would periodically identify and make appropriate adjustments to the relative values for the services identified as being potentially misvalued. The Secretary would examine the following, as appropriate: (1) codes (and families of codes as appropriate) for which there has been the fastest growth; (2) codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; (3) codes for new technologies or services within an appropriate period (such as three years) after the relative values are initially established for such codes; (4) multiple codes that are frequently billed in conjunction with furnishing a single service; (5) codes with low relative values, particularly those that are often billed multiple times for a single treatment; (6) codes that have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and (7) such other codes determined to be appropriate by the Secretary. The bill specifies the activities that the Secretary could undertake to review and adjust the codes, which include using existing processes, conducting surveys, undertaking other data collection activities, studies, or other analyses, or using analytic contractors to perform these tasks. The provision would repeal Section 4505(d) of the Balanced Budget Act of 1997, which established requirements for developing new resource-based practice expense relative value units, as well as Section 1868(a) of the Social Security Act (42 U.S.C. 1395ee(a)), which established the Practicing Physicians Advisory Council, a group of physicians who meet quarterly to discuss proposed changes in regulations and carrier manual instructions related to physician services.	*S. § 3134.* Substantially the same as the House provision. However, the Senate bill does not provide an additional appropriation.

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	The provision appropriates $20 million (in addition to any funds otherwise appropriated) to carry out this section.	
Payment for efficient areas. Current Law: In certain circumstances, physicians receive an additional payment in addition to the Medicare fee schedule amount to encourage targeted activities. These bonuses, typically a percentage increase above the Medicare fee schedule amounts, can be awarded for a number of activities including reporting on quality measures, participating in electronic prescribing, or practicing in underserved areas.	*H. § 1123.* The bill would create a new incentive payment for physicians; providers delivering services in counties or equivalent areas in the United States that fall in the lowest 5% based on per capita spending for Medicare part A and part B services would receive an additional 5% payment for the Medicare Part B physician services. The Secretary would standardize per capita spending to eliminate the effect of geographic adjustments in payment rates and would publish a list of qualifying areas. This provision would be in effect on or after Jan. 1, 2011 and before Jan 1, 2013.	No provision. However, see next row (*S. § 3007)* for related issue.
Value-based payment modifier under the physician fee schedule. Current Law: No provision.	No provision. However, see row above (*H. § 1123.)* for related issue.	*S. § 3007.* The Secretary of Health and Human Services would be required to establish and apply a separate, budget-neutral payment modifier to the Medicare physician fee schedule. The separate payment modifier would be based on the relative quality and cost of the care provided by physicians or physician groups. Quality of care would be evaluated on a composite of risk-adjusted measures of quality established by the Secretary, such as measures that reflect health outcomes. Costs, defined as expenditures per individual, would be evaluated based on a composite of appropriate measures of costs established by the Secretary that eliminate the effect of geographic adjustments in payment rates and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals and other factors determined appropriate by the Secretary.) By January 1, 2012, the Secretary would publish the specific measures of quality and cost, the specific dates for implementation of the payment adjustment, and the proposed prospective performance period. The Secretary would begin implementing the value-based

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		payment adjustment in the 2013 rulemaking process. During the performance period, which would begin in 2014, the Secretary would provide information to physicians about the value of care they provide, as reflected by the measures of relative quality and cost. The Secretary would apply the payment modifier for items and services furnished beginning on January 1, 2015, for specific physicians and groups of physicians the Secretary determines appropriate, and not later than January 1, 2017, for all physicians and groups of physicians. The Secretary would apply the payment modifier in a manner that promotes systems-based care and takes into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.
Modifications to the Physician Quality Reporting Initiative (PQRI). Current Law: The Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432) required the establishment of a physician quality reporting system (the Physician Quality Reporting Initiative, PQRI) that would include an incentive payment to eligible professionals who satisfactorily report data on quality measures. MIPPA made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5% of total allowable charges under the physician fee schedule in 2007 and 2008 to 2% in 2009 and 2010.	*H,. §1124.* The bill would modify the PQRI to include a feedback program for physicians, integrate PQRI and electronic health record (EHR) reporting, and extend the years of bonus payments. Not later than January 1, 2011, the Secretary would develop and implement a mechanism to provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under the PQRI program. By Jan 1, 2011, the Secretary would establish an appeals process for eligible professionals to seek a review of a determination that they did not submit data. The bill would integrate physician quality reporting under the PQRI and EHR reporting relating to the meaningful use of EHR. The integration would consist of the following (1) the development of measures that would both demonstrate meaningful use of an electronic health record for purposes of EHR reporting and provide information on the clinical quality of the care furnished to an individual; (2) the collection of health data to identify deficiencies in the quality and coordination of care for Medicare beneficiaries; and (3)	*S § 3002 as modified by S§ 10327.* The bill would extend PQRI incentive payments through 2014 and implement an incentive (penalty) for providers who did not report quality measures beginning in 2015. Eligible professionals who successfully report in 2010 would receive a one percent bonus in 2011; those who successfully report in 2011, 2012, and 2013 would receive a 0.5 percent bonus in 2012, 2013, and 2014, respectively. An additional 0.5% incentive payment would also be available in years 2011 through 2014 for eligible professionals who also meet the requirements of a Maintenance of Certification Program (MOCP). A MOCP would be defined as a continuous assessment program that advances quality and lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. MOCPs would require the physician to (1) maintain a valid, unrestricted medical license in the United States, (2) participate in educational and self-assessment programs that require an assessment of what was learned, (3) demonstrate,

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	other activities as specified by the Secretary. The Secretary would develop such a plan no later than January 1, 2012. Incentive payments under the PQRI program would be extended through 2012; for each of the years 2009 through 2012, the bonus would be 2% of Part B payments.	through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty, and (4) successfully complete the MOCP practice assessment. The MOCP practice assessment would (a) include an initial assessment of an eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine, (b) include a survey of patient experience with care, and (c) require a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment and then to remeasure to assess performance improvement after such an intervention. These eligible professionals would participate in and successfully complete a qualified MOCP practice assessment more frequently than is required to qualify for or maintain board certification status. The MOCP would submit information to the Secretary on behalf of the eligible professional that the professional has successfully met the program criteria and on the survey of patient experience with care, if requested. The provision would authorize the Secretary to incorporate participation and successful completion in a MCOP into the composite of measure of quality of care furnished pursuant to the physician fee schedule payment modifier. Subsequently, eligible professionals who failed to participate successfully in the program would face a 1.5 percent payment penalty in 2015, and a 2 percent payment penalty in 2016 and in subsequent years. The incentive payments and adjustments in payment would be based on the allowed charges for all covered services furnished by the eligible professional, based on the applicable percent of the fee schedule amount. The proposal would require CMS to develop a plan to integrate the PQRI program with the standards for meaningful use of certified electronic health records as created in the American Recovery and Reinvestment Act of 2009.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Adjustment to Medicare payment localities. Current Law: The Medicare fee schedule pays providers differently according to the geographic location, known as a Medicare physician payment locality, in which the provider practices. By construction, the costs of providing physician services were relatively consistent within each payment locality at the time when they were defined; sub-regions of a state were designated as separate payment localities only if the data showed a marked difference between the costs in that area compared with the rest of the state. Economic conditions have affected parts of the country differently in the years since the payment localities were created. If localities were to be created based on data from recent years using the original methodology, the resulting number and composition of the payment localities might not be the same as the ones that currently exist.	*H. § 1125.* The bill would alter the payment localities in the state of California used as the basis for the geographic adjustment of Medicare physician payments. Under the proposal, payments to California physicians would transition from a system based on the current localities to one based on Metropolitan Statistical Areas (MSAs) for services furnished on or after January 1, 2011. The construction of the payment localities under the new definition would follow an iterative process similar to that originally used to construct the county-based payment localities. The provision includes a hold harmless condition that would require that no geographic adjustments be reduced below the index in effect on Dec. 31, 2010 during the first five years of the transition from the former county-based payment localities to the MSA-based fee schedule areas. The new fee schedule areas would be subject to periodic review and adjustments.	No provision.

Part 2 – Market Basket Updates

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Incorporating adjustments for productivity improvements into market basket updates for certain Part B entities. Current Law: MIPPA changed Medicare's payment policies for outpatient dialysis services. Beginning in 2011, these services will be paid under a bundled payment system subject to certain limitations and adjustments. Starting in 2012, payment will be increased using the end stage renal disease (ESRD) market basket minus 1 percentage point. Medicare pays for hospital outpatient department	*H. §1131.* Starting in 2012, annual dialysis updates would not include the minus one percentage point reduction but would be subject to the productivity adjustment established earlier in the legislation and applicable to certain Part A providers, including IPPS hospitals. Starting in 2010, the update for OPPS, ambulance , laboratory, and certain DME services would be subject to the productivity adjustment.	*S. §3401 as modified by S §10319.* Generally, the provision would provide for updates based on the MB or CPI minus full productivity estimates for all Parts A and B providers and suppliers who are subject to a MB or CPI update. The productivity offset would be identical to that in HR. 3962. Specifically, this change would implement a full productivity adjustment for outpatient hospital services beginning in FY2012. For providers paid through the clinical laboratory test fee schedule, the proposal would

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
(HOPD) services using its outpatient prospective payment system (OPPS). Generally, Medicare's OPPS base payment amount is increased each year by an annual update that is linked to projected changes in specific market basket (MB) indices which are designed to measure the change in the price of goods and services purchased by the provider. Starting in CY2009, hospitals paid under OPPS that do not submit required quality data will have the applicable MB percentage reduced by two percentage points. The reduction would apply for that year and would not be taken into account in subsequent years.		replace the scheduled 0.5% payment reduction for calendar years 2011 through 2013 with a full productivity adjustment for calendar year (CY) 2011 and subsequent years. All other productivity adjustments for other Part B providers would begin in CY2011. Except where noted below, the application of the update adjustments would be able to result in a negative factor and a basis of payment that would be lower than in the preceding year. The update factors for Medicare suppliers would be subject to the following adjustments: **Outpatient hospitals:** Aside from the productivity factor beginning in FY2012, the MB update for outpatient acute hospitals services would be reduced 0.25 percentage point in FY2010 and FY2011. In FY2012 and FY2013, the MB update would be reduced 0.1 percentage point. For each of the fiscal years from FY2014 through FY2019, the 0.2 percentage point reduction to the MB would be contingent upon the level of the insured nonelderly population relative to the projection of insured population for the year preceding enactment (CBO's fiscal year estimate at time of enrollment of the bill in either House). Specifically, only if the level of non-elderly insured population is 5 or fewer percentage points above the projections, would the MB update be reduced by 0.2 percentage point. **Dialysis:** the ESRD MB would no longer be subject to a 1 percentage point reduction beginning in 2012, but would be subject to the productivity factor adjustments starting in 2012. **Ambulance services**: the productivity adjustment factor would be applied to the CPI-U used to increase the ambulance fee schedule starting in CY2011. **Ambulatory surgical center services**: the productivity adjustment factor would be applied to the CPI-U used to update payments for ambulatory surgical center services starting in CY2011. **Laboratory services**: the existing 0.5 percentage point reduction to the CPI-U update to the fee schedule in CY2009 and CY2010 would be retained. A 1.75 percentage point reduction to the update in CY2011 through CY2015

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		would be established; this reduction would be able to result in a negative update. The productivity adjustment factor would be applied to the CPI-U starting in CY2011, but in the application of the adjustment would not be able to reduce the increase to less than zero. **Certain durable medical equipment:** the productivity adjustment factor would be applied to the CPI-U used to increase the fee schedules for certain durable medical equipment (DME) beginning in CY2011. Certain DME would have received a payment increase of CPI-U plus 2 percentage points in CY2014. The 2 percentage point increase was eliminated. **Prosthetic devices, orthotics, and prosthetics:** the productivity adjustment factor would be applied to the CPI-U update for the applicable fee schedule for this DME category starting in CY2011. **Other items:** the productivity adjustment factor would be applied to the CPI-U update for this DME category starting in CY2011.

Part 3 – Other Provisions

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Rental and purchase of power driven wheelchairs. Current Law: Medicare pays for new or replacement power-driven wheelchairs in one of two ways: either Medicare will pay the supplier a monthly rental amount during the beneficiary's period of medical need (not to exceed 13 continuous months), or, payment is made on a lump-sum basis at the time the supplier furnishes the chair. Power wheelchairs are classified into 3 broad groups based on their reported performance in categories such as speed, range of travel and the height of the vertical obstruction they can climb. Rental payments for wheelchairs are statutorily determined as 10% of the purchase price of the chair for each of the	*H. §1141.* This bill would restrict the 'lump-sum' payment provision for new and replacement power-driven wheelchairs to those recognized by the Secretary as classified within group 3 or higher. The provision would be effective for chairs furnished on or after January 1, 2011, but would not apply to areas where the payments for Medicare DMEPOS are based on the competitive bids of suppliers where bids had been submitted before October 1, 2010.	*S. §3136.* Like the House bill, the Senate bill would restrict the lump-sum payment option for certain power wheelchairs. The Senate bill restricts it to complex rehabilitative power wheelchairs – which include all power wheelchairs which are group 3 and higher, as well as group 2 chairs that have been upgraded. The implementation date in the Senate bill would be January 1, 2011. The Senate bill specifies that the provision would not apply to competitive acquisition areas prior to January 1, 2011. In addition, under the Senate bill, starting January 1, 2011, the rental payment for power-driven wheelchairs

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
first 3 months and 7.5% of the purchase price for each of the remaining 10 months of the rental period. Medicare pays for most DME on the basis of a fee schedule, except in Competitive Acquisition Areas where payments are to be determined based on supplier bids.		would be 15% of the purchase price for each of the first three months (instead of 10%), and 6% of the purchase price for each of the remaining 10 months of the rental period (instead of 7.5%).
Election to take ownership, or to decline ownership, of a certain item of complex durable medical equipment after the 13-month capped rental period ends. Current Law: Pressure reducing support surfaces are used for the care or prevention of pressure ulcers or bedsores and are a covered Medicare Part B DME benefit. For beneficiaries that fulfill coverage criteria for a pressure reducing support surface, Medicare will pay the supplier a monthly rental amount during the beneficiary's period of medical need (though payments are not to exceed 13 continuous months). On the first day after the 13th continuous month of rental payments, the supplier of the item is required to transfer title of the item to the beneficiary. After the supplier transfers title to the beneficiary, Medicare pays for maintenance and servicing for parts and labor not otherwise covered under a manufacturer's warranty if the Secretary determines that payments are reasonable and necessary. Payment amounts for such maintenance and services are determined by the Secretary. Support surfaces come in different categories. A group 3 support surface is a complete bed system known as air-fluidized beds. It simulates the movement of fluid by circulating filtered air through silicone-coated ceramic beads.	*H. §1141A.* This bill would eliminate the automatic transfer of title of group 3 support surfaces to beneficiaries after 13 months of continuous use. Effective upon enactment, this provision would require DME suppliers, during the 10th continuous month of rental, to offer the beneficiary the option to accept or reject the transfer of title to a group 3 support surface after the 13th month of rental. The beneficiary would be deemed to reject the title, unless it was accepted within one month of the offer. If the individual accepted the title, it would be transferred on the first day that begins after the 13th month of continuous rental. If on the effective date of this legislation, the individual's rental period has exceeded 10 continuous months, but has not reached the first day after the 13th month of continuous rental, the supplier would be required to offer the beneficiary the option to reject or accept title to the group 3 support surface. The supplier would be required to do so within 1 month of the effective date. The beneficiary has one month to accept or reject the title. The beneficiary is deemed to reject the title unless it is accepts the title. The provision would require the supplier to continue to supply the support surface for the reasonable useful lifetime of the surface without charge if the beneficiary rejects the transfer of title but continues to require the support surface. Reasonable and necessary maintenance and servicing not otherwise covered by a manufacturer's warranty would be covered by Medicare, as under current law. This provision would be effective not later than January 1, 2011.	No provision.
Extend cost reimbursement for HOPD brachytherapy services.	*H. §1142.* This bill would extend cost reimbursement for	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Current Law: MMA required Medicare's outpatient prospective payment system to make separate payments for specified brachytherapy sources. As mandated by TRHCA, this separate payment was to be made using hospitals' charges adjusted to their costs until January 1, 2008. MMSEA extended cost reimbursement for brachytherapy services in hospital outpatient departments (HOPDs) until July 1, 2008. MMSEA also specified that therapeutic radiopharmaceuticals were to be paid using this methodology for services provided on or after January 1, 2008, and before July 1, 2008. MIPPA extended HOPD cost reimbursement for brachytherapy and therapeutic radiopharmaceuticals until January 1, 2010.	brachytherapy and therapeutic radiopharmaceuticals in HOPDs until January 1, 2012	
Home infusion therapy report for Congress. Current Law: Infusion therapy involves the administration of medication through a needle or a catheter. If a physician determines that it is medically appropriate for a particular patient, some infusion therapies may be provided in a patient's home. Infusion drugs administered in a patient's home are covered under the Medicare Part D drug benefit. Medicare Part D does not, however, cover supplies, equipment or professional services associated with home infusion therapy.	*H. §1143.* This bill would require the Medicare Payment Advisory Committee (MedPAC) to submit a report to Congress by not later than July 1, 2011. The report would be required to include (a) an analysis of the scope of coverage for home infusion therapy services (and the scope of services provided) in traditional Medicare, Medicare Advantage, the Veterans Health Administration, and among private payers (b) the benefits and costs of providing such coverage under the Medicare program, including a calculation of the potential savings achieved through avoided or shortened hospital or nursing home stays (c) an assessment of data on home infusion therapy that might be used to construct payment mechanisms under Medicare and (d) recommendations, if any, on the structure of a payment system under the Medicare program for home infusion therapy services, including an analysis of MA and private plan payment methodologies for home infusion therapy and their applicability to the Medicare program.	No provision.
Require ambulatory surgical centers (ASCs) to submit cost and other data. Current Law: ASCs must meet certain health, safety, and other specified standards in order to participate in	*H. §1144.* The Secretary would require ASCs to submit reports on their facility costs as a condition for agreeing to participate in Medicare. The specifications for this data	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Medicare. CMS is implementing a new ASC payment system starting in January 1, 2008. The system which will be phased in over a 4-year period uses the ambulatory payment classification groups that are the basis for Medicare's outpatient prospective payment system (OPPS) for HOPDs. ASCs have never been required to submit cost reports. In March 2009, MedPAC recommended that Congress require ASCs to submit cost data and quality data that would allow for an effective evaluation of the adequacy of Medicare's payment rates.	would take into account the requirements for hospital cost data. No later than 3 years from enactment, an ASC cost reporting form would be developed. The ASC cost reports would be periodically audited. The requirements would apply to agreements applicable to cost reporting periods beginning 18 months after the date the Secretary develops the cost reporting form. The Secretary would require ASCs to report quality data, including data on health care associated infections. The amendment would apply starting 2012.	
Pay for HOPD services in cancer hospitals. Current Law: Eleven cancer hospitals are exempt from IPPS used to pay inpatient hospital services provided by acute care hospitals. Historically, they have been paid on a reasonable cost basis, subject to certain payment limitations and incentives. These hospitals are also held harmless under OPPS and will not receive less from Medicare under this payment system than under the prior outpatient payment system. Under OPPS, Medicare pays for outpatient services using ambulatory payment classification (APS) groups.	*H. §1145.* The Secretary would be required to determine if the costs incurred by cancer hospitals with respect to APCs exceed those costs incurred by other hospitals reimbursed under OPPS. If the costs in cancer hospitals exceed the costs incurred by other hospitals, the Secretary would be required to provide for an appropriate adjustment for cancer hospitals for outpatient services furnished starting January 1, 2011.	*S. §3138.* Identical provision, except that the Senate bill would also require the Secretary when conducting the study to take into consideration the cost of drugs and biologicals incurred by such hospitals.
Payment for imaging services. Current law: Under the Medicare fee schedule, some services have separate payments for the technical component and the professional component. Medicare pays for each of these components separately when the technical component is furnished by one provider and the professional component by another. When both components are furnished by one provider, Medicare makes a single global payment that is equal to the sum of the payment for each of the components. Imaging procedures generally have two parts: the actual taking of the image (the technical component), and the interpretation of the image (the professional component). CMS's method for calculating the Medicare fee schedule reimbursement rate for advanced imaging services	*H. § 1146.* The bill proposes to increase the utilization rate for calculating the payment for advanced diagnostic imaging equipment from 50% to 75%; this would result in a decrease in the payment. In addition, for single session imaging involving continuous body parts, the proposal would reduce the technical component fees for additional imaging services to 50% to reflect efficiency. These modifications would apply to services furnished on or after January 1, 2011.	*S. § 3135.* The proposal would change the utilization rate assumption for calculating the payment for advanced imaging equipment from 50% to 65% for 2010 through 2012. The rate would be further increased to 70% for services provided in 2013 and 75% for services provided during and after 2014. By January 1, 2013, the CMS Chief Actuary would conduct and make publicly available an analysis of whether the cumulative expenditure reductions attributable to these adjustments are projected to exceed $3 billion for the period 2010 through 2019. The Senate bill contains a similar proposal for single session imaging, however it would apply starting July 1, 2010.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
assumes that imaging machines are operated 25 hours per week, or 50% of the time that practices are open for business. Setting the equipment use factor at a lower—rather than at a higher—rate has led to higher payment for these services. Citing evidence showing that the utilization rate is 90%, rather than the 50% previously assumed, MedPAC is urging CMS to use the higher utilization rate in the calculation of fee schedule payments for advanced imaging services.		
Durable medical equipment program improvements – Waiver of surety bond requirement. Current Law: To be eligible to receive a provider number from CMS and bill Medicare, DME suppliers are required to provide the Secretary with a surety bond in the amount of $50,000 or greater. A surety bond issued by a State would satisfy this requirement. The Secretary has the authority to impose these requirements on other Part A and B providers and suppliers, except physicians. Home health agencies are required to provide the Secretary with a surety bond equal to 10% of the aggregate Medicare and Medicaid payments made to the agency for that year or $50,000, whichever is smaller. A surety bond for a home health agency is effective for 4 years, with limited exceptions.	*H. §1147(a).* This bill would waive the surety bond requirement for a pharmacy or supplier that exclusively furnishes eyeglasses or contact lenses, or a pharmacy or supplier that (1) supplies durable medical equipment, prosthetics, orthotics, and supplies, (2) has been issued a provider number for at least 5 years, and (3) has not received an adverse action.	*S. §6402(g).* The provision would give the Secretary the authority to require certain providers and suppliers to provide surety bonds commensurate with the volume of billing. The value of the bond, however, could not be less than $50,000. The Secretary would also have the authority to impose this requirement on other providers and suppliers considered to be at risk by the Secretary.
Durable medical equipment program improvements – Ensuring supply of oxygen equipment. Current Law: Medicare makes rental payments for oxygen equipment. The monthly payments are made for the period of medical need, not to exceed 36-months. The statute requires suppliers to continue furnishing the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, which is defined by the Secretary as 5 years (or 60 months).	*H. §1147(b) and (d).* This bill would modify the time period during which the supplier would be required to furnish medically necessary oxygen and oxygen equipment. As of the 27th month of the 36 month rental period, the supplier furnishing the equipment would be required to continue furnishing the equipment (either directly or through arrangements with other suppliers) during any subsequent period of medical need for the remainder of the reasonable useful lifetime of the equipment regardless of the location of the individual, unless another supplier accepted the responsibility to furnish equipment during the remainder of the period. This	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	provision would apply to equipment furnished to individuals for whom the 27th month of a continuous period of use occurred on or after July 1, 2010. This provision would also allow a beneficiary to begin a new 36 month rental period if the supplier who had been furnishing oxygen and oxygen equipment to the beneficiary was declared bankrupt and its assets were liquidated and at the time of the declaration and liquidation more than 24 months of rental payments had been made.	
Durable medical equipment program improvements – Treatment of current accreditation applications. Current Law: MMA required the Secretary to establish and implement quality and accreditation requirements for Medicare suppliers of DMEPOS. MIPPA exempted a group of health care professionals from having to become accredited unless the Secretary determined the standards were designed specifically to be applied to those professionals. The Secretary was given authority to exempt other professionals from the accreditation. Pharmacies and pharmacists are not exempt from the accreditation requirements. Medicare pays for most DME on the basis of a fee schedule, except in Competitive Acquisition Areas where payments are to be determined based on supplier bids. A supplier must be accredited to be eligible to be a supplier in a Competitive Acquisition Area.	*H. §1147(c).* This bill would exempt pharmacies enrolled as Medicare DMEPOS suppliers from the accreditation requirement for the purposes of supplying diabetic testing supplies, canes, and crutches. Any supplier that had submitted an application for accreditation before August 1, 2009 would retain their Medicare provider or supplier number until an accreditation organization had determined compliance with the accreditation requirement.	*S. §3109.* Like the House bill, the Senate bill would exempt certain pharmacies from the accreditation requirements. Unlike the House bill, the Senate bill allows the Secretary to create and apply an alternative accreditation requirement that would be more appropriate to pharmacies. The Senate bill extends the deadline for accreditation until January 1, 2011 for pharmacies. A pharmacy that would be exempt from the accreditation requirement (if the Secretary did not create and apply alternative accreditation requirements) would be a pharmacy identified by the following circumstances: (1) the pharmacy submits an attestation that its total Medicare DMEPOS billings are and continue to be less than a rolling three year average of five percent of total pharmacy sales; (2) the pharmacy submits an attestation that it is enrolled as a provider of durable medical equipment, prosthetics, orthotics, and supplies under the Medicare program for at least 5 years and has had no adverse determination against it for the last 5 years due to fraud; and (3) the pharmacy is willing to submit documentation to the Secretary (based on a random sample of pharmacies) that would allow the Secretary to verify the information in (1) and (2). The documentation submitted for (3) would be required to consist of an accountant certification or filing of tax returns by the pharmacy. This provision would not affect accreditation requirements for pharmacies to qualify for competitive

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		bidding.
Bone mass measurement. Current Law: Dual energy X-ray absorptiometry (DXA) machines are used to measure bone mass to identify individuals who may have, or be at risk of having, osteoporosis. For those individuals who are eligible, Medicare will pay for a bone density study once every two years, or more frequently if the procedure is determined to be medically necessary. As reported by CMS and MedPAC, spending for imaging services reimbursed under the Medicare physician fee schedule grew rapidly between 2003 and 2005. The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) capped reimbursement of the technical component for x-ray and imaging services at the lesser rate of the hospital outpatient rate or the physician fee schedule. Specifically, designated imaging services with a Medicare physician fee schedule technical payment (prior to geographic adjustment) that exceeds the comparable hospital outpatient prospective payment system (HOPPS) technical payment (prior to geographic adjustment), are capped at the 2007 HOPPS payment amount. (The professional component is not affected by the DRA provision.) Bone density procedures are subject to the DRA provisions. Payments for imaging services have also been affected by revisions to payments for practice expense in the 2007 physician fee schedule rule. CMS implemented a new methodology for determining resource-based practice expense payments for all services that has led to reductions in the professional component reimbursement. The new formula is being phased in over four years from 2007 to 2010.	*H. §1148.* The Medicare Payment Advisory Commission would be required to conduct a study regarding bone mass measurement, including computed tomography, dual-energy x-ray absorptiometry, and vertebral fracture assessment. The study would focus on the following: (1) an assessment of the adequacy of Medicare payment rates for such services, taking into account costs of acquiring the necessary equipment, professional work time, and practice expense costs; (2) the impact of Medicare payment changes since 2006 on beneficiary access to bone mass measurement benefits in general and in rural and minority communities specifically; (3) a review of the clinically appropriate and recommended use among Medicare beneficiaries and how usage rates among such beneficiaries compare to such recommendations; and (4) in conjunction with the findings under (3), recommendations, if necessary, regarding methods for reaching appropriate use of bone mass measurement studies among Medicare beneficiaries. Not later than 9 months after enactment, the Commission would submit a report to the Congress containing a description of the results of the aforementioned study and the conclusions and recommendations, if any, regarding each of the issues described above.	*S. §3111.* This provision would set payments for DXA at 70% of the 2006 reimbursement rates for these services in 2010 and 2011. The provision would also direct the Secretary to arrange with the Institute of Medicine of the National Academies to study and report to the Secretary and Congress on the ramifications of Medicare reimbursement reductions for DXA on beneficiary access to bone mass measurement benefits.
Timely access to post-mastectomy items. Current Law: A breast prosthesis is covered by Medicare Part B for a patient who has *had* a mastectomy. An external breast prosthesis garment, with mastectomy form is covered for use in the	*H. §1149.* By not later than January 1, 2011, the bill would specify that payment for post-mastectomy external breast prosthesis garments would be made regardless of whether the items were supplied to the beneficiary prior	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis. The breast prosthesis and garment are not covered by Medicare prior to the mastectomy or breast cancer surgery as there is no medical need for the items.	to or after the mastectomy procedure or other breast cancer surgical procedure. The Secretary would be required to develop policies to ensure appropriate beneficiary access and utilization safeguards.	
Payment for biosimilar biological products. Current Law: A biologic is a preparation, such as a therapeutic product or a vaccine, that is made from living organisms. Medicare Part B pays for a limited number of drugs and therapeutic products, including biologics, administered to patients in physician offices and hospital outpatient departments, or those administered through durable medical equipment (DME) and billed by pharmacy suppliers. CMS assigns a Healthcare Common Procedure Coding System (HCPCS) code to each drug, and Medicare payments for Part B drugs are based on the average sales price (ASP) for each HCPCS code. Medicare payment for Part B drugs equals 106% of the applicable price for a multiple or single source drug. CMS uses the same HCPCS code for all drug products listed as therapeutically equivalent in FDA's *Orange Book*. Therefore, a brand-name drug and any generic versions of the same drug would have the same drug code and the prices would be averaged together for ASP determinations.	*H. §1149A.* Under this provision, interchangeable biological products and their reference biological product would be included in the same billing and payment code and reimbursed at ASP, as determined using the methodology for multiple source Part B drugs, plus 6% of this ASP. A biosimilar product would be reimbursed at ASP, using the methodology applied to such biosimilar biological product for all National Drug codes assigned to such product in the same manner as applied to single source drugs, plus 6% of that ASP or, when applicable, 6% of the ASP of the reference biological product. If a biological product is the reference product for both an interchangeable biological product and a biosimilar product, its reimbursement would be based on the ASP methodology (plus 6%) used for multiple source drugs. An interchangeable biological product would mean a biologicial product licensed as an interchangeable biological product under the Public Health Service Act (PHSA), and a biosimilar biological product would be defined as a biological product licensed as a biosimilar biological product under the PHSA. The term "reference biological product" would mean the licensed biological product that is referred to in the application for the biosimilar or interchangeable biological product. This provision assumes enactment of Section 2575 of the Act which would expand the regulatory activities of FDA by opening a licensure pathway for the approval of biosimilars.	*S. §3139.* The Senate bill would set prices for biosimilar products using a similar methodology as H.R. 3962. The Senate bill, however, does not establish a reimbursement methodology for interchangeable biological products. Specifically, the provision would allow a Part B biosimilar product approved by the Food and Drug Administration and assigned a separate billing code to be reimbursed at the ASP of the biosimilar plus 6% of the ASP of the reference product. (The term reference biological product means the licensed biological product that is referred to in the application for the biosimilar product.) This provision assumes the enactment of Title VII of the Senate bill that would expand the regulatory activities of FDA by opening a pathway for the approval of biosimilars.
Study and report on DME competitive bidding process. Current Law: Medicare Part B covers a wide variety of	*H. §1149B.* This bill would require the Comptroller General of the United States to conduct a study to evaluate the	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
durable medical equipment, prosthetics, orthotics, and other medical supplies (DMEPOS) if they are medically necessary and are prescribed by a physician. Medicare pays for most DME on the basis of a fee schedule. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, P.L.108-173) required the Secretary to establish a competitive acquisition program for specified durable medical equipment; the competitive acquisition program is to use payments based on *suppliers*' bids to replace the Medicare fee schedule payments. The program is to be phased-in, starting in nine of the largest metropolitan statistical areas (MSAs) in 2009 (round 1); expanding to an additional 70 of the largest MSAs in 2011 (round two) and remaining areas after 2011.	potential establishment of a program under Medicare to acquire DMEPOS through a competitive bidding process among *manufacturers* of medical equipment and supplies. The study would be required to address (1) identification of appropriate types of DME for the program, (2) recommendations of the structure of an acquisition program to promote fiscal responsibility and beneficiary access, (3) recommendations on how to phase-in a program and on what geographic level, (4) recommendations on criteria (in addition to price) that could be factored into the bidding, (5) recommendations on how suppliers could be compensated for furnishing and servicing equipment and supplies acquired in the program, (6) comparison of such program to the current Medicare DMEPOS competitive acquisition program, as well as other federal acquisition programs, and (7) other relevant considerations. The study would be required to be submitted to Congress not later than 12 months from enactment.	
Adjust the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program. Current Law: Medicare Part B covers a wide variety of durable medical equipment, prosthetics, orthotics, and other medical supplies (DMEPOS) if they are medically necessary and are prescribed by a physician. Medicare pays for most DME on the basis of a fee schedule. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, P.L.108-173) required the Secretary to establish a competitive acquisition program for specified durable medical equipment; the competitive acquisition program is to use payments based on *suppliers*' bids to replace the Medicare fee schedule payments. The program is to be phased-in, starting in nine of the largest metropolitan statistical areas (MSAs) in 2009 (round 1); expanding to an additional 70 of the largest MSAs in 2011 (round two) and remaining areas after 2011.	No provision.	*S. §6410.* The proposal would expand the number of areas included in round two of the program to 100 of the largest MSAs (from 79 MSAs under current law). The Secretary would extend the program, or apply competitively-bid rates, to remaining areas by 2016. All other provisions in current law would remain in place, such as the Secretary's discretion to exempt rural areas and areas with low population density within a MSA.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Starting in 2011, the Secretary has the authority to use information on payments determined in competitive acquisition areas to adjust payments for items and services in non-competitive acquisition areas. Before 2015, the following three types of areas are exempt from the competitive acquisition program: (a) rural areas; (b) metropolitan statistical areas (MSA) not selected under round 1 or round 2 with a population of less than 250,000; and (c) areas with a low population density within an MSA that is otherwise selected to be part of the competitive acquisition program.		
Develop prospective payment system (PPS) for FQHCs. Current Law: Generally, Medicare pays FQHCs an all-inclusive per visit payment amount based on reasonable costs as reported on its annual cost report subject to certain payment limits. Including productivity screens. The beneficiary pays no Part B deductible for FQHC services but is responsible for paying a coinsurance with the exception of FQHC-supplied influenza and pneumococcal vaccines (which Medicare pays at 100%). The coinsurance for FQHC services is 20% of the clinic's reasonable and customary billed charges except for mental health treatment services. FQHCs that contract with Medicare Advantage (MA) plans receive rates from the plan comparable to the rates paid to other providers for similar services. FQHCs are then entitled to receive additional payments from the Medicare program equal to the difference between the amount received from the plan and what they would otherwise receive as a Medicare FFS payment .	No provision.	*S. §10501(i).* A new Section 1834(o) of the SSA for the development and implementation of a new PPS for FQHC services would be established. The PPS would establish payment rates for specific codes that would take into account the type, intensity and duration of services. It could include appropriate geographic adjusters. FQHCs would be required to submit necessary data no later than January 1, 2011. The new payment system would be established for cost reporting periods beginning on or after October 1, 2014. Initial FQHC payments under the new PPS would equal 100% of reasonable costs (determined without application of a per visit payment limit or productivity screen) that would have been reimbursed if the PPS system had not been implemented. In subsequent years, payments rates would be increased by the MEI (in the first year) or by a MB promulgated by regulations if available. FQHC payment codes would be able to be implemented by program instruction. Program payments for FQHC services would be made at 80% of the lesser of actual charge or the PPS amount. FQHCs that contract with MA plans would receive what they would otherwise receive under the new PPS. Medicare's payments for FQHCs services would no longer be subject to reasonableness tests.

Subtitle C – Provisions Related to Medicare Parts A and B

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Reducing potentially preventable hospital readmissions. *Reducing potentially preventable hospital readmissions in acute care hospitals.* Current Law: Medicare pays for most acute care hospital stays using a prospectively determined payment for each discharge. Payment also depends on the relative resource use associated with a patient classification group, referred to as the Medicare Severity Diagnosis Related Groups (MS-DRGs), to which the patient is assigned based on an estimate of the relative resources needed to care for a patient with a specific diagnosis and set of care needs. Medicare's IPPS includes adjustments that reflect certain characteristics of the hospital. For instance, a hospital with an approved resident training program would qualify for an indirect medical education (IME) adjustment; hospitals that serve a sufficient number of poor Medicare or Medicaid patients would receive higher Medicare payments because of their disproportionate share hospital (DSH) adjustment; a few hospitals receive a low volume payment adjustment because they treat a small number of Medicare patients. Certain types of hospitals that qualify as sole community hospitals (SCHs) or Medicare dependent hospitals (MDHs) receive additional hospital specific payments. Hospitals in Maryland are not paid using IPPS; rather they receive Medicare payments based on a state-specific Medicare reimbursement system. Medicare pays for inpatient services in other types of hospitals such as IRFs, IPFs, children's hospitals, and LTCHs hospitals using different reimbursement systems.	*H. §1151.* Starting for discharges on October 1, 2011, the Secretary would establish a hospital readmissions reduction program for certain potentially preventable Medicare inpatient hospital readmissions covering 3 conditions with high volume or high rate (or both). Medicare's base operating DRG payment amounts would be reduced by an adjustment factor. The base operating DRG payment amount is the base amount that would have been paid under IPPS reduced by payments associated with IME and DSH. In the case of hospitals in Maryland, the base amount would be the payment amount under their state system. Certain components of Medicare hospital payments would be exempt from these payment reductions including IME and DSH. IPPS hospitals and acute care hospitals in Maryland paid under a state-specific Medicare payment system would receive reduced payments for potentially preventable hospital readmissions; hospitals with lower potentially preventable readmission rates would receive smaller payment reductions while hospitals with higher potentially preventable readmission rates would receive higher payment reductions. Reduced hospital payments for readmissions would be calculated by multiplying the base operating DRG payment amount by an adjustment factor.	*S. §3025 as modified by S. §10309.* Same general policy as H.R.3962 with certain exceptions. Payment reductions would start for discharges on October 1, 2012 (not October 1, 2011). The base operating amount would exclude outlier and low volume payments as well as IME and DSH payments. Also, hospital specific payments made to SCHs and MDHs (only for FY2012 and FY2013) would be exempt as well. Finally, acute care hospitals in Maryland would be exempt from these payment adjustments if a comparable state program achieves the same or higher patient outcomes and cost savings.
Establish an adjustment factor, either a floor adjustment factor or a ratio. Current Law: No provision.	*H. §1151* The adjustment factor for a hospital in a fiscal year would be the greater of (1) a floor adjustment factor	*S. §3025 as modified by S. §10309.* Same general policy as House bill. The floor adjustment factor would be 0.99 of the discharge payments in

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	equal to a reduced percentage of the discharge payment or (2) the excess readmissions ratio for the applicable fiscal year. The floor adjustment factor would be 0.99 of the discharge payments in FY2012, 0.98 of the discharge in FY 2013, 0.97 in FY 2014; or 0.95 in subsequent fiscal years. The excess readmissions ratio would equal 1 minus the ratio of the aggregate payments for excess readmissions for the hospital divided by the aggregate payments for all discharges. Aggregate payments for excess readmissions for a hospital for a fiscal year would be the sum for applicable conditions of the product of the base operating DRG payment for that condition multiplied by the number of admissions for that condition multiplied by the excess readmissions ratio minus one. The excess readmissions ratio is the ratio of the risk adjusted readmissions based on actual readmissions divided by the risk adjusted expected readmissions. This number would not be less than one. The ratio would be calculated for each applicable condition for a hospital for the applicable period. The aggregate payments for all discharges would be calculated as the sum of the hospital's base operating DRG payments for all discharges for all conditions for such a fiscal year.	FY2013 (not FY2012), 0.98 of the discharge in FY2014 (not FY2012), 0.97 in FY2015 (not FY2014) and remain 0.97 in subsequent fiscal years (not 0.95 in subsequent years).
Adjust readmissions ratio in FY2014. Current Law: No provision.	*H. §1151.* To encourage hospitals to continue to reduce their potentially preventable readmission rates over time, beginning with discharges for FY2014, the Secretary would be able to determine the excess readmissions ratio based on a ranking of hospitals by readmission ratios (from lower to higher readmissions) normalized to a benchmark that is lower than the 50th percentile.	No provision.
Exclude conditions with low volume discharges. Current Law: No provision.	*H. §1151.* Excess readmissions for any hospital would not include readmissions for conditions with an insufficient number of discharges for an applicable period as determined by the Secretary.	*S. §3025 as modified by S. §10309.* Same provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Define applicable condition and role of consensus based organization. Current Law: No provision.	*H. §1151.* An applicable condition would be defined as a condition or procedure that represents high volume or high expenditures for Medicare or meets other specified criteria that also satisfies certain measures of readmissions. These measures of readmission would be those that have been endorsed by a consensus based entity with a performance measurement contract under 1890 of the Social Security Act, excluding readmissions that are unrelated to the prior discharge (such as a planned readmission or transfer to another applicable hospital). Readmission would be defined as an admission to the hospital of an individual who had been discharged from either the same or another applicable hospital within a time period from the date of discharge as specified by the Secretary.	*S. §3025 as modified by S. §10309.* Same provision.
Expand applicable conditions. Current Law: No provision.	*H. §1151.* Starting in FY2012, the Secretary would select three applicable conditions that have been endorsed by the consensus based entity as of the date of enactment. Beginning with FY2013, the Secretary would be required to expand the list of applicable conditions for such readmissions to include 4 conditions identified by the MedPAC in its June 2007 Report to Congress. The Secretary would also be able to include an appropriate all-condition measure of readmissions. In expanding the list of conditions, the Secretary would be required to seek the endorsement by a consensus-based entity, but would be able to apply such conditions with such endorsement	*S. §3025 as modified by S. §10309.* The same provision, but starting in FY2013. Beginning in FY2015, to the extent practicable, the number of applicable conditions would be expanded beyond the initial 3 conditions to 4 additional conditions that were identified by MedPAC in its June, 2007, Report to Congress and other appropriate conditions. These additional conditions would not be required to be endorsed by a consensus based organization in the case of a specified area or medical topic for which a feasible and practical measure has not been endorsed as long as due consideration has been given to measures that have been endorsed or adopted.
Limit administrative and judicial review. Current Law: No provision.	*H. §1151.* No administrative or judicial review or otherwise could be conducted of the determination of the base operating DRG amounts; the methodology for determining the adjustment factor and its various components (excess readmissions ratio, aggregate payments for excess	*S. §3025 as modified by S. §10309.* Same provisions precluding review of the determination of the base operating DRG amounts; the methodology for determining the adjustment factor and its various components (excess readmissions ratio, aggregate payments for excess readmissions and aggregate

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	readmissions and aggregate payments for all discharges, applicable conditions, and applicable periods); measures of readmissions; the determination of a targeted hospital for additional DSH payments, the increase in DSH payments, the aggregate DSH cap, the hospital-specific DSH limit, and the form of DSH payment.	payments for all discharges, applicable conditions, and applicable periods) as well as measures of readmissions.
Monitor hospitals' actions to avoid certain patients. Current Law: No provision.	*H. §1151.* The Secretary would be required to monitor activities of applicable hospitals to determine if such hospitals took the steps to avoid patients at risk to reduce the likelihood of increasing readmissions for applicable conditions. If the Secretary would determine that such a hospital had taken such steps, the Secretary could impose an appropriate sanction after having provided notice to the hospital and the opportunity for that hospital to alleviate such steps.	No provision.
Special treatment for DSH hospitals. Current Law: No provision.	*H. §1151.* For fiscal years beginning on or after FY2011, the Secretary would be required to increase DSH payments to targeted hospitals that received $10 million or more in disproportionate share payments in their most recently settled cost report. These targeted hospitals would be required to provide satisfactory assurances that the increased payments would be used for transitional care activities. These would be activities designed to address the patient noncompliance issues that result in higher than normal readmission rates, such as one or more of the following: (1) providing care coordination services to assist in transitions from the targeted hospital to another setting; (2) hiring translators and interpreters; (3) increasing services offered by discharge planners; (4) ensuring that individuals receive a summary of care and medication orders upon discharge; (5) developing a quality improvement plan to assess and remedy preventable readmission rates; and (6) assigning discharged individuals to a medical home; and (7) doing other activities as determined by the Secretary.	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	The Secretary would estimate the percent of the DSH increase subject to aggregate and hospital-specific caps. In the aggregate, increases would not exceed 5% of the estimated savings that would occur in a fiscal year from hospital readmissions policies describe above. For specific hospitals, DSH increases would not exceed the estimated difference in spending that would occur in a fiscal year for a hospital due to the application of the excess readmissions policy. The Secretary would make these additional DSH payments on a lump sum basis, a periodic basis, a claim by claim basis or in any other form deemed appropriate. Not later than 3 years after funds are first made available, GAO would be required to submit a report on the use of such funds.	
Report hospital specific readmission rate information for acute care hospitals. Current Law: No provision.	No provision	*S. §3025 as modified by S. §10309.* Readmission information for acute care hospitals would be made publically available after a hospital has the opportunity to review and correct the data prior to being made public. Readmission data for all patients would be submitted by acute care hospitals, IRFs, IPFs, children's hospitals, and LTCHs and be made publically available after appropriate review. The required data would be able to be submitted by a state or other appropriate entity rather than by each hospital. The information would be posted on the Hospital Compare Internet website in an easily understood format.
Establish program to improve readmission rates. Current Law: No provision.	No provision	*S. §3025 as modified by S. §10309.* No later than two years after enactment, a program to improve readmission rates through the use of patient safety organizations would be established for eligible hospitals. An eligible hospital would be those with historically high rates of risk adjusted readmissions that have not taken appropriate steps to reduce readmissions and improve patient safety. Eligible hospitals and patient safety organizations would report on the processes used to improve readmission rates and resulting impact on such readmissions.

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Apply readmission policy to Critical Access Hospitals (CAHs) . Current Law: CAHs are limited-service facilities that are located more than 35 miles from another hospital (15 miles in certain circumstances) or designated by the state as a necessary provider of health care; offer 24-hour emergency care; have no more than 25 acute care inpatient beds; and have a 96-hour average length of stay. Medicare pays CAHs on the basis of 101% of the reasonable costs of the facility for inpatient and outpatient services. Certain aspects of the CAH payment system are not subject to administrative or judicial review.	*H. §1151.* CAHs would receive reduced payments for preventable hospital readmissions starting for cost reporting periods beginning in FY2012 and in subsequent fiscal years. The adjustment factor for acute care hospitals would be applied. The methodology for determining the adjustment factor, including the determination of aggregate payments for actual and expected readmissions, applicable periods, applicable conditions and measures of readmission would not be subject to administrative or judicial review.	No provision.
Apply readmission policy to post acute care (PAC) providers (SNFs, IRFs, home health agencies, HHA, and LTCHs) Current Law: PAC providers are paid under separate, unique prospective payment systems. Certain special provisions will apply for certain discharges from long term care hospitals (LTCHs) that are considered interrupted stays. An interrupted stay is a case where a LTCH patient is discharged and then admitted directly to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF), or a swing-bed and then returns to the same LTCH within a fixed period of time which varies by provider type. The limit is 9 days or less in an acute care hospital; 27 days or less in an IRF; 45 days or less in an SNF or in a swing-bed. If the patient returns to the LTCH within these fixed limits, Medicare treats the case as an interrupted stay and only one payment to the LTCH is made.	*H. §1151.* The proposal would also reduce Medicare payments on certain claims from PAC providers for patients readmitted to an applicable hospital or a CAH. LTCH interrupted stays cases would not be included in this policy. If the Medicare claim submitted by a post acute provider indicates that the patient was readmitted to a hospital from a post acute care provider or admitted from home and under the care of an HHA within 30 days of an initial discharge from a hospital or a CAH, payments to post-acute providers would be reduced by 0.996 for the fiscal year or rate year 2012; 0.993 for the fiscal or rate year 2013; and 0.99 for fiscal or rate year 2014. This policy would apply to the discharges or services furnished on or after the first day of the rate year, beginning on or after October 1, 2011. The Secretary would be required to develop appropriate measures of readmissions rates for post acute care providers, submit such measures for endorsement through a consensus-based entity under contract, but may adopt and apply such measures without endorsement. The Secretary would be able to expand	No provision.

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	such measures in the same manner as for applicable hospitals established earlier in the legislation. The Secretary would adopt similar payment policies applied to applicable hospitals and CAHS for post acute providers on or after October 1, 2014. Post acute providers would also be subject to the monitoring and penalties established for applicable hospitals and CAHs earlier in this proposed legislation.	
Study the extension of readmissions policy to physicians. Current Law: No provision.	*H. §1151.* The Secretary would be required to conduct a study to determine how this readmissions policy could be applied to physicians and issue a public report no later than one year after enactment. Such approaches would be required to be considered: (1) creating a code (or codes) and budget neutral payment amount(s) under the fee schedule for services furnished by an appropriate physician who sees an individual within the first week after discharge from a hospital or CAH; (2) developing measures of readmissions rates for individuals treated by physicians; (3) applying a payment reduction for physicians who treat the patient during the initial admissions that results in a readmission; and (4) methods for attributing payments or payment reductions to the appropriate physician or physicians.	No provision.
Funding for readmission section. Current Law: No provision.	*H. §1151.* Annual appropriations of $25 million would be made to the Program Management Account of CMS starting FY2010. The funds would be available until expended.	No provision.
Reduce Medicare payments for conditions acquired in hospitals. Current Law: Medicare pays acute care hospitals using the inpatient prospective payment system (IPPS), where each patient is classified into a Medicare severity adjusted diagnosis-related group (MS-DRG). Generally, except for outlier cases, a hospital receives a predetermined amount for a given MS-DRG regardless of the services provided to a patient. In some instances,	No provision.	*S. §3008.* Starting for discharges during FY2015, IPPS hospitals in the top quartile of national, risk-adjusted hospital acquired condition (HAC) rates for an applicable period in a fiscal year would receive 99% of their otherwise applicable payment. Acute care hospitals in Maryland paid under their state specific Medicare system would be exempt if an annual report documents that a similar state program achieves at least comparable quality

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Medicare patients may be assigned to a different MS-DRG with a higher payment rate based on secondary diagnoses. Starting October 1, 2008, hospitals did not receive additional Medicare payment for complications that were acquired during a patient's hospital stay for certain select conditions. These hospital acquired conditions (HACs) are: (1) high cost, high volume, or both; (2) identified though a secondary diagnosis that will result in the assignment to a different, higher paid MS-DRG; and (3) reasonably preventable through the application of evidence-based guidelines.		outcomes and cost savings. Prior to FY2015, the hospitals would receive confidential reports with respect to their HAC conditions which would be made publicly available on the Hospital Compare Internet website after the hospital has the opportunity to review and correct the data. There would be no administrative or judicial review of certain aspects of the program. The Secretary would submit a report to Congress by January 1, 2012, with recommendations with respect to expanding Medicare's HAC payment policy to other facilities, including IRFs, LTCHs, HOPDs, IPFs, cancer hospitals, SNFs, ASCs and health clinics. In addition, Sec. 3013(b) as modified by Sec. 10303(b) would require the Secretary to the extent practicable, to publicly report on measures for hospital-acquired conditions that are currently used by CMS for the adjustment of payment to hospitals based on rates of hospital-acquired infections.
Post acute care services payment reform plan and bundling pilot program Current Law: As Medicare beneficiaries with complex health conditions and multiple co-morbidities move between hospital stays and a range of post-acute care providers, Medicare makes separate payments to each provider for covered services. Medicare pays for hospitals and most post-acute care (PAC) services, including skilled nursing facilities (SNF), long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), and HH, under prospective payment systems (PPS) established for each type of provider. Payments across PAC settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar. The Medicare Payment Advisory Commission (MedPAC), among others, has suggested that Medicare test new incentives and payment models to encourage providers to better coordinate across patients' episodes of care and to evaluate the full spectrum of care a	*H. §1152(a) and (b).* *Plan details:* The Secretary would be required to develop a detailed plan for bundling payments for Medicare's post-acute care services (i.e., Medicare-covered services by SNFs, IRFs, LTCHs, hospital based outpatient rehabilitation facilities, and HHAs services provided after discharge from a hospital, and as determined appropriate by the Secretary). The goals of this payment reform plan would be to improve the coordination, quality and efficiency of post-acute care services and improve outcomes for individuals such as reducing the need for readmission to hospitals from providers. The plan would be required to include consideration of the following issues: (1) the nature of payments under a post acute care bundle, including the type of provider or entity to whom payment should be made, the scope of activities and services included in the bundle, whether payment for physicians' services should be included in the bundle, and	S. *§3023 as modified by S. §10308* No provision. However, a related provision, *S. §3023 as modified by S.§10308 which* would create a National Pilot Program on Payment Bundling is described below. The Secretary would be able to expand the pilot program at any point after January 1, 2016 if certain conditions were met.

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patient may receive during these episodes.	the period covered by the bundle. (2) Whether the payment would be consolidated with the payment under the inpatient prospective system or a separate payment should be established for such bundle, and if a separate payment is established, whether it should be made only upon use of post acute care services or for every discharge. (3) Whether the bundle should be applied across all categories of providers of inpatient services (including critical access hospitals) and post acute care services or whether it should be limited to certain categories of providers, services, or discharges, such as high volume or high cost MS-DRGs. (4) The extent to which payment rates could be established to achieve offsets for efficiencies that could be expected to achieve with a bundle payment, whether such rates should be established on a national basis or for different geographic areas, should vary according to discharge, case mix, outliers, and geographic differences in wages or other appropriate adjustments, and how to update such rates. (5) The nature of protections needed for individuals under a system of bundled payments to ensure that individuals receive quality care, are furnished the level and amount of services needed as determined by an appropriate assessment instrument, are offered choice of provider, and the extent to which transitional care services would improve quality of care for individuals and the functioning of a bundled post-acute system. (6) The nature of relationships that may be required between hospitals and providers of post acute care services to facilitate bundled payments, including the application of gainsharing, anti-referral, anti-kickback, and anti-trust laws. (7) Quality measures that would be appropriate for reporting by hospitals and post acute providers (such as measures that assess changes in functional status and quality measures appropriate for each type of post acute services provider including how the reporting of such	

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	quality measures could be coordinated with other reporting of such quality measures by such providers otherwise required. (8) How cost-sharing for a post acute care bundle should be treated relative to current rules for cost-sharing for inpatient hospital, HH, SNF, and other services. (9) How other programmatic issues should be treated in a post acute care bundle, including rules specific to various types of post-acute providers such as the post-acute transfer policy, three-day hospital stay to qualify for services furnished by SNFs, and the coordination of payments and care under the Medicare and Medicaid programs. (10) Such other issues as the Secretary deems appropriate. *H. §1152(c). Consultations, Analysis and Data Collection:* In developing the plan, the Secretary would be required to consult with relevant stakeholders and would be required to consider experience with such research studies and demonstrations that the Secretary determines appropriate. The Secretary would be required to (A) analyze the issues described above and other issues that the Secretary determines appropriate; (B) analyze the impacts (including geographic impacts) of post acute service reform approaches, including bundling of such services on individuals, hospitals, post acute care providers, and physicians; (C) use existing data (such as data submitted on claims) and collect such data as the Secretary determines are appropriate to develop this plan; and (D) if patient functional status measures are appropriate for the analysis, to the extent practical, build upon the CARE tool being developed. *H. §1152(d). Funding:* In addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there would be appropriated to the Secretary for the CMS Management Account, $15 million for each of FYs 2010 through 2012. Such	

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	amounts would be required to be available until expended. *H. §1152(e).* In addition to issuing interim public reports on a periodic basis, the Secretary would be required to issue a final public report on this plan no later than three years after this Act's enactment.	
Post acute care services payment reform plan and bundling pilot program – conversion of demonstration to pilot program and expansion of post acute services. Current Law: The Deficit Reduction Act of 2005 (P.L. 109-171) required the Centers for Medicare and Medicaid Services (CMS) to develop a Post Acute Care Payment Reform Demonstration (PAC demonstration) to standardize patient assessment information from PAC settings and to use these data to guide payment policy in the Medicare program. This demonstration began in 2008 and a report is expected to be submitted to Congress by the Secretary in 2011. CMS has also established a three-year Acute Care Episode (ACE) Demonstration to test the effects of using a bundled payment for hospital and physician services for a set of 9 orthopedic and 28 cardiovascular conditions. There are five participants in the ACE demonstration which began early in 2009.	*H. §1152(f) –* *Creates new SSA§1866D(a)(1),(b),(c) and (d).* For purposes of promoting the use of bundled payments to promote efficiency, coordinated, and high quality delivery of care, this provision would also require the Secretary, by no later than January 1, 2011 to convert the acute care episode demonstration into a pilot program. Expansion could occur only if the demonstration increases quality of care and reduces program expenditures, resulting in estimated spending that would be less than what it would otherwise be. The Secretary would also be required to expand the program to include post-acute services and such other services the Secretary determines, possibly including transitional services. The Secretary would be required to set specific goals for the number of acute and post-acute bundling test sites under the pilot to ensure that over time the pilot would be sufficient in size and scope to: (1) test the approaches under the pilot program in a variety of settings, including urban, rural, and underserved areas; (2) include geographic areas and additional conditions that account for significant program spending, as defined by the Secretary; and (3) subject to CMS' Chief Actuary's certification regarding whether expansion of the pilot would result in lower spending, disseminate the pilot program rapidly on a national basis. To the extent that the Secretary finds inpatient and post-acute care bundling to be successful in improving quality and reducing costs, the Secretary would be required to implement such mechanisms and reforms under the pilot	*S. §3023 as modified by S. §10308* *Creates new SSA§1866C.* The Senate bill would not require the conversion of an acute care episode demonstration, but would require the Secretary, by no later than January 1, 2013, to establish, test, and evaluate alternative payment methodologies for Medicare services through a five-year, national, voluntary pilot program that would be designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care around a hospitalization. Under this pilot program, integrated care would be delivered to applicable beneficiaries during an episode of care around a hospitalization to improve coordination, quality, and efficiency. *New SSA§1866C* (c)(1). The Secretary would be able to expand the duration and scope of the pilot project at any point after January 1, 2016 if the Secretary determines that such expansion would reduce Medicare spending without reducing quality of care or improve the quality of care and reduce spending. The Chief Actuary of CMS would certify that an expansion would reduce Medicare spending. Finally, the Secretary would determine that an expansion would not deny or limit the coverage or provision of Medicare benefits. No later than 3 years after the implementation of the pilot program, the Secretary would be required to submit to Congress a final report on the evaluation's results. *New SSA§1866C* (g). The Secretary would separately test the continuing care hospital model which would be tested without the limitation of 10 conditions. An episode of care would be the full period that a patient

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	on as large a geographic scale as practical and economical.	stays in a continuing care hospital plus the first 30 days following discharge from the hospital. A continuing care hospital would be an entity that had demonstrated its ability to meet patient care and safety standards and provides under common management medical and rehabilitation services provided by IRFs, LTCHs, and SNFS that are located in an acute care hospital.. *New SSA§1866C* (h). Regulations related to the coordination of federal information policy, found in Chapter 35 of title 44 of the US Code, would not apply to the selection, testing, evaluation, or expansion of this pilot.
Post acute care services payment reform plan and bundling pilot program – Payments under the pilot. Current Law: No provision.	*H. §1152(f)* *Creates new SSA§1866D(a)(2).* Under this pilot program, the Secretary could apply bundled payments to: (i) hospitals and physicians; (ii) hospitals and post-acute-care providers; (iii) hospitals, physicians, and post-acute care providers; or (iv) combinations of post-acute providers. The Secretary would be required to apply bundled payments so as to include collaborative care networks and continuing care hospitals. Collaborative care networks would mean a consortium of health care providers that provide a comprehensive range of coordinated and integrated health care services to low-income patient populations (including the uninsured) which may include coordinated and comprehensive care by safety net providers to reduce any unnecessary use of items and services furnished in emergency departments, manage chronic conditions, improve quality, and efficiency of care, increase preventive services and promote adherence to post-acute and follow-up care. Continuing care hospitals would mean entities that have demonstrated the ability to meet patient care and patient safety standards and that provide under common management the medical and rehabilitation services provided in inpatient rehabilitation hospitals and units, long-term care hospitals, and skilled nursing facilities located in a long-	*S. §3023 as modified by S. §10308* *Creates new SSA§1866C(a)(2)(D) and (c)(3).* The Secretary would be required to develop provider payment methods that could include bundled payments and bids from entities for episodes of care. *New SSA§1866C(a)(2)(D).* Unless otherwise established by the Secretary, an episode of care would include the three days prior to a hospital admission for an applicable condition, the hospital length of stay, and 30 days following discharge. *New SSA§1866C(c)(3).* The bundled payment would comprehensively cover the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary). Payments for items and services could not result in spending more than would otherwise be expended for such entities if the pilot program were not implemented. The payment methodology would also include payment for services, such as care coordination, medication reconciliation, discharge planning and transitional care services, and other patient-centered activities, as determined appropriate by the Secretary. The Secretary would also be required to establish procedures for payment in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care.

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	term care hospital.	
Post acute care services payment reform plan and bundling pilot program – Voluntary participation. Current Law: No provision.	*H. §1152(f) – New SSA§1866D(e).* Participation in this pilot would be voluntary and nothing would limit the number of hospitals, physician groups, nor hospital and post-acute provider groups that may participate in the pilot.	*S. §3023 as modified by S. §10308 – New SSA§1866C(c)(2).* Any Medicare provider of services and suppliers, including hospitals, physician groups, SNFs, and HHAs could apply to the Secretary to participate in this pilot. The Secretary would be required to develop participation requirements for this pilot that would ensure adequate beneficiary choice of providers and suppliers.
Post acute care services payment reform plan and bundling pilot program – Evaluation of pilot. Current Law: No provision.	*H. §1152(f) – New SSA§1866D(f) and (g).* The Secretary would be required to conduct an evaluation of the pilot program to study its effect on program costs and care quality. Findings would be included in the final report (*H. §1152(f)(2)* of the Affordable Health Care for America Act). Secretary would also be required to provide a study of and development of a plan, that could be implemented by the Secretary in a demonstration, to test additional ways to increase bundling of payments for physicians in connection with an episode of care.	*S. §3023 as modified by S. §10308 – New SSA§1866C(e).* The Secretary would also be required to conduct an independent evaluation of the pilot, including an examination of the extent to which the pilot had improved quality measures, improved health outcomes, improved beneficiary access to care and reduced Medicare spending. No later than 2 years after the pilot's implementation, the Secretary would be required to submit to Congress a report on the initial results of the independent evaluation.
Post acute care services payment reform plan and bundling pilot program – Applicable beneficiaries. Current Law: No provision.	No provision.	*S. §3023 as modified by S. §10308 – New SSA§1866C(a)(2)(A) and (b)(1).* *New SSA§1866C(a)(2)(A)* . Applicable beneficiaries would mean individuals who are entitled to or enrolled in Medicare Part A, and enrolled for benefits under Medicare Part B. Beneficiaries could not be enrolled in Medicare Advantage or a Program for All-Inclusive Care for the Elderly (PACE). Beneficiaries could have one or more of ten conditions selected by the Secretary. In selecting these conditions, the Secretary would be required to consider: (1) whether the conditions selected include a mix of chronic and acute conditions; (2) whether the conditions selected include a mix of surgical and medical conditions; (3) whether a condition is one for which there is evidence of an opportunity for

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		providers of services and suppliers to improve the quality of care furnished while reducing total Medicare expenditures: (4) whether a condition has significant variation in the number of readmissions; and the amount of expenditures for post-acute care spending; (5) whether a condition is high-volume and has high post-acute care expenditures; (6) which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns. *New SSA§1866C (b)(1).* The Secretary would be required to determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation, CARE, tool) would be required to be used under the pilot program to evaluate the condition of a beneficiary for purposes of determining the most clinically appropriate site for the provision of post-acute care.
Post acute care services payment reform plan and bundling pilot program – Covered services. Current Law: No provision.	No provision.	*S. §3023 as modified by S. §10308 – New SSA§1866C(a)(2)(C).* Covered services, referred to as applicable services, would be acute care inpatient services; physicians' services delivered in and outside of an acute care hospital setting; outpatient hospital services including emergency department services; post-acute care services, including HH services, skilled nursing services, inpatient rehabilitation services; inpatient hospital services furnished by a LTCH; and other services determined appropriate by the Secretary.
Post acute care services payment reform plan and bundling pilot program – Quality measurement. Current Law: No provision.	No provision.	*S. §3023 as modified by S. §10308 – New SSA§1866C(b)(2), (c)(4), and (f).* *New SSA§1866C(b)(2).* The Secretary, in consultation with the Agency for Healthcare Research and Quality (AHRQ), would be directed to establish site-neutral quality measures for the pilot for episodes of care and post-acute care. These quality measure would be required to be done in a manner that is consistent with certain other quality requirements under Medicare applicable to post-acute care settings. *New SSA§1866C(c)(4).* Quality measures would be

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		required to include measures for (1) functional status improvement; (2) reducing rates of avoidable hospital readmissions; (3) rates of discharge to the community; (4) rates of admission to an emergency room after a hospitalization; (5) incidence of health care acquired infections; (6) efficiency measures; (7) measures of patient centeredness of care; (8) measure of patient perception of care; (9) other measures, including measures of patient outcomes, determined appropriate by the Secretary. Entities would be required to submit data to the Secretary on quality measures during each pilot program year (in a form and manner specified by the Secretary). To the extent practicable, the Secretary would be required to specify that data on measures be submitted through the use of qualified electronic health records. *New SSA§1866C(f).* The Secretary would be required to consult with representatives of small rural hospitals, including critical access hospitals, regarding their participation in the pilot. Such consultation would be required to include consideration of innovative methods of implementing bundled payments in hospitals, taking into consideration any difficulties in doing so as a result of the low volume of services provided by these hospitals.
Home health payment update for 2010. Current Law: HHAs are paid under a PPS in which payments are based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, aide visits, medical supplies, and others. Durable medical equipment is not included in the HH PPS. The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the HH market basket (MB) index. This index measures changes in the costs of goods and services purchased by	*H. §1153.* The provision would eliminate the MB update for HH payments for 2010. HHAs would still be subject to the requirement to submit required quality data in subsequent years. Subject to another provision regarding a productivity adjustment, payments for HHAs would be increased by the HH MB percentage change for the fiscal year involved for each subsequent fiscal year.	*S. §3401.* See description of update adjustment to hospice payments Section 3401 starting on page 1.

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HHAs. For CY2010, the HH MB is expected to be 2.2%. Starting in 2007, HHAs were required to submit to the Secretary health care quality data. A HHA that does not submit the required quality data now receives an update of the MB minus two percentage points. This reduction only applies to the fiscal year in question.		
Payment adjustments for home health care – Acceleration of adjustments for case mix changes. Current Law: HHAs are paid under a PPS based on 60-day episodes of care for beneficiaries, subject to several adjustments. The base payment amount of the PPS is adjusted for differences in the care needs of patients (case mix) using "HH resource groups" (HHRGs) and outlier adjustments (to account for extraordinarily costly patients), among other adjustments. Presently, there is no difference between urban and rural base payment amounts. In CY2008, CMS made refinements to the PPS that resulted in payment reductions established in 42 CFR §484.220 as described in the Federal Register issued on August 29, 2007 (72 FR 49879). This regulation established changes to the HHA case-mix index to account for the relative resource utilization of different patients. These changes modified the coding or classification of different units of service that do not reflect real changes in case-mix. As a result, the national prospective 60-day episode payment rate was adjusted downward by 2.75% for CY2008; by 2.75% for each CY2009 and CY2010, and by 2.71% for CY2011. The proposed rule for CY2010 would continue with the previously promulgated 2.75% reduction to the HH PPS rates in CY2010. It would also cap outlier payments at 10% of total HH PPS payments, update the fixed dollar loss ratio to 0.67, and target outlier payments to be no more than 2.5% of total HH PPS payments.	*H. §1154(a).* The provision would accelerate the case-mix adjustments by implementing both the planned CY2011 adjustment of 2.71% and the planned CY2010 of 2.75% at the same time in CY2010. These adjustment amounts would not be limited if more recent data were to indicate that a greater adjustment would be appropriate.	No provision.

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Payment adjustments for home health care – Rebasing home health prospective payment amount. Current Law: In CY2008, CMS made refinements to the PPS that resulted in payment reductions established in 42 CFR §484.220 as described in the Federal Register issued on August 29, 2007 (72 FR 49879). This regulation established changes to the HHA case-mix index to account for the relative resource utilization of different patients. These changes modified the coding or classification of different units of service that do not reflect real changes in case-mix. As a result, the national prospective 60-day episode payment rate was adjusted downward by 2.75% for CY2008; by 2.75% for each CY2009 and CY2010, and by 2.71% for CY2011. The proposed rule for CY2010 would continue with the previously promulgated 2.75% reduction to the HH PPS rates in CY2010. It would also cap outlier payments at 10% of total HH PPS payments, update the fixed dollar loss ratio to 0.67, and target outlier payments to be no more than 2.5% of total HH PPS payments.	*H. §1154(b).* Starting in 2011, PPS amounts would be adjusted by a uniform percentage determined appropriate by the Secretary and based on analysis of certain factors, such as changes in the average number and types of visits in an episode, the change in intensity of visits in an episode, growth in cost per episode, and other factors that the Secretary considers to be relevant. After 2011, such amounts would be required to be equal to the amount paid for the previous year updated by the HH MB. If the Secretary is not able to compute the changed prospective payment amounts for 2011 on a timely basis, then the Secretary would be required to pay 95% of what the prospective payment amount would have been had this provision not applied and to compare, before July 1, 2011, amounts paid to amounts that would have been paid had the Secretary been able to compute the adjustment on a timely basis. For 2012, the Secretary would be required to decrease or increase the prospective payment amount (or at the Secretary's discretion, over a period of several years beginning with 2012), by the amount (if any) by which the amount applied is greater or less, respectively, than the amount that should have been applied.	*S. §3131(a), as modified by S. §10315.* Starting in CY2014, the Secretary would be directed to rebase HH payments by a percentage considered appropriate by the Secretary to, among other things, reflect the number, mix and level of intensity of HH services in an episode, and the average cost of providing care. In doing so, the Secretary could consider the differences between HH agencies in regards to hospital-based and freestanding providers; for-profit and non-profit providers; and resource costs between urban and rural providers. Any such adjustments that would result would be required to be made before the next HH market basket payment update. A four-year phase-in, ending in 2017, would be provided for, in equal increments that could not exceed 3.5% of applicable amounts for each year. The provision would require MedPAC to conduct a study on the implementation of the HH payment adjustment provision, including an analysis of its impact on access to care, quality outcomes, the number of HH agencies, and rural agencies, urban agencies, for-profit agencies, and nonprofit agencies. No later than January 1, 2015, MedPAC would be required to submit to Congress a report on this study, together with recommendations for legislation and administrative action.
Payment adjustments for home health care – Program-specific outlier cap. Current Law: None.	No provision.	*S. §3131(b).* Starting in CY2011, the Secretary would be directed to establish a provider-specific annual cap of ten percent of revenues that a HH agency may be reimbursed in a given year from outlier payments.
Application of the Medicare rural home health add-on policy. Current Law: The Medicare Prescription Drug Improvement and Modernization Act of 2003 (P.L. 108-173) provided for a one-year 5% additional payment for home health services furnished in rural areas. The	No provision.	*S. §3131(c).* For visits ending on or after Apri1 1, 2010 and before January 1, 2016, the Secretary would be directed to provide for a three percent add-on payment for HH providers serving rural areas. Additional payments of 3% would be provided for HH

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temporary payment began for episodes and visits ending on or after April 1, 2004 and before April 1, 2005. It was made without regard to certain budget neutrality provisions and was not included in the base for determination of payment updates. Section 5201of the Deficit Reduction Act of 2005 (P.L. 109-171) extended the 5% additional payment for rural HH episodes or visits beginning on or after January 1, 2006 and before January 1, 2007.		episodes and visits furnished in rural areas ending on or after April 1, 2010, and before January 1, 2016,
Study and report on the development of home health payment revisions in order to ensure access to care and payment for severity of illness. Current Law: No provision.	No provision.	*S. §3131(d), as modified by S. §10315.* The Secretary would be required to conduct a study on HH agency costs involved with providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness. In conducting the study, the Secretary could analyze items such as the following: (A) Methods to potentially revise the HH prospective payment system to account for costs related to patient severity of illness or to improving beneficiary access to care, such as (i) payment adjustments for services that may involve additional or fewer resources; (ii) changes to reflect the resources involved with providing HH services to low-income Medicare beneficiaries or Medicare beneficiaries residing in medically underserved areas; (iii) ways the outlier payments might be revised to reflect costs of treating Medicare beneficiaries with high severity levels of illness; (iv) other issues determined appropriate by the Secretary. (B) Operational issues involved with potential implementation of potential revisions to the HH payment system, including impacts for both HHAs and administrative and systems issues for CMS, and any possible payment vulnerabilities associated with implementing potential revisions. (C) Whether additional research might be needed. (D) Other items determined appropriate by the Secretary.

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		In conducting this study, the Secretary could consider whether patient severity of illness and access to care could be measured by factors, such as (A) population density and relative patient access to care; (B) variations in service costs for providing care to individuals who are Medicare and Medicaid dually eligible; (C) the presence of severe or chronic diseases, which might be measured by multiple, discontinuous HH episodes; (D) poverty status, as evidenced by the receipt of SSI; and (E) other factors determined appropriate by the Secretary. No later than March 1, 2014, the Secretary would be required to submit to Congress a report on the study, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. In conducting the study, the Secretary would be required to consult with appropriate stakeholders, such as groups representing HHAs and groups representing Medicare beneficiaries. Taking into account this study's results, the Secretary could, as determined appropriate, provide for a demonstration project to test whether payment adjustments for HH services would substantially improve access to care for patients with high severity of illness or for low-income or underserved Medicare beneficiaries. The Secretary would be prohibited from reducing the standard prospective payment amount (or amounts) applicable to HH services furnished during the period to offset any increase in payments during such period resulting from the application of the payment adjustments. Such payment adjustments for a period would be prohibited from applying to payments for HH Medicare services after that period and would be prohibited from

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		being taken into account in calculating the payment amounts applicable for such services after such period. If the Secretary determines it appropriate to conduct the demonstration, the Secretary would be required to conduct the project for a four-year period beginning not later than January 1, 2015. The Secretary would be required to provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, in the proportion as the Secretary determines appropriate, of $500 million for the period of fiscal years 2015 through 2018. Such funds would be required to be made available for the study and the design, implementation and evaluation of the demonstration. Amounts would be required to be available until expended. The Secretary would also be required to conduct an evaluation of the project, and submit a report to Congress, by a date specified by the Secretary.
Incorporating productivity improvements into market basket update for home health services. Current Law: Home health agencies (HHAs) are paid under a prospective payment system (PPS). The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the HH MB index. This index measures changes in the costs of goods and services purchased by HHAs. HHAs are required to submit to the Secretary health care quality data. A HHA that does not submit the required quality data will receive an update of the MB minus two percentage points.	*H. §1155.* The provision would make annual updates by the HH MB, beginning with 2011, subject to a productivity adjustment as long as the annual update would not be less than zero. The productivity adjustment would equal the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity.	*S. §3401.* See description of update adjustment to hospice payments Section 3401 on page 1.
MedPAC study on variation in home health margins. Current Law: In its March 2009 report, MedPAC reported that HHAs experienced margins of 16.6% in 2007, about equal to the average of 16.5% for 2002–2007. In its view, HHA margins (generally the difference	*H. §1155A.* The provision would require MedPAC to conduct a study regarding variation in performance of HHAs to explain variation in Medicare margins across agencies. Such study would be required to include an examination of at least the following issues:	No provision.

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between the cost of providing the services and Medicare payments received for those services) provide an indication of whether payment rates have been established and updated at an appropriate level for efficient providers to provide necessary services. Sustained substantial positive margins might indicate that the rates are excessive in the aggregate or for particular subgroups of providers. As a result, MedPAC concluded that HH payments should be significantly reduced in 2010 and payments rebased and revised in 2011 to ensure that Medicare does not continue to overpay HH providers.	(1) The demographic characteristics of individuals served and the geographic distribution associated with transportation costs. (2) The characteristics of such agencies, such as whether such agencies operate 24 hours each day, provide charity care, or are part of an integrated health system. (3) The socio-economic status of individuals served, such as the proportion of such individuals who are dually eligible for Medicare and Medicaid benefits. (4) The presence of severe and/or chronic disease or disability in individuals served, as evidenced by multiple discontinuous HH episodes with a high number of visits per episode. (5) The differences in services provided, such as therapy and non-therapy services. No later than June 1, 2011, the Commission would be required to submit a report to Congress on the results of the study. It would be required to include in the report the Commission's conclusions and recommendations, if appropriate, on the above listed issues.	
Permitting home health agencies to assign the most appropriate skilled service to make the initial assessment visit under a Medicare home health plan of care for rehabilitation cases. Current Law: With some exceptions, Medicare regulations require a registered nurse to conduct an initial assessment visit of a HHA beneficiary to determine the immediate care and support needs of the patient, and, for Medicare patients, to determine eligibility for Medicare HH benefits, including whether the individual meets Medicare's requirement that he or she is homebound. One exception to this rule is applied when rehabilitation therapy services (speech, language pathology, physical therapy, or occupation therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility. In this case, the initial assessment visit may be made by the	*H. §1155B.* The provision would allow HHAs to determine the most appropriate skilled therapist to make the initial assessment visit for an individual who is referred (and may be eligible) for HH services, but who does not require skilled nursing care as long as the skilled service (for which the therapist is qualified to provide) is included as part of the HH care plan.	No provision.

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appropriate rehabilitation professional.		
Develop plans for a value-based purchasing program for skilled nursing facilities and home health agencies. Current Law: No provision.	No provision.	*S. §3006 as modified by S. §10301 .* The Secretary would be required to develop three plans (for HHAs, SNFs, and ASCs) to implement Medicare value-based purchasing programs and submit them to Congress no later than October 1, 2011 for HHAs and SNFs and no later than January 1, 2011 for ASCs. These plans would be required to consider the following: (1) the ongoing development, selection, and modification process of measures, to the extent feasible and practicable, of all dimensions of quality and efficiency; (2) the reporting, collection, and validation of quality data; (3) the structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment; (4) methods for the public disclosure of information on performance; and (5) other issues determined appropriate by the Secretary. In developing this plan, the Secretary would be required to consult with relevant affected parties and consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program.
Protecting home health benefits. Current Law: No provision.	No provision.	*S. §3143.* Nothing in the provisions of, or amendments made by, this Act would result in the reduction of guaranteed HH benefits under Medicare.
Limitation on self-referral exception for existing physician owned hospitals. Current Law: Physicians are generally prohibited from referring Medicare patients for certain services to facilities in which they (or their immediate family members) have financial interests. However, among other exceptions, physicians are not prohibited from referring patients to whole hospitals in which they have ownership or investment interests. Providers that furnish substantially all of its designated health services	*H. §1156.* Only physician owned hospitals meeting certain requirements would be exempt from the prohibition on self-referral. Hospitals (including rural providers) that had physician ownership and a provider agreement in operation on January 1, 2009 and that met other specified reporting and disclosure requirements would be exempt from this self-referral ban. The percentage of the total ownership or investment held in the hospital (or in an entity whose assets include the hospital) by	*S. §6001as modified by S. §10601.* Same general provision that only physician-owned hospitals meeting certain requirements would be exempt from the prohibition on self-referral. Hospitals that have physician ownership and a provider agreement in operation on August 1, 2010, and that meet other specified requirements would be exempt from this self-referral ban. The same general strictures as in H.R. 3962 would apply.

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to individuals residing in rural areas are exempt as well.	physician owners or investors in the aggregate would not be able to exceed such percentage as of the date of enactment. With certain exceptions, the number of operating rooms, procedure rooms, or beds of the hospital would not be able to increase after the enactment date. The hospital could not have converted from an ambulatory surgical center to a hospital after enactment.	
Require reporting and ownership disclosure to Secretary. Current Law: Entities receiving Medicare payment for covered items and services are required to provide the information on the entities' ownership, investment, and compensation arrangements. This information includes the covered items and services provided by the entity, and the names and unique physician identification numbers of all physicians (or those whose immediate relatives) who have an ownership or investment interest, or certain compensation arrangements.	*H. §1156.* To be able to be exempt from the self-referral prohibition, entities receiving Medicare payment for covered items and services would be required to provide the information on the entities' ownership, investment, and compensation arrangements. This information includes the covered items and services provided by the entity, and the names and unique physician identification numbers of all physicians (or those whose immediate relatives) have an ownership or investment interest, or certain compensation arrangements. Such information would be provided in the form, manner, and at such times as specified. This requirement would not apply to designated health services provided outside of the United States or to entities deemed to provide infrequent services paid by Medicare. An exempt entity would also be (1) required to submit an initial report and periodic updates at specified intervals that contain a detailed description of the identity of each physician owner and investor as well as any other owners and investors in the hospital; and any other information on the nature and extent of all ownership interests in the hospital; (2) required that any referring physician owner or investor disclose to each patient (by a time that permits the patient to make a meaningful decision regarding the receipt of care) their ownership interest in the hospital and, if applicable, any such ownership interest of the treating physician; and (3)	*S. §6001as modified by S. §10601.* The Secretary would be required to collect physician ownership and investment information for each hospital in order to establish whether a hospital had physician ownership as of August 1, 2010 and the aggregate level of such ownership. There is no exception for designated health services provided outside of the United States or to entities deemed to provide infrequent services paid by Medicare as in H.R. 3962. In order to prevent conflicts of interest, the hospital would be required to submit an annual report containing a detailed description of the identity of each physician owner or investor as well as any other owners and investors in the hospital; and any information on the nature and extent of all ownership interests in the hospital. Same requirement with respect to disclosure of ownership and investments of referring and treating physicians to patients by a time that permits meaningful decisions regarding the receipt of care. Same requirement with disclosure of ownership and investment on hospital's public website and public advertising. Same requirement that data would be published and periodically updated on the CMS Internet website. There are no explicit penalties established for the failure to report or disclose required information as in H.R. 3962.

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	required to disclose the fact that the hospital is partially or wholly owned by one or more physician investors on any public website for the hospital and in any public advertising for the hospital. This requirement would not apply to designated health services provided outside of the United States or to entities deemed to provide infrequent services paid by Medicare. Information provided by hospitals would be published and periodically updated on the CMS Internet website. Any person who fails to meet required reporting and disclosure requirements would be subject to a civil monetary penalty of not more than $10,000 for each day for which reporting is required to have been made or for each case in which disclosure is required to have been made.	
Ensure physician's bona fide ownership and investment interests. Current Law: No provision.	*H. §1156.* Exempt hospitals would ensure bona fide ownership and investment by meeting the following requirements: (1) any ownership or investment interest offered to a physician could not be offered on more favorable terms than those offered to an individual who is not in a position to refer patients or otherwise generate hospital business; (2) the hospital (or investors in the hospital) could not directly or indirectly provide loans or financing for physician owners or investors in the hospital; (3) the hospital or its investors could not guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan to any individual physician owner, investor, group of physician owners or investors that is related to acquiring an ownership or investment interest in the hospital; (4) ownership or investment returns must be distributed to investors in the hospital in an amount that is directly proportional to the investment or ownership by the hospital investor; (5) the investment interest of the owner or investor is directly proportional to the capital contributions made at the time the ownership or investment interest is obtained; (6) physician owners and investors do not	*S. §6001as modified by S. §10601.* Same provisions with slight wording differences except that there is no requirement that the investment interest of the owner or investor be directly proportional to the owner's or investor's capital contributions made at the time the ownership or investment interest is obtained, as in H.R.3962. Also, one requirement (that a hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital) that is in H.R. 3692 to ensure bona fide ownership is included in the Senate bill as requirement to prevent conflicts of interest.

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	receive any guaranteed receipt or right to purchase other business related interests in the hospital, including the purchase or lease of any property under the control of other investors in the hospital or located near the premises of the hospital; (7) the hospital does not offer a physician owner the opportunity to purchase or lease any property under hospital control on more favorable terms than those offered to others and (8) the hospital does not condition any physician ownership or investment interests on the physician making or influencing referrals to the hospital or generating business for the hospital.	
Ensure patient safety. Current Law: No provision.	*H. §1156.* As an additional patient safety requirement, those exempt hospitals that do not offer emergency services would have to have the capacity to (1) provide assessment and initial treatment for medical emergencies; and (2) refer and transfer the patient with the medical emergency to the hospital with the required capability if it lacks the capabilities to treat the involved emergency. Those hospitals that do not have a physician available on the premises 24 hours per day, 7 days a week would be required to disclose such a fact to the patient before admitting the patient. Following such a disclosure, the hospital would receive a signed acknowledgement from the patient that the patient understands that fact.	*S. §6001as modified by S. §10601* A hospital that admits a patient and does not have any physician available on premises to provide services during all hours the hospital is providing services to such patient, before admitting the patient, would disclose this fact to the patient and receive a signed acknowledgment. The hospital would have the capacity to (1) provide assessment and initial treatment for patients; and (2) refer and transfer the patient to hospitals with the capability to treat the needs of the patient involved.
Retain termination of participation rights. Current Law: No provision.	*H. §1156.* The Secretary would retain the ability to terminate a hospital's provider agreement if the hospital is not in compliance with Medicare's conditions of participation.	*S. §6001as modified by S. §10601* Same provision.
Establish process to limit expansion of facility capacity. Current Law: No provision.	*H. §1156.* With certain exceptions, exempt hospitals would not be permitted to increase the number of operating rooms, procedure rooms or beds after the date of enactment. A procedure room includes a room in which catheterizations, angiographies, angiograms, and	*S. §6001as modified by S. §10601* Same general provisions. The application process for expansion would be implemented by February 1, 2011 (not one month after the promulgation of regulations). The implementing regulations would be promulgated no later than January 1, 2011 (not 18 months after the first

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	endoscopies are furnished. This would not include emergency rooms or departments (except for rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished). A process which would provide the opportunity for community input would be established to allow certain hospitals to expand. The exception process would be implemented one month after applicable regulations are promulgated. The regulations establishing the exception process would be promulgated no later than the first day of the month beginning 18 months after the date of enactment. The exception process would be implemented one month after the date regulations are promulgated. These regulations would be able to be issued as interim final regulations. The final decision regarding an expansion request would be posted on the CMS website no later than 120 days after a complete application is received. There would be no administrative or judicial review of this exception process, including the establishment of the process as well as any determination.	month after enactment). There is no provision that these regulations could be issued on an interim final basis. The Secretary would publish the final decision in the *Federal Register* no later than 60 days after receiving a complete application. There would be no administrative or judicial review of this exception process, including the establishment of the process. Certain aspects of this provision are exempt from administrative review; however a determination made as a result of this process is not included.
Establish criteria for hospital expansion. Current Law: No provision.	*H. §1156.* In order to expand, eligible hospitals would (1) be located in a county where the population increased during the most recent 5 year period at a rate that is at least 150% of the State's population increase; (2) have a Medicaid inpatient admission percentage equal to or greater than the average percentage for all hospitals located in the county; (3) not discriminate against beneficiaries of Federal health care programs and would not permit physicians practicing at the hospital to discriminate against such beneficiaries; (4) would be located in a State with an average bed capacity less than the national average; (5) have an average bed occupancy rate that is greater than the State average bed occupancy rate; and (6) meet other established requirements. A special rule would be established to permit the expansion of a hospital with a percentage of total Medicaid inpatient admissions greater than any	*S. §6001as modified by S. §10601* Same provisions except it does not establish that the hospital would have to meet other conditions as determined by the Secretary or contain the special rule for facilities with high Medicaid admissions.

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	other in the county for each of the 3 most recent cost reporting periods that meet other established criteria and does not discriminate against Federal patients.	
Limit approved capacity expansions. Current Law: No provision.	*H. §1156.* Any approved capacity increase would be limited to facilities on the main campus of the hospital and could not exceed 200% of the number of operating rooms, procedure rooms and beds at the time of enactment. An eligible hospital would be permitted to apply for the expansion exception up to once every two years.	*S. §6001as modified by S. §10601* Same provisions.
Require compliance and implementation activities. Current Law: No provision.	*H. §1156.* The Secretary would be required to establish policies and procedures to ensure compliance with the physician ownership and patient safety requirements, beginning on the date the requirements apply. The enforcement efforts would be able to include unannounced site reviews and audits of hospitals. Certain federal laws with respect to the coordination of federal information policy established by Chapter 35 of Title 44 of the USC would not apply to these requirements.	*S. §6001as modified by S. §10601* Same general provisions except that the enforcement activities do not include audits of hospitals. Also the provision does not explicitly establish that policies and procedures used to verify compliance would be effective beginning on the date that requirements apply. Instead, beginning no later than May 1, 2012, audits would be conducted to determine if hospitals would be in violation. No waiver of the coordination of federal information policy is included.
Establish funding. Current Law: No provision.	*H. §1156.* In addition to funds otherwise available, starting in FY2010, $5 million would be appropriated in each fiscal year from not otherwise appropriated funds in the Treasury for purposes of carrying out this section. Appropriated funds would be available until expended.	No provision.
IOM study on geographic adjustments to Medicare's payments. Current Law: Generally, Medicare's payment systems include adjustment factors to account for the geographic differences in the costs of providing health care services. For example, Medicare's physician fee schedule (which with modifications is used to reimburse other health care practitioners) uses the geographic practice cost index (GPCI) for this purpose; Medicare's IPPS uses a hospital wage index to adjust payments for acute care	*H. §1157.* Under this provision, the Secretary would enter into a contract with the Institutes of Medicine (IOM) to conduct an empirical study with appropriate recommendations on the accuracy of the geographic adjustment factors established for Medicare's physician fee schedule and for Medicare's IPPS. The study would also examine the effect of the adjustment factors on the level and distribution of the health workforce within the United States as well as the effect of the adjustment	No provision.

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hospitals. With modifications, the IPPS wage index is used to calculate payments for inpatient rehabilitation hospitals, inpatient psychiatric hospitals, long term care hospitals, skilled nursing facilities, and home health agencies.	factors on population health, quality of care, and the ability of providers to furnish efficient, high value care. The IOM report would be submitted to the Secretary and to Congress no later than one year from enactment. Necessary funds would be authorized to be appropriated to carry out this study.	
Revisions to Medicare's geographic adjustments. Current Law: Generally, Medicare's payment systems include adjustment factors to account for the geographic differences in the costs of providing health care services. In the previous section, IOM was required to conduct a study of the GPC used to adjust Medicare's physician fee schedule and the hospital wage index used in Medicare's IPPS. With modifications, Medicare's physician fee schedule and the hospital wage index are used to reimburse other practitioners and providers. Generally, the CMS promulgates changes to Medicare's physician fee schedule and IPPS through an annual rulemaking process where proposed changes and a notice of a public comment period are published in Federal Register with the final rule establishing the payment polices and responding to the public comments issued subsequently in the Federal Register. Medicare's IPPS and physician payments are on different payment years and therefore rulemaking schedules. Generally the new IPPS payment rates are effective October 1st of each year and new physician fee schedule is effective as of January 1st of each year.	*H. §1158.* Under this provision, the Secretary would be required to take into account the IOM recommendations and include appropriate proposals to revise the respective geographic adjustments in the physician fee schedule and IPPS proposed rules. The proposals would be included in the next applicable rulemaking cycle after submission of the IOM report to the Secretary. The Secretary would be able to change the geographic adjustments accordingly. For payment years before 2014, the geographic adjustment would not be below that which applied in the payment system in the prior year. For payment years starting in 2014, the geographic adjustment would not be implemented in a way that would otherwise increase Medicare expenditures. For years before 2014, the Secretary would ensure that the additional expenditures resulting from the implementation of the provisions of this section, as estimated by the Secretary, would not exceed $8 billion, and do not exceed half of this amount in any payment year. Amounts in the Medicare Improvement Fund (MIF) would be available to fund these changes in the geographic factors for services before January 1, 2014; no more than half of the available funds would be spent in any one payment year. MIF would have $8 billion authorized for FY2011 to FY2019. Starting in FY2014, monies not used for the geographic adjustment would be returned to the MIF.	No provision.
Revision to the Medicare Improvement Fund. Current law: Section 188 of MIPPA established the Medicare Improvement Fund (MIF), available to the Secretary to make improvements under the original fee-	No provision.	*S. § 3112.* The provision would eliminate the funding in the MIF.

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for-service program under Parts A and B for Medicare beneficiaries. Under current law, more than $22 billion is available for services furnished during FY2014.		
IOM study of geographic variation in health care spending. Current Law: No provision.	*H. §1159.* This provision would require the Secretary to enter into an agreement with the Institute of Medicine (IOM) of the National Academies to conduct a study on geographic variation and growth in volume and intensity of services in per capita health care spending among the Medicare, Medicaid, privately insured and uninsured populations. The IOM would then make recommendations for improving payments under fee-for-service Medicare, private insurance, and other programs by promoting "high value care," defined as the efficient delivery of high quality, evidence-based, patient-centered care. The IOM study would include evaluations or assessments of many variables pertinent to geographic variation, including (1) the extent of the geographic variation, (2) how much the geographic variation can be attributed to differences in input prices, health status, practice patterns, access to and supply of medical services, or to other factors, (3) the correlation between variations in spending and patient access to care, insurance status, distribution of health care resources, health care outcomes, and consensus-based measures of health care quality, (4) how much the variation can be attributed to physician and practitioner discretion in making treatment decisions, (5) the extent to which variation can be attributed to patient preferences and patient compliance with treatment protocols, (6) the degree to which variation cannot be explained by empirical evidence, (7) the extent to which variations in spending for Medicare beneficiaries are correlated with various indicators of insurance status, and (8) other factors as the IOM would deem to be appropriate.	No provision.

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	The IOM would take into account the study findings as well as the changes to the payment systems made by this Act and recommend changes to fee-for-service Medicare payments to address variation in Medicare per capita spending (not including add-ons for graduate medical education, disproportionate share payments, and health information technology). These recommendations would promote high value care with particular attention to high-volume, high-cost conditions. In making the recommendations, the IOM would specifically address whether Medicare payment systems for physicians and hospitals should be further modified to incentivize high-value care. In so doing, the IOM would consider the adoption of a value index based on a composite of appropriate measures of quality and cost that would adjust provider payments on a regional or provider-level basis. If the Institute were to find that application of such a value index would significantly incentivize providers to furnish high-value care, it would make specific recommendations on how such an index would be designed and implemented. In so doing, it would identify specific measures of quality and cost appropriate for use in such an index, and include a thorough analysis (including on a geographic basis) of how Medicare payments and spending would be affected by such an index. The IOM would submit a report containing findings and recommendations of the study to the Secretary and to each House of Congress not later than April 15, 2011. Following submission of the above report, the IOM would use the data collected and analyzed to issue a subsequent report, or series of reports, on how best to address geographic variation or efforts to promote high-value care for items and services reimbursed by private insurance or other programs. These reports would include a comparison to the IOM's findings and recommendations regarding the Medicare program.	

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	These reports, and any recommendations, would not be subject to the procedures outlined in section 1160. To carry out this section, $10 million would be authorized to be appropriated from the general fund of the Treasury. This amount would remain available until expended.	
Implementation and Congressional review of proposal to revise Medicare payments to promote high value health care. Current law: No provision.	*H. §1160.* This section sets forth conditions for the Secretary to submit both a preliminary as well as a final implementation plan in response to the IOM report on geographic variations in health care spending (from §1159) and establishes several rules regarding Congressional procedures for taking up the plan. The implementation plan would take into consideration, as appropriate, the recommendations of the IOM report and the changes to the payment systems made by this Act. To the extent the implementation plan were to require a substantial change to the payment system, it would include a transition phase-in that would take into consideration possible disruption to provider participation in the Medicare program and preserves access to care for Medicare beneficiaries. The report would describe proposed changes to payment for items and services under Medicare parts A and B (which could include payment for inpatient and outpatient hospital services for services furnished in PPS and PPS-exempt hospitals, physicians' services, dialysis facility services, skilled nursing facility services, home health services, hospice care, clinical laboratory services, durable medical equipment, and other items and services, but which would exclude add-on payments for graduate medical education, disproportionate share payments, and health information technology. The preliminary report would be due to each House of Congress not later than 90 days after the IOM submits the report containing findings and recommendations to each House of Congress, while the final implementation plan would be due to each House of Congress not later	No provision.

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	than 240 days after the date of receipt by the Secretary and each House of Congress of the IOM's report. With the submission of the final implementation plan, the Secretary would include a certification by the CMS Chief Actuary that over the initial 10-year period during which the plan were to be implemented, the aggregate level of net expenditures under the Medicare program would not exceed the aggregate level of expenditures that would have occurred if the plan were not implemented. To the extent the final implementation plan were to propose changes that would not otherwise be permitted under the Medicare program, the Secretary would specify in the plan the specific waivers required to implement such changes. Except as provided below, the Secretary would be authorized to waive the requirements specified in order to implement such changes. In addition, both the preliminary and final implementation plans would include a detailed assessment of the effects of the proposed payment changes by provider or supplier type and State, relative to the payments that would otherwise apply. Not later than 45 days after the preliminary implementation plan was to be received by each House of Congress, the MedPAC and the Comptroller General would each evaluate the plan and submit a report to each House of Congress containing its analysis and recommendations regarding implementation of the plan, including an analysis of the effects of the proposed changes in the plan on payments and projected spending. The Secretary would include appropriate proposals to revise Medicare payments in accordance with the final implementation plan submitted and the specified waivers required to carry out the plan, unless a joint resolution is enacted (described below). If such a joint resolution were to be enacted, the Secretary would not be authorized to implement the plan and the waiver authority would no longer be effective. For purposes of this section, the "Congressional action	

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	deadline" with respect to a final implementation plan as described above would be May 31, 2012, or, if later, the date that is 145 days after the date of receipt of such plan by each House of Congress. The provision includes several modifications and restrictions regarding Congressional procedures that would pertain to the implementation plan. First, on the day on which the final implementation plan was to be received by the House of Representatives and the Senate, a joint resolution would be introduced in the House of Representatives by the majority leader and minority leader of the House of Representatives and in the Senate by the majority leader and minority leader of the Senate. This joint resolution is defined to mean only a joint resolution that (i) does not have a preamble, (ii) the title of which would be the "Joint resolution disapproving a Medicare final implementation plan of the Secretary of Health and Human Services submitted under section 1160(a) of the Affordable Health Care for America Act", and (iii) the sole matter after the resolving clause would be as follows: "That the Congress disapproves the final implementation plan of the Secretary of Health and Human Services transmitted to the Congress on——————.", with the blank space being filled with the appropriate date. Second, regarding consideration in the House of Representatives, any committee of the House of Representatives to which a joint resolution introduced as above would be referred would report the joint resolution to the House not later than 50 legislative days after introduction. If a committee were to fail to report the joint resolution within that period, a motion to discharge the committee from further consideration of the joint resolution would be in order, but only at a time designated by the Speaker in the legislative schedule within two legislative days after the day on which the proponent were to announce an intention to offer the motion. Notice could not be given on an anticipatory basis. Such a motion would not be in order after the last	

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	committee authorized to consider the joint resolution were to report it to the House or after the House would have disposed of a motion to discharge the joint resolution. The previous question would be considered as ordered on the motion to its adoption without intervening motion except for 20 minutes of debate equally divided and controlled by the proponent and an opponent. A motion to reconsider the vote by which the motion were to be disposed of would not be in order. Similarly, after each committee authorized to consider a joint resolution were to report the joint resolution to the House of Representatives or were to be discharged from its consideration, a motion to proceed to consider the joint resolution would be in order, but only at a time designated by the Speaker in the legislative schedule within two legislative days after the day on which the proponent were to announce an intention to offer the motion. Notice could not be given on an anticipatory basis. Such a motion would not be in order after the House of Representatives were to have disposed of a motion to proceed on the joint resolution. The previous question would be considered as ordered on the motion to its adoption without intervening motion. A motion to reconsider the vote by which the motion were to be disposed of would not be in order. The joint resolution would be considered in the House and would be considered as read. All points of order against a joint resolution and against its consideration would be waived. The previous question would be considered as ordered on the joint resolution to its passage without intervening motion except two hours of debate equally divided and controlled by the proponent and an opponent. A motion to reconsider the vote on passage of a joint resolution would not be in order. Third, regarding consideration in the Senate, any committee of the Senate to which the joint resolution were to be referred would report the joint resolution to the Senate within 50 legislative days. If a committee	

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	were to fail to report the joint resolution at the close of the 15th legislative day after its receipt by the Senate, such committee would be automatically discharged from further consideration of the joint resolution and the joint resolution(s) would be placed on the calendar. A vote on final passage of the joint resolution would be taken in the Senate on or before the close of the second legislative day after the joint resolution were to be reported by the committee or committees of the Senate to which it was referred, or after such committee or committees were to have been discharged from further consideration of such joint resolution. A motion in the Senate to proceed to the consideration of a joint resolution would be privileged and not debatable. An amendment to such a motion would not be in order, nor would it be in order to move to reconsider the vote by which such a motion were to be agreed to or disagreed to. Debate in the Senate on a joint resolution, and all debatable motions and appeals in connection therewith, would be limited to not more than 20 hours. The time would be equally divided between, and controlled by, the majority leader and the minority leader or their designees. Debate in the Senate on any debatable motion or appeal in connection with a joint resolution would be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the resolution, except that in the event the manager of the joint resolution were to be in favor of any such motion or appeal, the time in opposition thereto would be controlled by the minority leader or a designee. Such leaders, or either of them, could, from time under their control on the passage of a joint resolution, allot additional time to any Senator during the consideration of any debatable motion or appeal. A motion in the Senate to further limit debate would not debatable, and a motion to recommit a joint resolution would not be in order. Fourth, the provision would establish rules relating to both the Senate and House of Representatives. If, before	

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	the passage by one House of a joint resolution of that House, that House were to receive from the other House a joint resolution, then the following procedures would apply: (i) the joint resolution of the other House would not be referred to a committee; (ii) with respect to the joint resolution of the House receiving the resolution, the procedure in that House would be the same as if no such joint resolution were to have been received from the other House, but the vote on passage would be on the joint resolution of the other House. If, following passage of a joint resolution in the Senate, the Senate then were to receive the companion measure from the House of Representatives, the companion measure would not be debatable. These rules would be enacted by Congress (i) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it would be deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a joint resolution, and it would supersede other rules only to the extent that it were to be inconsistent with such rules, and (ii) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House. For the purposes of consideration of a joint resolution, the Chairmen of the House of Representatives and Senate Committees on the Budget would exclude any effects that are directly attributable to disapproving a Medicare final implementation plan submitted by the Secretary as above from the evaluation of the budgetary effects of the measure.	

Subtitle D – Medicare Advantage Reforms

Part 1 – Payment and Administration

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Phase-in of Payment based on fee-for-service costs – benchmark changes. Current Law: Medicare Advantage (MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private plans are paid a per-person amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. Payments to MA plans are determined by comparing plan bids to a benchmark. Each bid represents the plan's estimated revenue requirement for providing required Medicare services to an average Medicare beneficiary. The benchmark is the maximum amount Medicare will pay a plan. If the plan bid is below the benchmark, the plan payment is the bid plus a rebate equal to 75% of the difference between the bid and the benchmark. Plans must spend the rebate on reduced cost sharing or Part D or B premiums, or supplemental benefits; plans determine how to apportion their rebates. If the bid is above the benchmark, the plan is paid the benchmark and each plan enrollee must pay a premium equal to the difference between the bid and the benchmark. Payments to plans are risk adjusted based on the demographics and health history of the enrollee. MA benchmarks are based, in part, on historical Medicare private plan payment rates. (MA benchmarks for Regional MA plans are based in part on historical MA plan payments, and in part on Regional MA plan bids.) Benchmark amounts are increased each year by the growth in Medicare spending (the national MA per capita growth percentage), or in certain years, the benchmark may be set at the greater of the previous year's rate increased by the growth in Medicare or average spending in original Medicare in that area, with adjustments. Local MA plans choose the counties they	*H. §1161(a).* The bill would phase-in MA benchmarks equal to per capita FFS spending in each county starting in 2011 and continuing over a three-year period. MA benchmarks would be equal to per capita FFS spending in each county starting in 2013. Benchmarks could not be less than per capita FFS spending. The provision would not apply to Programs of All-Inclusive Care for the Elderly (PACE).	*S. §3201(a), (b), (c) and (i).* This bill would also change the calculation of the benchmark, but it would do it through a bidding process rather than reducing it to the level of spending in original Medicare. *S. §3201(b).* In 2011, the national MA per capita growth percentage would be reduced by three percentage points. *S. §3201(a).* Starting in 2012, the calculation of local MA benchmarks based average plan bids would begin to be phased-in. Specifically, local MA benchmarks would be based on 33 percent of the enrollment weighted average of plan bids for each payment area and 67 percent of the current law MA benchmarks. In 2013, 67 percent of the benchmark rates would be based on the enrollment weighted average of plan bids for each payment area, while the remaining 33 percent would be based on the current law MA benchmarks. The proposal would require that the Secretary use the enrollment figures from the most recent month from which data is available. In 2014, the local MA benchmarks would be based on the actual plan bids from the prior year (i.e., 100% of enrollment weighted average of 2013 plan bids increased by the national MA growth percentage). Beginning in 2015, the MA local benchmarks would be determined by the enrollment weighted average of all MA bids in each payment area. If only one plan was offered in an area, the enrollment weight would be equal to one. If no plans had been offered the previous year, but multiple plans were offered the next year, the weight would be a simple average of plan bids. Local benchmarks would be prohibited from exceeding those

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wish to serve. Regional plans must serve an entire region defined by the Secretary, and may choose to serve more than one region. Regions are made up of states or groups of states. Though all MA organizations are required to have a quality improvement program by January 1, 2010, payments to MA plans are not contingent on the quality of care provided to plan enrollees.		under current law. Bids from all local MA plans (except regional plans, PACE plans and 1876 cost plans) would be used to set the MA benchmarks. Regional plan benchmarks would continue to be calculated as a weighted blend of the regional bids and local MA benchmarks. However, the statutory portion would be based on the new MA benchmarks instead of statutory rates. *S. §3201(c).* Beginning in 2014, rebates for plans that bid below the benchmark would equal 100% of the difference, rather than 75% of the difference under current law. *S. §3201(i).* PACE plans would be exempt from changes to the MA benchmarks beginning with the transition to competitive bidding in 2012. The Senate bill also includes MA plan bidding rules, plan service areas, grandfathering supplemental benefits, and transitional benefits, which are described at the end of this table.
Phase-in of Payment based on fee-for-service costs – quality bonus payments. Current Law: Payments to MA plans are not contingent on the quality of care provided to Medicare beneficiaries. However, all MA organizations are required to have a quality improvement program before January 1, 2010. As part of the quality improvement program, plans must collect, analyze, and report data to measure health outcomes and other indices. The Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275, MIPPA) required the Medicare Payment Advisory Commission (MedPAC) to conduct a study on how comparable quality measures of performance and patient experience can be collected and reported by 2011 for MA and original Medicare.	*H. §1161(b).* For plan years starting with 2011, a qualifying plan in a qualifying county would receive an *increase in their benchmark* amounts equal to 2.6% in 2011, 5.3% in 2012 and 8.0% in subsequent years. A qualifying plan would be defined as a plan that, in a preceding year specified by the Secretary, had a quality ranking (based on the quality ranking system established by CMS) of 4 stars or higher. A qualifying county would be defined as a county, for a year, (a) that was within the lowest quarter of counties with respect to per capita spending in original Medicare, and (b) within which, 50 percent of individuals were enrolled in MA and of the residents enrolled, at least 50 percent were enrolled in a plan with a quality ranking of 4 stars or higher. Starting	*S. §3201(f).* This Senate bill would also include additional payments for MA plans meeting specific quality and location criteria (rather than adjustments to a benchmark). Beginning in 2014, the bill would establish two new bonus payments for local and regional MA plans: (1) a care coordination and management bonus, and 2) a quality bonus. The care coordination and management bonus would pay a plan 0.5% of the national monthly per capita costs for expenditures under original Medicare for each care coordination and management program the plan offers (up to a maximum bonus of 2.0%). Care management programs considered for a bonus payment include: (1) care management programs that target individuals with one or more chronic conditions, identify

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The report is to be submitted to Congress not later than March 31, 2010. Payments to MA plans are determined by comparing plan *bids* to a *benchmark*. Each bid represents the plan's estimated revenue requirement for providing required Medicare services to an average Medicare beneficiary. The benchmark is the maximum amount Medicare will pay a plan. If the plan bid is below the benchmark, the plan payment is the bid plus 75% of the difference between the bid and the benchmark. If the bid is above the benchmark, the plan payment is equal to the benchmark and each plan enrollee must pay a premium equal to the difference between the bid and the benchmark. In November 2007, CMS implemented a 5 star-rating system for MA plans	in 2010, the Secretary would be required to notify the qualifying MA organization that is offering a qualified plan in a qualifying county of their status through the annual announcement of benchmark rates and through publication on the Medicare program website. The Secretary would have the authority to disqualify a plan if the Secretary identifies deficiencies in the plan's compliance with MA rules under this part.	gaps in care, and facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants; (2) programs that focus on patient education and self-management of health conditions, including interventions that help manage chronic conditions, reduce declines in health status and foster patient/provider collaboration; (3) transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and re-admissions; (4) patient safety programs, including provisions for hospital-based patient safety programs in their contracts with hospitals; (5) financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements or pay-for-performance programs; (6) medication therapy management programs that focus on poly-pharmacy and medication reconciliation, periodic review of drug regimens, and integration of medical and pharmacy care for chronically-ill, high-cost beneficiaries; (7) health information technology programs, including electronic health records, clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care; (8) programs that address, identify, and ameliorate health care disparities among principal at-risk subpopulations; or other programs identified by the Secretary. Plans would be required to report data to determine eligibility for the bonuses and the Secretary would provide for annual auditing of the program. The bill would create a second bonus for prior year achievement or improvement in plan quality, a bonus for new plans, and a bonus for plans with low enrollment. Performance would be measured based on a ranking system that measures clinical quality and enrollee satisfaction on a 5-star rating scale at the contract or

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		plan level. MA plans would receive 2 percent of the national monthly per capita cost for expenditures of individuals in original Medicare if they achieve a 3-star rating or 4 percent if the plan received a 4 or 5-star rating. Plans that do not achieve at least a 3-star rating would be eligible for a 1 percent quality bonus if their ratings improve over a prior year. If the Secretary does not use a 5-star ranking system to measure quality under the MA program, bonus payments would continue to be available to plans at levels that reflect similar levels of achievement and improvement as the 5-star ranking system. In making quality bonus payments to plans, the Secretary would use data from the preceding year. Plans that failed to report data would be counted as having the lowest performance and improvement ratings. New MA plans that first submit a bid for 2012 or a subsequent year and do not receive a quality bonus, or quality improvement bonus would receive a bonus of 2 percent of national monthly per capita cost for expenditures under original Medicare. In the fourth year of operation, the new plans would be paid in the same manner as other plans with comparable enrollment. For plans with low enrollment that would not otherwise receive a quality or quality improvement bonus, or a new plan bonus, the Secretary would be required to use the regional or local mean of plan ratings to determine whether MA plans would be eligible for a quality or improved quality bonus, or to determine whether the low enrollment plan is eligible for a bonus. The proposal would risk adjust both the care coordination and quality bonus payments to reflect the demographics and actual health status of each enrollee. MA plans would be required to use 100 percent of the performance bonus payment amounts to cover the costs of additional benefits offered to their enrollees as specified in *§3202*.

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Authority for Secretarial coding intensity adjustment. Current Law: In general, Medicare payments to MA plans are risk-adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals. The Medicare risk adjustment models take into account the variation in expected medical expenditures of the Medicare population associated with demographic characteristics (age, sex, current Medicaid eligibility, original Medicare eligibility due to a disability), as well as medical diagnoses. The Deficit Reduction Act of 2005 (P.L. 109-171, DRA) required the Secretary, when risk adjusting payments to MA plans during 2008, 2009, and 2010, to adjust for patterns of diagnosis coding differences between MA plans and providers under parts A and B of Medicare, to the extent that the Secretary identified such differences based on an analysis of data submitted for 2004 and subsequent years.	*H. §1162.* This bill would extend the requirement that MA plan payments be adjusted for differences in coding patterns beyond 2010. The provision would require the Secretary to conduct analyses of coding differences periodically and incorporate the findings on a timely basis.	*S. §3203.* The bills are similar. The Senate bill would require the Secretary to conduct an analysis of the differences in coding patterns between MA and original Medicare, but would limit the years in which the Secretary was to incorporate those results (2011, 2012, and 2013). The Senate bill would, however, grant the Secretary the authority to incorporate the results of further analyses for subsequent years.
Simplification of annual beneficiary election periods. Current Law: Medicare beneficiaries may enroll in or change their enrollment in MA from November 15 to December 31 each year (the annual, coordinated election period). Changes go into effect January 1st of the next year. During the first three months of the year, beneficiaries can enroll in an MA plan, and individuals enrolled in an MA plan can either switch to a different MA plan or return to original Medicare. This period is known as the continuous open enrollment and disenrollment period. However, during the three-month period, beneficiaries cannot change their drug coverage.	*H. §1163.* This bill would move the annual, coordinated election period to 15 days earlier in the year -- November 1st to December 15th, rather than from November 15th to December 30th starting in CY2011. Effective for plan years beginning with 2011, the bill would eliminate the continuous open enrollment and disenrollment period (during the first three months of the year.)	*S. §3204.* The Senate bill is similar to the House bill in that it changes the dates of the annual, coordinated election period. However, the Senate bill would shift the enrollment period by 30 days earlier in the year rather than 15 days and would extend it by an additional week (from October 15 to December 7). Also, the effective date for the Senate provision would be CY2012 – one year later than in the House bill. The Senate bill does not eliminate the continuous open enrollment and disenrollment period, but does prohibit beneficiary choices during the first 45 days of a plan year. Specifically, the bill would prohibit beneficiaries from switching MA plans or enrolling in a MA plan from original Medicare after the start of the benefit year. The bill would, however, allow beneficiaries who had

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		enrolled in MA during the annual, coordinated election period to disenroll and return to original Medicare during the first 45-day period of the new benefit year (January 1-February 15), and allow those beneficiaries to enroll in a Part D prescription drug plan.
Extension of reasonable cost contracts. Current Law: Reasonable cost plans are MA plans that are reimbursed by Medicare for the actual cost of providing services to enrollees. Cost plans were created in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA, P.L. 97-248). BBA 97 included a provision to phase-out the reasonable cost contracts, however, the phase-out has been delayed over the years through congressional action. These plans are allowed to operate indefinitely, unless two other plans of the same type (i.e., either 2 local or 2 regional plans) offered by different organizations operate for the entire year in the cost contract's service area. After January 1, 2010, the Secretary may not extend or renew a reasonable cost contract for a service area if (1) during the entire previous year there were either two or more MA regional plans or two or more MA local plans in the service area offered by different MA organizations; and (2) these regional or local plans meet minimum enrollment requirements.	*H. §1164.* This provision would extend for two years—from January 1, 2010, to January 1, 2012—the length of time reasonable cost plans could continue operating regardless of any other MA plans serving the area. The provision would modify the minimum enrollment requirement used as one of the criteria the Secretary considers when determining whether to renew or extend a reasonable cost plan. The minimum enrollment criteria would apply to the portion of the MA regional or local plan's service area for the year that it was within the service area of the reasonable cost contract (and not the total service area of the MA regional or local plan).	*S. §3206.* This bill is similar to the House bill, except that it would extend for three years (instead of two years) – from January 1, 2010, to January 1, 2013 – the length of time reasonable cost plans could continue operating regardless of any other MA plans serving the area. This bill would not modify the minimum enrollment criteria.
Limitation of waiver authority for employer group plans. Current Law: The Secretary has the authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employer or union sponsored MA plans. Such plans can be offered either under contracts between the union or employer group and a MA organization, or directly by the employer or union group.	*H. §1165.* For all employer or union group MA plans, the Secretary would only have authority to waive or modify MA requirements for the plan if 90% of eligible individuals enrolled in the plan live in a county in which the MA organization offers an MA local plan. This provision would apply to plan years on or after January 1, 2011, and would not apply to plans in effect as of December 31, 2010.	No provision. However, *S. §3207* extends the Secretary's waiver authority with respect to employers who contract directly with CMS to offer an MA private fee-for-service plan (PFFS).
Improving risk adjustment for payments. Current Law: In general, Medicare payments to MA plans are risk adjusted to account for the variation in the	*H. §1166.* This bill would require the Secretary to evaluate and report on the adequacy of MA risk adjustments at	No provision.

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cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals. The Medicare risk adjustment models take into account the variation in expected medical expenditures associated with demographic characteristics (age, sex, current Medicaid eligibility, original Medicare eligibility due to a disability), as well as medical diagnoses, and differences in coding practices between MA and providers under Medicare Part A and B.	predicting costs for beneficiaries with chronic or co-morbid conditions, beneficiaries dually-eligible for Medicare and Medicaid, and non-Medicaid eligible low-income beneficiaries. The report would also address the need and feasibility of including further gradations of diseases or conditions and multiple years of beneficiary data. Taking this report into account, not later than January 1, 2012, the Secretary would be required to implement necessary improvements to the MA risk adjustment system.	
Elimination of MA Regional Plan Stabilization Fund. Current Law: MMA created the MA Regional Program and established the MA Regional Plan Stabilization Fund to encourage plans to enter into and/or remain in the MA Regional Program. The fund was originally set at $10 billion with additional money added to the fund from savings in the bidding process. Funds were to be available from 2007 through the end of 2013. Subsequent legislation decreased the amount of funds available and delayed their availability. Most recently, MIPPA reduced the initial funding of the program to one dollar. Money from the regional plan bidding process continues to flow into the Fund, but availability is delayed until 2014.	*H. §1167.* This bill would eliminate the Fund and transfer amounts in the Fund to the Part B Trust Fund.	*S. §10327.* Same provision.
Study regarding the effects of calculating Medicare Advantage payment rates on a regional average of Medicare fee for service rates. Current Law: No provision.	*H. §1168.* This bill would require CMS to conduct a study to determine the potential effects of calculating MA rates on a more aggregated geographic basis, rather than using county boundaries. The study would consider whether the alternatives would effect (a) plan quality, (b) plan networks including implications for provider contracting, and (c) the predictability of benchmark amounts. CMS would be required to consult with certain experts and stakeholders. CMS would be required to submit a report to Congress, including recommendations, no later than one year after the date of enactment.	No provision. However, *S. §3201(e)* would redefine local MA plan service areas, starting in 2012, to be either an entire urban area consisting of a core based statistical area, or rural area, consisting of a county, See below.

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Medicare Advantage payment – Bidding rules. Current Law: Private plans that submit MA plan bids must include with their bid, the actuarial basis for determining the bid amounts and any additional information the Secretary may require to verify the actuarial basis of the plan bids. In general, the Secretary has the authority to negotiate bids submitted by MA plans similar to the authority of the Director of the Office of Personnel Management with respect to negotiations with plans participating in the Federal Employees Health Benefits Program. The Secretary may only accept a bid after determining that it is supported actuarially and that it reasonably and equitably reflects the revenue requirements of benefits provided under the plan. The Secretary's authority to negotiate with plans does not apply to Private Fee-for-Service (PFFS) MA plans.	No provision.	*S. §3201(d).* For bid amounts submitted on or after January 1, 2012, the bill would require bid information submitted by MA plans to be certified by a qualified member of the American Academy of Actuaries and would be required to meet actuarial guidelines established by the Secretary. The Secretary (acting through the chief actuary at CMS) would be required to establish actuarial guidelines for the submission of bid information and bidding rules that plans would follow to protect the integrity and fairness of the bidding process. The proposal would require the Secretary to deny bids that do not meet the actuarial standards and guidelines or abide by the rules established for the competitive bid process. The Secretary would be required to report plan actuaries who repeatedly do not comply with bidding rules and standards to the Actuarial Standards Board for Counseling and Discipline. The Secretary would have the authority to refuse to accept additional bids from MA organizations that had submitted bids with consistent misrepresentations.
Medicare Advantage payment – MA local plan service area. Current Law: In general, local MA plans define their own service areas, which consist of counties and county parts, identified at the zip code level. Regional plans must serve an entire region defined by the Secretary, and may choose to serve more than one region. There are 26 regions consisting of states or groups of states.	No provision.	*S. §3201(e).* The bill would require the Secretary to establish new MA local plan payment areas for plan years beginning in 2012. In urban areas, payment areas would be based on the definition of Core Based Statistical Area (CBSA) as determined by the Office of Management and Budget or conceptually similar classification. The Secretary would be required to divide CBSAs that cover more than one state, and would be allowed to adjust CBSA-based payment areas to reflect patterns of actual health care use. The service area for plans serving rural areas would be a county or groups of counties that do not qualify to be part of a CBSA. Beginning in 2015, the Secretary would have the authority to adjust service area boundaries for urban and rural areas to reflect patterns of health care service

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		use, as determined through analyses. The bill would allow the Secretary to make limited exceptions to service area requirements for plans that have historical licensing agreements that preclude the offering of benefits throughout an entire payment area or that have historical limitations in their structural capacity to offer benefits throughout an entire payment area. Under the bill, bidding and service areas would be the same as payment areas beginning in 2012. MA plans would be allowed to choose which payment areas they would like to serve, but they must bid and serve the entire payment area, and would no longer be allowed to apply different premiums to different segments of their service area. If a plan were to leave an area, it would no longer be able to offer enrollees the option to remain enrolled in the plan.
Medicare Advantage payment – Grandfathering supplemental benefits for current enrollees after implementation of competitive bidding. Current Law: No provision.	No provision.	*S. §3201(g).* MA plans would be allowed to grandfather extra benefits for their current enrollees (as of enactment) in certain areas of the country where average bids were not greater than 75% of local fee-for-service costs in 2009. Plans would be able to grandfather enrollees beginning in 2012. The amount of extra benefits would be reduced by 5% each year beginning in 2013.
Medicare Advantage payment – Transitional extra benefits. Current Law: No provision.	No provision.	*S. §3201(h) as amended by S. §10318.* Starting in 2012, the Secretary would provide for transitional rebates for extra benefits to specified enrollees. This provision would apply to beneficiaries who enroll in an MA local plan and experience a significant reduction of benefits as a result of competitive bidding. The policy would apply to (1) the two largest metropolitan statistical areas if the total amount of extra benefits for each enrollee for the month in those areas was greater than $100 in 2009, or (2) a county where the MA benchmark amount in 2011 was equal to the legacy urban floor amount, the Medicare Advantage enrollment penetration was greater than 30% in 2011,

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		and the average of MA plan bids was below local fee-for-service costs, with adjustments. The total amount available for transitional benefits would be $5 billion through 2019.
Technical correction to MA private fee-for-service plans. Current Law: MA coordinated care plans are required to meet medical access requirements by forming networks of contracted providers. Prior to 2011, PFFS plans can meet medical access requirements either by establishing payment rates for providers that are not less than rates paid under original Medicare or by developing contracts and agreements with a sufficient number and range of providers within a category to provide covered services under the terms of the plan. Starting in 2011, PFFS plans sponsored by employers or unions are required to establish contracted networks of providers to meet access requirements. Non-employer sponsored MA PFFS plans are required to establish contracted networks of providers in "network areas" defined as areas having at least two plans with networks (such as health maintenance organizations [HMOs], provider sponsored organizations [PSOs], or local preferred provider organizations [PPOs]). In areas without at least two network-based plans, the non-employer PFFS plans retain the ability to establish access requirements through establishing payment rates that are not less than those under original Medicare.	No provision.	*S. §3207.* The bill would allow the Secretary to grant employer-based PFFS plans a waiver from the network requirements in a manner similar to the Secretary's authority to waive or modify other MA requirements for employer-based coordinated care plans as specified in a 2008 service area extension waiver policy, as modified in an April 11, 2008 CMS memo entitled "2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans."
Development of new standards for certain Medigap plans. Current Law: Many Medicare beneficiaries have individually purchased health insurance policies, commonly referred to as "Medigap" policies. Beneficiaries with Medigap insurance typically have coverage for Medicare's deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals generally select from one of a set of standardized plans (Plan "A"	No provision.	*S. §3210.* The bill would request that NAIC create new model plans for C and F that include nominal cost sharing to encourage the use of appropriate Part B physician services. The nominal cost sharing would be based on evidence either published or from integrated delivery systems. The revisions would be consistent with rules applicable to changes in NAIC Model Regulations. The new models C and F would be available in 2015.

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through Plan "L", though not all plans are offered in all states). The law incorporates by reference, as part of the statutory requirements, certain minimum standards established by the National Association of Insurance Commissioners (NAIC) and provides for modification where appropriate to reflect program changes.		
No cuts in guaranteed benefits. Current Law: Medicare Advantage plans are required to provide all Medicare covered benefits, except hospice.	No provision.	*S. §3602* This provision would require that nothing in the Senate bill could result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.

Part 2 – Beneficiary Protections and Anti-Fraud.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Limitation on cost-sharing for individual health services. Current Law: Each MA plan must provide all required Part A and B Medicare benefits (other than hospice) to individuals entitled to Medicare Part A and enrolled in Part B. The aggregate amount of cost sharing in a MA plan must be equal to the aggregate amount of cost sharing in original Medicare. Cost sharing per enrollee (excluding premiums) for covered services cannot be more than the actuarial value of the deductibles, coinsurance, and co-payments under traditional Medicare. Dual eligibles are persons also entitled to the full range of benefits under their state's Medicaid program. Qualified Medicare beneficiaries (QMBs) are those aged or disabled individuals that are entitled to have some of their Medicare cost sharing and Part B premiums paid by the federal-state Medicaid program, but are not entitled to coverage of Medicaid plan services.	*H. §1171.* For plan years beginning on or after January 1, 2011, MA plans would be prohibited from offering benefits with cost sharing requirements that are greater than the cost sharing requirements imposed under the traditional Medicare program. The "actuarially equivalent" standard in the statute would be eliminated. Medicare Advantage plans would not be prohibited from using flat co-payments or per diem rates in lieu of the cost sharing amounts imposed under Part A and B Medicare, as long as they did not exceed the level of cost sharing under traditional Medicare. This provision would also prohibit plans from imposing cost-sharing for dual-eligible individuals or qualified Medicare beneficiaries enrolled in a Medicare MA plan that exceeds the cost-sharing amounts permitted under the Medicare and Medicaid statutes.	*S. §3202.* Similar except the provision would prohibit MA plans from charging cost sharing that is greater than the cost sharing under traditional Medicare for certain services only (chemotherapy treatment, renal dialysis, skilled nursing care, and other services identified by the Secretary). Beginning in 2012, the provision would also restrict plans' authority to apportion their rebates and bonus payments between additional benefits, reduced cost sharing and reduced premiums. MA plans would have to apply the full amount of rebates, bonuses, and supplemental premiums according to the following priority order: (1) reduction of cost sharing, (2) coverage of preventive and wellness benefits, and (3) other benefits not covered under original Medicare.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Continuous open enrollment for enrollees in plans with enrollment suspension. Current Law: Special Election Periods (SEPs) allow beneficiaries the option to discontinue or change their enrollment in a MA plan outside of the annual coordinated election period. The circumstances in which an enrollee can exercise this option include (1) an MA plan terminates its participation in the MA program or in a specific area, (2) an individual's place of residence changes, (3) the MA plan violates a provision of its contract or misrepresents the plan's provisions in marketing the plan, or (4) other exceptional conditions as provided by the Secretary. Medicare beneficiaries may enroll in or change their enrollment in MA from November 15 to December 31 each year (the annual, coordinated election period). Changes go into effect January 1st of the next year. During the first 3 months of the year, beneficiaries can enroll in an MA plan, and individuals enrolled in an MA plan can either switch to a different MA plan or return to original Medicare (the continuous open enrollment and disenrollment period).	*H. §1172.* This provision would require the Secretary to take into account the health or well-being of an individual when determining what constitutes eligibility for a SEP. This provision would expand the categories of beneficiaries eligible to participate in a SEP to include beneficiaries enrolled in MA plans that have been suspended for not meeting the terms of their contract.	No provision.
Information for beneficiaries on MA plan administrative costs. Current Law: The Secretary must provide for activities to disseminate information to current and prospective Medicare beneficiaries about MA plans, including, but not limited to benefits, cost sharing, service area, access, out-of-area coverage, emergency coverage, and supplemental benefits. By the first Monday in June, each local MA plan must submit to the Secretary an aggregate monthly bid amount (which includes separate bids for required services, any offered supplemental benefits, and any offered drug benefits) for each MA plan it intends to offer in the upcoming calendar year. The bid is based on the average revenue requirements in the payment area for an enrollee with a national average risk profile. The	*H. §1173.* This provision would require the publication of administrative cost information, including the medical loss ratio (MLR), for MA plans. Plans that fail to meet a minimum MLR would be subject to sanctions, such as enrollment suspension and potential termination. Beginning in 2011, the Secretary would be required to publish the MLR for the previous year by November 1st for each MA plan contract. The definition of MLR would be defined by the Secretary, taking into account the definition adopted by the Health Choices Commissioner under section 116 of this Act. Each MA plan would be required to submit to the Secretary, in a manner and form specified by the Secretary, the necessary data for	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Secretary has the authority to evaluate and negotiate the plan's bid amounts and its proposed benefit packages.	publishing MLR information on a timely basis. For 2010 and 2011, the data submitted would be required to be consistent in content with the data reported as part of the MA plan bid in June 2009 for 2010. For contract years beginning in 2010, the Secretary would be required to develop and implement standardized elements and definitions for reporting the data necessary to calculate a MLR. The elements and definitions would be developed in consultation with the Health Choices Commissioner, representatives of MA organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners. The Secretary would be required to publish a report describing the elements and definitions no later than December 31, 2010. Beginning in 2014, if the Secretary determines that a MA plan failed to have a MLR of at least 0.85, the Secretary would be required to mandate that the MA plan provide enrollees with a rebate of their Part C premiums (or Part B or D, if applicable) by the amount necessary to meet a MLR of at least 0.85. The Secretary would also be required to restrict enrollment in the MA plan for 3 consecutive years and terminate the plan's contract if the plan failed to meet the MLR requirements for 5 consecutive years.	
Strengthening audit authority. Current Law: The Secretary is required to conduct annual audits of the financial records of at least 1/3 of MA plans. An audit of a plan's financial records would include an audit of data related to Medicare utilization and costs, including allowable costs. Each contract with a MA plan is required to provide that the Secretary has the right to inspect or evaluate the quality, appropriateness and timeliness of services performed under the contract. Contracts must also provide the Secretary with the right to audit any plan's books and	*H. §1174.* The provision would require that the Secretary audit Part C data related to risk adjustment in addition to the plan's data on utilization and costs. The provision would also add a new paragraph to the MA beneficiary and fraud protections section related to the enforcement of audits. Specifically, the paragraph would require that each contract with a MA plan include information on the statutory protections against fraud. The paragraph would also authorize the Secretary to take action, including the pursuit of financial recoveries, to address deficiencies	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
records related to the plan's ability to bear risk, the services delivered, or any amounts payable under the contract.	identified during an annual audit or other activity. The provision would apply to Part D Prescription Drug Plans (PDPs) in the same manner as it applies to Part C plans. The provision would apply to audits conducted for contract years beginning on or after January 1, 2011.	
Authority to deny plan bids. Current Law: By the first Monday in June, each local MA plan must submit to the Secretary an aggregate monthly bid amount (which includes separate bids for required services, any offered supplemental benefits, and any offered drug benefits) for each MA plan it intends to offer in the upcoming calendar year. The bid is based on the average revenue requirements in the payment area for an enrollee with a national average risk profile. Potential PDP sponsors are also required to submit bids by the first Monday in June of the year prior to the plan benefit year. The following information must be included with the bid: (1) coverage to be provided; (2) actuarial value of qualified prescription drug coverage in the region for a beneficiary with a national average risk profile; (3) information on the bid, including the basis for the actuarial value, the portion of the bid attributable to basic coverage and, if applicable, the portion attributable to enhanced coverage, and assumptions regarding the reinsurance subsidy; and (4) service area. The bid also includes costs (including administrative costs and return on investment/profit) for which the plan is responsible. The bid must exclude costs paid by enrollees, payments expected to be made by CMS for reinsurance, and any other costs for which the sponsor is not responsible. In general, the Secretary has the authority to negotiate bids submitted by MA and PDP plans similar to the authority of the Director of the Office of Personnel Management with respect to negotiations with plans participating in the Federal Employees Health Benefits Program. The Secretary may only accept a bid after	*H. §1175.* Beginning January 1, 2011, the Secretary would not be required to accept any or every bid submitted by a MA or PDP plan.	*S. §3209.* Similar provision, except Senate bill also provides the Secretary with the authority to deny bids that propose significant increases in cost sharing or decreases in benefits.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
determining that it is supported actuarially and that it reasonably and equitably reflects the revenue requirements of benefits provided under the plan. The Secretary's authority to negotiate with plans does not apply to Private Fee-for-Service (PFFS) MA plans.		
State authority to enforce standardized marketing requirements. Current Law: The Secretary is required to establish standards, through rulemaking, related to the administration of MA plans. The standards established by the Secretary supersede any State law or regulation, other than those related to licensing or solvency. The standards are required to include guidelines for reviewing marketing materials. In accordance with the guidelines, the Secretary is required to disapprove inaccurate or misleading materials. MA plans are prohibited from distributing marketing materials and enrollment forms unless two conditions are met: 1) they submit the materials to the Secretary 45 days in advance (10 days for model marketing materials) and, 2) the Secretary has not disapproved the materials. MA plans are required to conform to fair marketing standards, which include: 1) prohibiting cash, gifts, prizes, or other monetary rebates to induce enrollment; 2) prohibiting activities such as door-to-door solicitation, cross selling, and sales activities at certain events; and, 3) engaging in other marketing activities such as co-branding, training agents, and making appointments with prospective enrollees in accordance with certain limitations established by the Secretary. Beginning January 1, 2010, MA plans are required to ensure that each MA plan name includes the type of plan (using standard terminology developed by the Secretary).	*H. §1175A.* The provision would allow States to conduct a market conduct examination and impose CMPs against MA and PDP plans as well as their agents and brokers for marketing violations. States would have the authority to recommend to the Secretary that sanctions be imposed against certain plans or their agents. The Secretary would be required to respond to the State's recommendation within 30 days on whether or not the Secretary plans to pursue an investigation. The provision would prohibit States and the Secretary from imposing CMPs for the same violations.	No provision.

Part 3 – Treatment of Special Needs Plans.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Limitation on enrollment outside open enrollment period of individuals into Chronic Care Specialized MA Plans for Special Needs Individuals. Current Law: MMA established a new type of MA coordinated care plan focused on individuals with special needs. Special needs plans (SNPs) are allowed to target enrollment to one or more types of special needs individuals including 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions. Subsequent legislation has extended the effective date of SNPs (which was set to expire December 31, 2008). MMSEA authorized the SNP program through December 31, 2009, but also established a limited moratorium on the creation of SNPs after January 1, 2008 (existing plans could continue to enroll qualified individuals). More recently, MIPPA, among other changes, authorized the SNP program and extended the moratorium on designation of new SNPs until January 1, 2011. Medicare beneficiaries may enroll in or change their enrollment in MA during an annual, coordinated open enrollment period from November 15th to December 31st each year. Changes go into effect January 1st of the next year.	*H. §1176.* The provision would require that beginning January 1, 2011, SNPs serving beneficiaries with severe or disabling conditions only enroll eligible individuals (a) during an annual, coordinated open enrollment period or (b) at the time of diagnosis of the disease or condition that would qualify an individual for a chronic care SNP.	No provision.
Extension of authority of Special Needs Plans to restrict enrollment -- General. Current Law: Prior to January 1, 2011, SNPs may restrict enrollment to those who are in one or more classes of special needs individuals. Starting January 1, 2010, *new* SNP enrollment must be limited exclusively to individuals that meet the criteria for which the SNP is designated: dual eligible, chronic care, and institutional care. Further, MIPPA required that dual eligible SNPs contract with state Medicaid agencies to provide medical	*H. §1177(a).* The provision would extend the time period, from January 1, 2011 to January 1, 2013, during which SNPs would be authorized to restrict current enrollment to individuals who meet the definition of the respective SNP. The provision would also authorize SNPs to restrict enrollment to beneficiaries who met the definition of special needs individuals through January 1, 2016 if these plans had contracts with a state program to operate an integrated Medicaid-Medicare program	*S. §3205(a),(c), and (d).* Similar provision, except the time period during which SNPs would be authorized to restrict enrollment would be extended from January 1, 2011 to January 1, 2014. The provision would also temporarily extend authority through the end of 2012 for SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service area. The bill would require the Secretary to establish a process to transition SNP beneficiaries that do not qualify as special

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
assistance services, which may include long-term care services.	that was approved by CMS as of January 1, 2004.	needs individuals, to fee-for-service Medicare and other MA plans. As part of the transition process, the Secretary would provide for an exception process for beneficiaries who lose Medicaid coverage to reapply for benefits.
Extension of authority of Special Needs Plans to restrict enrollment – Analysis and report on specified dual eligible plans. Current Law: If SNPs do not have contracts with Medicaid agencies by January 1, 2010, they can continue to operate, but are prohibited from expanding their service areas. However, state Medicaid agencies are not required to enter into contracts with SNPs.	*H. §1177(b) and (c).* The provision would require that the Secretary provide an analysis of the integrated Medicare/Medicaid dual eligible SNPs that were approved by CMS as of January 1, 2004. The analysis of these grandfathered SNPs would include the impact of such plans on cost, quality of care, patient satisfaction, and other subjects as specified by the Secretary. By December 31, 2011, the Secretary would be required to submit a report to Congress including recommendations on the appropriate treatment of these plans.	No provision.
Extension of Medicare senior housing plans. Current Law: In general, MA plans are required to serve an area no smaller than a county, which prevents plans from targeting smaller areas of healthier, low-cost enrollees. However, it is possible for an MA plan to receive a waiver of this requirement to be able to restrict enrollment to residents of a retirement community.	*H. §1178.* For periods prior to January 1, 2013, the provision would authorize a new type of MA plan called a MA Senior Housing Facility Plan, which would be allowed to limit its service area to a senior housing facility within a geographic area. An MA Senior Housing Facility Plan would be an MA plan that serves beneficiaries who reside in a continuing care retirement community, has a sufficient number of on-site primary care providers as determined by the Secretary, supplies transportation benefits to other providers, and was in existence under a demonstration for at least one year prior to January 1, 2010. The plan would be precluded from expanding its service area or serving additional senior housing facilities.	*S. §3208.* Similar provision except the effective dates differ (for the Senate the effective date starts in January 1, 2010; for the House it is effective for periods before January 1, 2013) and the provision would require that MA Senior Housing Facility Plans provide beneficiaries with transportation to other providers. The Senate bill does not preclude a Senior Housing Plan from expanding its service area or serving another senior housing facility.
Authority to apply frailty adjustment under PACE payment rules. Current Law: In general, the Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit	No provision.	*S. §3205(b).* The provision would require the Secretary to establish a frailty payment adjustment, similar to PACE, for fully-integrated dual-eligible SNPs. The Secretary would only

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. Most PACE beneficiaries are eligible for both Medicare and Medicaid, and providers receive payments from both Medicare and Medicaid. Under the Medicare, CMS pays PACE providers a monthly capitation rate which is a blend of two components; (1) a county rate multiplied by a uniform PACE frailty adjuster and (2) a risk adjusted payment. Under the Medicaid program, the monthly capitation rate is negotiated between the PACE provider and state Medicaid agencies. The capitation rate is fixed during the contract year regardless of changes in the participant's health status.		have authority to adjust payments to dual-eligible SNP when those plans had fully integrated Medicare and Medicaid benefits, including long-term care, and met other criteria. Fully-integrated dual-eligible SNPs would be exempted from the IME payment phase-out applicable to all MA plans.
Authority to require Special Needs Plans to be National Committee for Quality Assurance (NCQA) approved. Current Law: No provision.	No provision.	*S. §3205(e).* Beginning in 2012, based on standards developed by the Secretary, SNPs would be required to be approved by the National Committee for Quality Assurance in order to serve targeted populations.
Risk Adjustment for Special Needs Plans. Current Law: SSA Sec. 1853(a)(1)(c) requires the Secretary to risk-adjust Medicare payments to MA plans to account for variations in the cost of providing care to older, sicker beneficiaries and to discourage preferential enrollment of younger healthier individuals. Medicare risk adjustment models account for variations in expected medical expenditures for demographic characteristics (age, sex, current Medicaid eligibility, original Medicare eligibility due to a disability), as well as medical diagnoses.	No provision.	*S. §3205(f).* Beginning in 2011, and periodically thereafter, the Secretary would be required to improve, evaluate, revise, and publish the MA risk adjustment payment methodology to recalibrate payments for higher medical and care coordination costs for specified conditions. The Secretary would be required to use these risk scores instead of the default risk score for new SNP enrollees.

Subtitle E – Improvements to Medicare Part D

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Part D coverage gap – Immediate reduction in 2010. Current Law: Medicare law sets out a defined standard benefit structure under the Part D prescription drug benefit. In 2009, the standard benefit includes a $295 deductible and a 25% coinsurance until the enrollee reaches $2,700 in total covered drug spending. After this initial coverage limit is reached, there is a gap in coverage in which the enrollee is responsible for the full cost of the drugs until total costs hit the catastrophic threshold, $6,153.75 in 2009. Each year, the deductible, co-payments, and coverage thresholds are increased by the annual percentage increase in average per-capita aggregate expenditures for covered outpatient drugs for Medicare beneficiaries for the 12-month period ending in July of the previous year.	*H. §.1181(a).* This provision would increase the previously announced 2010 standard initial coverage limit of $2,830 by $500, thus decreasing the time that a Part D enrollee would need to be in the coverage gap. There would be no change in the premiums, bids, or any other parameters as a result of this increase. Additionally, the Secretary would be required to establish procedures to reimburse drug plan sponsors for the associated reduction in beneficiary cost sharing. The Secretary would also be required to develop an estimate of the additional increased costs for increased drug utilization and financing and administrative costs, and use such estimates to adjust payments to Part D sponsors.	*S § 3315.* Substantially similar provision except the initial coverage limit for plan years beginning on January 1, 2011 would be determined as if this 2010 increase had not occurred.
Part D coverage gap – Additional closure in gap beginning in 2011. Current Law: Medicare law sets out a defined standard benefit structure under the Part D prescription drug benefit. In 2009, the standard benefit includes a $295 deductible and a 25% coinsurance until the enrollee reaches $2,700 in total covered drug spending. After this initial coverage limit is reached, there is a gap in coverage in which the enrollee is responsible for the full cost of the drugs until total costs hit the catastrophic threshold, $6,153.75 in 2009. Each year, the deductible, co-payments, and coverage thresholds are increased by the annual percentage increase in average per-capita aggregate expenditures for covered outpatient drugs for Medicare beneficiaries for the 12-month period ending in July of the previous year.	*H. §.1181(b).* This provision would gradually phase out the coverage gap until it is completely eliminated in 2019. Beginning in 2011, the Secretary would progressively increase the initial coverage limit (ICL) and decrease the annual out-of-pocket thresholds (OPT) from the amounts computed under current law, until, beginning in 2019, there is a continuation of coverage through the ICL to the catastrophic threshold. For each year beginning with 2011, the ICL, as computed under current law, would be increased by a cumulative ICL phase-in percentage times the out-of-pocket gap amount for the year. If the ICL computed under current law would be less than the ICL applied during 2010, the ICL for that year would be the ICL determined by Sec. 1181(a) in 2010. The cumulative ICL phase-in percentage means for a year the sum of the annual ICL phase-in percentage for the year and the annual ICL phase-in percentages for each previous year	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	beginning with 2011. The ICL phase-in percentages would mean for 2011, 8.25%; for 2012, 2013 and 2014, 4.5%; for 2015 and 2016, 6%; for 2017, 7.5%; for 2018, 8%, and for 2019, 8% or such other percent that may be necessary to provide for a full continuation of coverage. For each year beginning with 2011, the annual OPT calculated under current law, would be decreased by the cumulative OPT phase-in percentage of the out-of-pocket gap amount for the year multiplied by 1.75. The annual OPT phase-in percentage means for 2011, 0%; for 2012, 2013, and 2014, 4.5%; for 2015 and 2016, 6%; for 2017, 7.5%; ad for 2018 and 2019, 8%. Except as otherwise provided, this provision would be applied as if no increase had been made in the ICL (under 1181(a)).	
Part D coverage gap – Rebates. Current Law: Federal assistance is provided to certain low-income persons to help them meet Medicare Part D premium and cost-sharing charges. In general, beneficiaries may qualify for the Part D low-income subsidy if they have an annual income below 150% of the FPL and if their resources do not exceed a certain limit (in 2009, $12,510 for individuals or $25,010 if married). Prior to the implementation of the Medicare Part D outpatient prescription drug benefit in 2006, Medicaid was the primary payer for drugs for beneficiaries eligible for both Medicare and Medicaid (dual-eligible) beneficiaries. Drug manufacturers who wish to have their drugs available for Medicaid enrollees must provide state Medicaid programs with rebates on drugs paid on behalf of Medicaid beneficiaries. Rebates in the Part D program are negotiated between the drug plans and manufacturers.	*H. § 1181(c).* Under this provision, drug manufacturers would be required to provide the Secretary a rebate for any covered Part D drug of the manufacturer dispensed after December 31, 2009 to any rebate eligible individual for which payment was made by a prescription drug plan (PDP) sponsor or a MA organization, including payments passed through the low-income and reinsurance subsidies. A rebate eligible individual would initially be defined as a full-benefit dual eligible individual (as defined in section 1935(c)(6) of the SSA). For drugs dispensed after December 31, 2014, the definition of rebate eligible would be expanded to include all Part D low income subsidy eligible individuals (as defined in section 1860D-14(a)(3)(A)). In general, the provision would require manufacturers to pay the federal government the difference in the rebate amounts provided to Part D sponsors and the Medicaid rebate for a particular drug for drugs dispensed to rebate eligible enrollees. (Section 1742 of this Act would	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	increase the minimum Medicaid rebate percentage for single source drugs to 23.1% from 15.1% of average manufacturer price (AMP).) The rebates for full-benefit dual eligible Medicare drug plan enrollees would be paid into the Medicare Prescription Drug Account in the Supplementary Medical Insurance Trust Fund and used to pay for all or part of the gradual elimination of the coverage gap. A rebate agreement would, in general, be effective for an initial period of not less than 1 year and would be automatically renewed for a period of not less than 1 year. Drugs or biological products produced by manufacturers who decline to enter into a rebate agreement for the period beginning on January 1, 2010 and ending on December 31, 2010 would not be included as a "covered Part D drug" for the subsequent plan year. The Secretary would be required to establish other terms and conditions of the rebate agreement including terms and conditions related to compliance. For contract years beginning on or after January 1, 2011, each drug plan contract entered into with a PDP sponsor or a MA organization would require that the sponsor or organization report to each manufacturer, no later than a date specified by the Secretary, the following information: (1) the total number of units of each dosage, form, and strength of each drug the manufacturer dispensed to rebate eligible Medicare drug plan enrollees under any PDPs or MA–PDs operated by the sponsor during the rebate period; (2) the price discounts, price concessions, and rebates for such drugs for such form, strength, and period; (3) the extent to which such price discounts, price concessions, and rebates apply equally to rebate eligible Medicare drug plan enrollees and enrollees who are not rebate eligible plan enrollees; and (4) any additional information that the Secretary determines is necessary to calculate the average Medicare drug program rebate eligible rebate	

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	amount. The information submitted would be treated as confidential. The rebate would be paid by the manufacturer to the Secretary not later than 30 days after the date of receipt of this information.	
Discounts for certain Part D drugs in original coverage gap. Current Law: In June 2009, the trade association representing brand-name pharmaceutical manufacturers—PhRMA—pledged to provide a 50% discount to seniors in the Part D coverage gap.	*H. §1182* Under this provision, manufacturers of prescription drugs would be required to, as a condition of allowing any of the drugs they manufacture to be treated as covered drugs under Medicare Part D, enter into agreements with Medicare Part D drug plan sponsors to provide discounts on qualifying (brand-name) drugs provided to plan enrollees in the coverage gap period. This provision would be applicable to drugs dispensed after December 31, 2010.	*S. § 3301.* Similar provision. The Senate provision would establish a Medicare coverage gap discount program under 1860d-14A of the SSA and provide for manufacturer discounts on applicable (brand-name) drugs for beneficiaries who enroll in Part D and have drug spending that falls into the coverage gap. This provision would be applicable to Part D drugs dispensed on or after July 1, 2010.
	Drugs Included . A qualifying drug would be defined as drug that is produced under an original new drug application approved by the FDA, or a drug that was initially marketed under such an application, or a biological product approved under Section 351(a) of the Public Health Service Act, and that is covered under the plan's formulary and is dispensed to an individual who is in the original coverage gap.	*Drugs Included*: Similar definition to the House provision. An applicable drug would mean a covered Part D drug approved under a new drug application under section 505(b) of the Federal Food, Drug, and cosmetic Act or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act, that is covered under the beneficiary's plan's formulary, or is treated as being on the plan's formulary through an exception or appeals process.
	Discount Agreement: Under a discount agreement, a drug manufacturer would be required to provide to each PDP or MA–PD plan a discount for qualifying drugs dispensed to a qualifying enrollee when in the original Part D coverage gap. The Secretary would establish the terms and conditions of the discount agreement, including those relating to compliance, similar to the terms and conditions for rebate agreements between states and drug manufacturers for drugs provided to Medicaid recipients. However, the discounts would be applied to PDPs and MA-PD plans rather than to states. PDP sponsors and MA organizations, instead of states, would be required to provide the necessary utilization information to drug manufacturers and would be	*Discount Agreement:* The provision stipulates that drugs sold and marketed in the U.S. by a manufacturer would not be covered under Part D unless the manufacturer signs an agreement with the Secretary and agrees to participate in the coverage gap discount program. The Secretary would be required to establish a model agreement for use under the program by not later than April 1, 2010 in consultation with manufacturers. These conditions of coverage would not apply if the Secretary has made a determination that the availability of the drug would be essential to the health of beneficiaries or if the Secretary has determined that there are extenuating circumstances in the period between July 1, 2010 and December 31, 2010. For an agreement with a

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	responsible for reporting information on drug-component negotiated prices instead of other manufacturer prices used in calculating Medicaid rebates. For the period beginning January 1, 2010 and ending December 31, 2010, the Secretary may enter into agreements to directly receive the discount, collect the necessary information from PDP and MA-PD plans to calculate the discount amount, and provide the discount to beneficiaries as close as practicable after the point of sale.	manufacturer to be in effect by July 1, 2010, the manufacturer would need to enter into an agreement with the Secretary by May 1, 2010. Initial agreements would be for 18 months (until December 31, 2011) and automatically renewed unless terminated by the Secretary or the manufacturer. In order for an agreement to be in effect for plan year 2012 or a subsequent plan year, the manufacturer would be required to enter into an agreement by January 30 of the preceding year (if the agreement was not automatically renewed). The agreement would require manufacturers to discount drug prices at the pharmacy or through a mail order service at the point of sale. The Secretary would be allowed to provide for the manufacturer discount after the point-of-sale for a temporary period (July 1, 2010 through December 31, 2011) until the necessary data systems are in place to implement the discount at the point-of-sale. The Secretary would not be authorized to receive or distribute funds from manufacturers under the discount program, except for the period between July 1, 2010, and December 31, 2010, if the Secretary determines it is necessary to implement the discount program during that initial period of time. Manufacturers would be required to collect and have available appropriate data as determined by the Secretary to ensure that they can demonstrate compliance with the discount program. The Secretary would be authorized to terminate an agreement within 30 days notice for a knowing and willful violation of the requirements of the agreements or for other good cause. The Secretary would be required to provide, upon request, a hearing concerning such termination, and the hearing would take place prior to the effective date of the termination with sufficient time for the effective date to be repealed if the Secretary determines appropriate. Manufacturers would be allowed to terminate an agreement for any reason. Such

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		termination would not be effective until the end of the benefit year if terminated before January 30 and at the end of the following benefit year if terminated after January 30. Manufacturers could reenter the program for a benefit year if they reenter an agreement by January 30 of the preceding year.
	Amount and Timing of Discount. The amount of the discount for a discount period for a plan would be equal to 50 percent of the amount of the drug component negotiated price for qualifying drugs, and would not include any dispensing fee for the period involved. The sponsor or plan would provide the discount to the enrollee at the time the enrollee pays for the drug if the enrollee is in the actual gap in coverage, and in such cases the amount of the discount, in addition to the amount actually paid by the enrollee, would count toward costs incurred by the plan enrollee. If the enrollee is in the portion of the original gap in coverage that is not in the actual gap in coverage, the discount shall not be applied against the negotiated price for the purpose of calculating the beneficiary payment. However, the manufacturer would be required to provide the discount during the entire "original gap" period. The original gap in coverage is defined as the gap that would occur between the ICL and the OPT under current law. The actual gap in coverage refers to the gap between the initial coverage limit and the out-of-pocket threshold as modified by Section 1181. With regard to payments to pharmacists, discounts under this section are to be treated in a similar fashion to any other discounts, rebates, or price concessions provided to PDP sponsors, and payments to pharmacists in conjunction with these discounts are to be made consistent with prompt payment requirements under Section 1860D–12(b)(4), with the pharmacist to be fully reimbursed for clean claims within 14 days.	*Amount and Timing of Discount.* Beginning July 1, 2010, eligible beneficiaries would automatically receive a 50 percent discount off the negotiated price for applicable prescription drugs that are covered under Part D and covered by their plan's formulary or are treated as being on plan formularies through exceptions and appeals processes. For purposes of the discount, the negotiated price would be the same as defined in 42 CFR 423.100, which is the price that plans pay to pharmacies minus the amount of price concessions (i.e., rebates and discounts) that plans pass on to beneficiaries. Dispensing fees would be excluded from the negotiated price and the discount. Beneficiaries who receive the discount would continue to pay pharmacy dispensing fees. The discount would be made at the point of sale and apply to sole-source and multiple-source brand-name drugs. The provision would also allow 100 percent of the negotiated price of discounted drugs (excluding dispensing fees) to count toward the annual OPT that is used to define the coverage gap each year. The discount would be available during the entire coverage gap—that is, at the point when total prescription costs of a beneficiary exceed the ICL and until it reaches the catastrophic coverage limit each year. In the case where the entire amount of the negotiated price of an individual claim for an applicable drug does not fall within the coverage gap, the manufacturer would provide the discounted price on only the portion of the negotiated price that falls within the gap. For beneficiaries with supplemental benefits that provide some savings during the *doughnut hol*e, the discount would be applied to the costs remaining after the

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		supplemental benefits have been applied. Payment of the discount by manufacturers would be made to pharmacies no later than 14 days after the date of dispensing a discounted drug.
	Qualifying Enrollee. A qualifying enrollee is defined as an individual who is enrolled in a PDP or an MA-PD plan who is not a subsidy-eligible individual as defined in section 1860–D–14(a)(3).	*Qualifying Enrollee.* The discount program would apply to Medicare beneficiaries who enroll in Part D, do not qualify for the low-income subsidy, are not enrolled in an employee-sponsored retiree drug plan, and do not have annual income that exceeds the Part B income thresholds as determined under Present Law ($85,000 for singles and $170,000 for couples in 2009).
	Third Party Contractor. No provision.	*Third Party Contractor.* The provision would require the Secretary to contract with a third-party entity (or entities) to administer the drug discount program and would establish performance requirements for the third party contractors and safeguards to protect the independence and integrity of the activities carried out by the third party. At a minimum, the third party would (1) receive and transmit information between plans, manufacturers and the Secretary; (2) receive and distribute, or facilitate the distribution of, the funds from manufacturers in order to effect the discount to beneficiaries at the point of sale; (3) provide adequate and timely information to manufacturers as necessary for the manufacturer to fulfill its obligations under this section; and (4) permit manufacturers to conduct periodic audits of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program. Manufacturers would be required to contract with the same third party under terms specified by the Secretary in order to carry out their requirements under the discount program.
	Oversight. No provision.	*Oversight.* The provision would also require manufacturers who participate in the Part D drug discount program to be audited for compliance.

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		Manufacturers that do not comply with the discount would be subject to fines assessed and collected by the Secretary. Fines would be commensurate with the amount manufacturers would pay if they had adhered to the discount program, along with an additional penalty equal to 25 percent of the discount amount. The provision would also allow for a reasonable notice and dispute resolution mechanism before penalties could be assessed. The Secretary would be authorized to prohibit a manufacturer's drugs from being covered under Medicare Part D for repeated non-compliance.
Repeal of provision relating to submission of claims by pharmacies located in or contracting with long-term care facilities. Current Law: Section 172 of MIPPA amended Sections 1860D-12(b) and 1857(f)(3) of the SSA to provide for a new set of requirements for contracts between Part D drug plan sponsors and pharmacies located in or contracting with long-term care facilities for plan years beginning on or after January 1, 2010. Each contract entered into with a PDP sponsor or MA-PD plan is required to provide that a pharmacy located in or having a contract with a long-term care facility would have between 30 and 90 days to submit claims for reimbursement.	*H. §1183.* This provision would repeal Section 172 of MIPPA and eliminate these deadlines for pharmacies located in or contracting with long-term care facilities to submit claims for reimbursement.	No provision.
Including costs incurred by AIDS drug assistance programs and Indian health service in providing prescription drugs toward the annual out of pocket threshold under Part D. *Current Law:* Under a standard Medicare Part D plan, beneficiaries must incur a certain level of out-of-pocket costs ($4,350 in 2009) before catastrophic protection begins. These include costs that are incurred for the deductible, cost-sharing, or benefits not paid because they fall in the coverage gap. Costs are counted as incurred, and thus treated as true out-of-pocket (TrOOP) costs only if they are paid by the individual (or	*H. §1184.* This provision would allow costs paid by the Indian Health Service or under an AIDS Drug Assistance Program to count toward the OPT for costs incurred by Part D enrollees on or after January 1, 2011.	*S. §3314.* Identical provision.

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by another family member on behalf of the individual), paid on behalf of a low-income individual under the subsidy provisions, or paid under a State Pharmaceutical Assistance Program. Additional payments that do not count toward TrOOP include Part D premiums and coverage by other insurance, including group health plans, workers' compensation, Part D plans' supplemental or enhanced benefits, or other third parties.		
No mid-year formulary changes permitted. Current Law: Part D plans are permitted to operate formularies—lists of drugs that a plan chooses to cover and the terms under which they are covered. By law, Part D plans may not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year except as the Secretary may permit to take into account new therapeutic uses and newly approved covered part D drugs. Drug plans are also allowed to apply various utilization management restrictions to drugs on their formularies. These restrictions may include assignment of drugs to tiers that correspond to different levels of cost sharing; prior authorization, in which the beneficiary must obtain a plan's approval before it will cover a particular drug; step therapy, in which a beneficiary must first try a generic or less expensive drug; and quantity limits. If a plan removes a covered part D drug from a formulary or makes any change in the preferred or tiered cost-sharing status of a drug, appropriate notice must be provided to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.	*H §1185.* Under this provision, beginning January 1, 2011, Part D sponsors would be prohibited from removing a covered drug from a plan formulary or from making any other material change to the formulary that would have the effect of reducing coverage or of increasing cost-sharing for the drug, after the start of marketing activities for the upcoming plan year. The provision would allow for exceptions if the change is in regard to a brand name drug for which a generic drug was approved during the plan year, or if a recall or a withdrawal of a drug was issued by the Food and Drug Administration (FDA).	No provision.
Negotiation of lower covered Part D drug prices on behalf of Medicare beneficiaries. *Current Law:* Part D plan sponsors (or the pharmacy benefit managers they have contracted with) negotiate prices with drug manufacturers, wholesalers, and pharmacies and are required to provide enrollees with	*H. §1186.* This provision would strike SSA § 1860D-11(i), and in its place, add language that would require the Secretary to negotiate prescription drug prices (including discounts, rebates and other price concessions) that may be charged to PDP sponsors and MA organizations, but	No provision.

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access to these negotiated prices for covered Part D drugs. The law specifically states that the Secretary may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors. Further, the Secretary may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs. This is known as the "non-interference provision" (SSA § 1860D-11(i)).	would still allow prescription drug plans to obtain discounts or price reductions below those negotiated by the Secretary. The provision would maintain the prohibition against the establishment of a formulary by the Secretary; however, there would no longer be an explicit prohibition of the institution of a price structure. The provision would take effect on the date of enactment and would first apply to negotiations and prices for plan years beginning on January 1, 2011.	
Accurate dispensing in long-term care facilities. Current Law: Part D plans are required to offer a contract to any pharmacy willing to participate in its long-term care (LTC) pharmacy network so long as the pharmacy is capable of meeting certain minimum performance and service criteria and any other standard terms and conditions established by the plan for its network pharmacies. Each LTC facility selects at least one eligible LTC pharmacy to provide Medicare drug benefits to its residents. Plan formularies must be structured so that they meet the needs of long-term care residents and provide coverage for all medically necessary medications at all levels of care. Both physician prescribing patterns and pharmacy benefit manager (PBM) payment practices result in prescriptions commonly being dispensed in 30- or 90-day quantities. In situations when the full amount dispensed is not utilized by the patient, for example, due to discharge, death, or adverse reactions, the remaining medication may become waste.	*H. §1187.* To reduce waste, the provision would require Part D sponsors to employ utilization management techniques as determined by the Secretary, such as weekly, daily, or automated dose dispensing, to reduce the quantity dispensed per fill when dispensing medications to beneficiaries who reside in long-term care facilities. In establishing the requirements, the Secretary would be required to consult with the Administrators of the Environmental Protection Agency, the Food and Drug Administration, and the Drug Enforcement Administration; State Boards of Pharmacy; Pharmacy and Physician Organizations; and other appropriate stakeholders. This provision would be effective for plan years beginning on or after January 1, 2012.	*S. §3310.* Substantially similar provision. The Senate provision would require sponsors of PDPs to utilize *specific, uniform* dispensing techniques, such as weekly, daily, or automated dose dispensing, when dispensing covered Part D drugs to enrollees in long-term care facilities to reduce waste associated with 30-day fills. The requirements would be determined by the Secretary in consultation with relevant stakeholders including representatives and residents of nursing facilities, pharmacists, the pharmacy industry, Part D drug plans, and other stakeholders deemed appropriate. This provision would apply to plan years beginning on or after January 1, 2012.
Free generic refill. Current Law: Section 1128A(a) of the SSA authorizes the imposition of CMPs and assessments on a person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs. One form of prohibited conduct, described in section 1128A(a)(5), occurs when a person offers or transfers remuneration to a Medicare or Medicaid beneficiary when such person	*H. §1188.* This provision would amend section 1128A(i)(6) of the SSA to exclude from the definition of remuneration a reduction in or waiver of the copayment amount (under a prescription drug plan offered by a PDP sponsor or an MA-PD plan offered by an MA organization) that is given to an individual to induce the individual to switch to a generic, bioequivalent drug, or biosimilar. This provision would apply to remuneration offered, paid, solicited, or	No provision.

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knows or should know the remuneration is likely to influence the beneficiary's ordering or receiving items or services (payable by Medicare or Medicaid) from a particular provider, practitioner, or supplier. This conduct may be subject to penalties of up to $10,000 for each item received. Section 1128A(i)(6) of the Act defines "remuneration" to include waivers of copayments and deductible amounts (or any part thereof) and transfers of items or services for free or for other than fair market value, subject to certain exceptions.	received on or after January 1, 2011.	
State certification prior to waiver of licensure requirements under Medicare prescription drug program. Current Law: Medicare Part D participants must obtain coverage through a Part D sponsor—a private insurer or other entity that has contracted with Medicare to provide prescription drug benefits. According to Section 1860D-12 of the SSA, a sponsor of a PDP plan is required to be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state it offers a PDP. Under certain circumstances, a sponsor may apply to CMS for a waiver of this requirement. The National Association of Insurance Commissioners (NAIC) has noted instances in which PDP sponsors have been granted waivers from state licensure requirements but did not have fully completed applications for licensure pending at the time the waiver had been granted.	*H. §1189.* The provision would amend Section 1860D-12 of the SSA to require that CMS only grant a waiver of licensure for a particular state if it has received a certification from the State Insurance Commissioner that the prescription drug plan has a substantially complete application pending in that state. Additionally, the waiver could be revoked if the State Insurance Commissioner submits a certification to CMS that the sponsor committed fraud with respect to the waiver, did not make a good faith effort to satisfy state licensing requirements, or was determined by the state to be ineligible for licensure. The requirements would be effective for plan years beginning January 1, 2010.	No provision.
Improving formulary requirements for Prescription Drug Plans and MA-PD Plans with respect to certain categories or classes of drugs. Current Law: Section 1860D-4(b)(3) of the SSA requires Part D plans to operate formularies that cover drugs within each therapeutic category and class of covered Part D drugs, although not necessarily all drugs within such categories and classes. The Secretary of HHS published a regulation (42 CFR Section 423.120) that	No provision.	*S. §3307.* The provision would give the Secretary authority to identify classes of clinical concern as defined by the Secretary, and PDP sponsors would be required to include all drugs in these classes in their formularies. The proposal would also codify the current six classes of clinical concern as they are currently specified through sub-regulatory guidance until the Secretary issues a rule regarding classes of clinical concern to be protected on

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requires Part D plans to have at least two drugs within each therapeutic category and class. However, through sub-regulatory guidance, the Secretary protected access to certain classes of drugs by requiring Part D plans to cover all, or substantially all, of the drugs in the following six drug classes: immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, and anti-neoplastic. Section 176 of the MIPPA codified that, beginning in plan year 2010, the Secretary would identify the classes and categories of drugs that should be protected, or covered entirely by Part D plans, to ensure that beneficiaries have access to certain therapies and to a wide variety of therapy options for certain conditions and established certain criteria the Secretary would use to identify such drugs.		plan formularies. The proposed law would also remove the criteria specified in Section 176 of MIPPA that would have been used by the Secretary to identify protected classes of drugs. The provision would be effective for the 2011 plan year.
Reducing Part D premium subsidy for high-income beneficiaries. Current Law: Beginning in 2007, as required by the MMA, high-income beneficiaries are required to pay higher premiums for Part B benefits. Beneficiaries with a modified Adjusted Gross Income (AGI) that exceeds a threshold amount are charged additional premiums based on a sliding scale that ranges from 35 percent to 80 percent of the value of Part B. In 2009, threshold levels started at $85,000 for an individual tax return and $170,000 for a joint return (based on 2007 returns). The threshold amounts are specified in the law, and are adjusted annually for inflation using the Consumer Price Index (CPI). The income thresholds are tied to specific premium shares. Beneficiary premiums under Part D are not subject to income thresholds or means testing.	No provision.	*S §3308.* This provision would require Part D enrollees who exceed certain income thresholds to pay higher premiums. The income thresholds would be set in a similar manner to those under Part B. The provision would also inflate the income thresholds by the CPI, except for the period between 2010 and 2019 when the income thresholds would not be updated (see *§3402)*. In addition, the provision would expand the current authority for the IRS to disclose income information to the SSA for purposes of adjusting the Part B subsidy to include the Part D subsidy adjustments. Under the provision, upon written request from the Commissioner of Social Security, the IRS may disclose limited return information for a taxpayer whose Medicare Part D premium subsidy may be subject to this adjustment.
Improved Medicare Prescription Drug Plan and MA-PD complaint system. Current Law: Part D and MA related complaints are tracked and resolved through a centralized complaints system within the CMS, while complaints submitted directly to plan sponsors (grievances) are tracked and resolved by each plan sponsor using its own system.	No provision.	*S. §3311.* This provision would require the Secretary to develop and maintain a system, which is widely known and easy to use, to handle complaints regarding MA and Part D plans or their sponsors. The system would have the ability to report and initiate appropriate interventions and monitoring based on substantial complaints and to

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CMS maintains a central repository of MA and Part D-related complaints received by its Regional Offices, Central Office, or through 1-800-MEDICARE.		guide quality improvement. A plan complaint would be defined as a complaint that is received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office, the Medicare Beneficiary Ombudsman, a sub-contractor, a carrier, a fiscal intermediary, or a Medicare Administrative Contractor). The Secretary would be required to develop a model electronic complaint form to be used for reporting complaints under the system that would be displayed on the Medicare.gov and Medicare Beneficiary Ombudsman websites. The Secretary would also be required to conduct annual reports of the complaint system that would include an analysis of the numbers and types of complaints reported under the system; geographic variations in the complaints; the timeliness of agency or plan responses to the complaints; and the resolution of the complaints.
Uniform exceptions and appeals process for Prescription Drug Plans and MA-PD Plans. Current Law: Section 1852(g) of the SSA outlines general requirements regarding MA exceptions and appeals processes. The Part D program adapted many of the existing rules for appeals that apply to the MA program. The coverage and determination and appeals processes may vary among MA and Part D plans as long as these general requirements are met.	No provision.	*S. §3312.* This provision would require a PDP sponsor or MA organization offering MA-PD plans to use a single, uniform exceptions and appeals process with respect to the determination of prescription drug coverage for an enrollee under the plan and to provide instant access to this process through a toll-free telephone number and an Internet website. This provision would apply to exceptions and appeals made on or after January 1, 2012.
Improvement in Part D Medication Therapy Management (MTM) Programs. Current Law: Section 1860-D-4(c) of the SSA requires Part D sponsors to incorporate a Medication Therapy Management Program (MTM) into their plan benefit structures. An MTM program is a program of drug therapy management that may be furnished by a pharmacist and is designed to assure, with respect to targeted beneficiaries, that covered Part D drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk	No provision.	*S. §10328.* Section 1860D-4(c) would be amended to require Part D sponsors to include in their MTM programs an annual comprehensive medication review furnished in person or using telehealth technologies by a licensed pharmacist or other qualified provider, and follow-up interventions as warranted based on the findings of the annual review or the targeted medication enrollment (described below). Additionally, the plan sponsor would be required to have in place a process to assess on a quarterly basis the medication use of individuals who are

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of adverse events. Targeted individuals are those who have multiple chronic diseases, are taking multiple covered part D drugs, and are identified to likely incur annual costs for covered Part D drugs that exceed a level specified by the Secretary. The MTM program may include elements that promote enrollee understanding of the appropriate use of medication and increased adherence with medication regimes. MTMs are to be developed in cooperation with licensed and practicing pharmacists and physicians,		at risk but not enrolled in the MTM program, including individuals who have experienced a transition in care. The plan sponsor would also be required to have in place a process to automatically enroll targeted beneficiaries in the MTM program and permit such beneficiaries to opt out of enrollment in the program. The Secretary of HHS would have the authority to modify or broaden requirements for MTM programs and to study new MTM models through the Center for Medicare and Medicaid Innovation (as added by Section 3021).

Subtitle F – Medicare Rural Access Protections.

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Telehealth expansion and enhancements. Current Law: Medicare covers certain services including professional consultations, office and other outpatient visits, individual psychotherapy, pharmacological management, psychiatric diagnostic interview examinations, neurobehavioral status exams, and end stage renal disease related services delivered via an eligible telecommunications system. An interactive telecommunications system is required as a condition of payment. The originating site (the location of the beneficiary receiving the telehealth service) can be a physician or practitioner's office, a critical access hospital (CAH), a rural health clinic (RHC), a federally qualified health center (FQHC), a hospital-based renal dialysis center, a SNF, a community mental health center or a hospital. The originating site must be in a rural health professional shortage area or in a county that is not in a metropolitan statistical area or at an entity that participates in a specified federal telemedicine	*H. §1191.* A renal dialysis facility would be included as a covered telehealth originating site effective for services starting January 1, 2011. The Secretary would appoint a Telehealth Advisory Committee to make policy recommendations regarding telehealth services including the appropriate addition or deletion of covered services and procedure codes. The committee would be composed of 9 members: 5 would be practicing physicians; 2 would be practicing nonphysicians, and 2 shall be telehealth administrators. The Secretary would be required to ensure that each member has prior telemedicine or telehealth experience; would give preference to those who are currently providing such services or who are involved in such programs; would ensure that committee membership represents a balance of specialties and geographic regions; and would take into account the recommendations of stakeholders. This committee would meet at least twice each calendar year	No provision.

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demonstration project.	and at other times provided by the Secretary. Members would serve for the term specified by the Secretary. A member would not be able to participate in the consideration of a particular matter if such a member (or an immediate family member) had a financial interest that could be affected by the advice given to the Secretary. Section 14 of the Federal Advisory Committee Act governing termination, renewal and continuation of committees would not apply. The committee would not be affected by any restrictions on the number of advisory committees that may be established within HHS or otherwise. The Secretary would be required to take into account the recommendations of this committee in decisions regarding covered telehealth services. If a committee's recommendation is not implemented, the reason for such decision would be published in the *Federal Register*.	
Extend and expand HOPD hold harmless provisions. Current Law: Small rural hospitals (with no more than 100 beds) that are not sole community hospitals (SCHs) can receive additional Medicare payments if their payments for outpatient hospital services under OPPS are less than under the prior reimbursement system. For calendar year (CY) 2006, these hospitals received 95% of the difference between their OPPS payments and those that would have been made under the prior reimbursement system. The hospitals received 90% of the difference in CY2007 and 85% of the difference in CY2008 and CY2009. SCHs with not more than 100 beds received 85% of the payment difference for covered HOPD services furnished on or after January 1, 2009, and before January 1, 2010.	*H. §1192.* Small rural hospitals and sole community hospitals with not more than 100 beds would receive 85% of the payment difference for covered HOPD services furnished until January 1, 2012.	*S. §3121.* The provision would establish that small rural hospitals would receive 85% of the payment difference in CY2010. SCHs with not more than 100 beds would receive 85% of the payment difference in CY2010. The 100-bed limitation for SCHs would be removed so that all SCHs would receive 85% of the payment difference in CY2010.
Extend Section 508 reclassifications and other changes to hospital reclassification policies. Current Law: Section 508 of the MMA provided $900 million for a one-time, 3 year geographic reclassification of certain hospitals that were otherwise unable to qualify	*H. §1193.* The 508 and certain other hospital reclassifications would be extended until September 30, 2011. The Secretary would be required to use the FY2010 wage index data (promulgated in the August 27, 2009 *Federal*	*S. §3137 as modified by S. §10317* This provision would extend the Section 508 and other reclassifications until September 30, 2010. The Secretary would be required to use the FY2010 wage index data (promulgated in the August 27, 2009 *Federal Register* and

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for administrative reclassification to areas with higher wage index values. These reclassifications and other hospitals that were reclassified through the Secretary's authority to make exceptions and adjustments were subsequently extended until September 30, 2009. These extensions are exempt from any budget neutrality requirements.	*Register* and subsequent corrections).	subsequent corrections). Beginning on April 1, 2010, the average hourly wage data of these hospitals would be included in the reclassified area only if including the data results in a higher wage index. Certain hospitals that had a lower wage index from October 1, 2009 through March 31, 2010 than from April 1, 2010 through September 30, 2010 would be paid an additional amount to reflect such difference by December 31, 2010.
Hospital wage index improvement. Current Law: The hospital wage index is used to adjust the standardized amount to account for the local wage variation or cost of labor in the hospital's area. Starting in FY2005, CMS has adjusted this data to account for the relative skill mix of the hospitals in the area. This occupationally mix adjusted average hourly wage is then divided by the same measure calculated using data from all hospitals in the nation to establish the area's adjusted wage index. MedPAC issued its mandated report on recommended changes to the hospital wage index in June 2007. CMS has hired an independent consulting firm to further evaluate the impact of making the recommended changes.	No provision.	*S. §3137 as modified by S. §10317* By December 31, 2011, the Secretary would be required to provide a plan to Congress on how to comprehensively reform the Medicare wage index system; this plan would take into account MedPAC recommendations included in its June 2007, *Report to Congress*. The Secretary would also be required to restore the reclassifications thresholds used in determining hospital reclassifications to the percentages used for FY2009 Medicare Geographic Classification Review Board (MGCRB) decisions, starting in FY2011 and in subsequent fiscal years (until the first fiscal year beginning on or after the date that is one year after the date of the submission of the Secretary's wage index reform plan). This provision would be implemented in a budget neutral fashion.
Apply budget neutrality on a national basis to account for effect of rural and imputed rural floor. Current Law: As required by statute, the wage index for any urban area in a state cannot be less than the rural wage index of that state (often referred to as the rural floor). The effect of the rural floor (that is, raising the wage index for urban areas in a state to that state's rural wage index) is required to be implemented on a budget neutral basis by adjusting the wage index of all hospitals not affected by the rural floor. Until FY2009, CMS funded the budget neutrality requirement associated with the impact of the rural floor though a nationwide adjustment. Starting in FY2009, CMS began a transition	No provision.	*S. §3141.* The proposal would require application of budget neutrality requirement associated with the effect of the imputed rural and rural floor on a national basis (through a uniform, national adjustment to the area wage index) in the case of discharges starting October 1, 2010.

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to fund the budget neutrality requirement through a state-specific adjustment; the statewide adjustment would be fully implemented in FY2011. States with no hospitals receiving the rural floor wage index would not have a reduced payment; those hospitals within each state with urban areas paid at the higher rural wage index would fund the higher payments for the affected hospitals.		
Establish special hospital and physician payments for states with significant frontier counties Current Law: No provision.	No provision.	*S. §10324.* Starting for discharges on October 1, 2010, the area wage index of a hospital located in a frontier state (where 50% of the counties have less than 6 people per square mile) would be no less than one. This would not apply to states where hospitals receive an adjustment to their non-labor related share. This provision would not be applied on a budget neutral basis. The same provisions would apply to covered HOPD services furnished after January 1, 2011 in frontier states. A floor of one on the practice expense index would be established for physician services in these frontier states for physician services on or after January 1, 2011.
Extend geographic floor for work. Current law: The Medicare fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The geographic adjustments are indices that reflect how each area compares to the national average in a "market basket" of goods. A geographic practice cost index (GPCI) with a value of 1.00 represents an average across all areas. A series of bills set a temporary floor value of 1.00 on the physician work index beginning January 2004; most recently, Section 134 of the MIPPA extended the application of this floor when calculating Medicare physician reimbursement through December, 2009. The other geographic indices (for practice expense and medical malpractice) were not modified by these Acts.	*H. § 1194.* The proposal would extend the 1.00 floor for the geographic index for physician work for an additional two years through December 2011.	*S. §3102.* The proposal would extend the work geographic index floor and also add revisions to the practice expense geographic adjustment under the Medicare Physician Fee Schedule. The proposal would extend the 1.00 floor for the geographic index for physician work for an additional year through December 31, 2010. Second, the proposal would direct the Secretary to adjust the practice expense GPCI for 2010 to reflect 3/4 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (i.e. a blend of 3/4 local and 1/4 national) instead of the full difference under current law. For 2011, the adjustment would reflect 1/2 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and

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		the national averages (i.e. a blend of 1/2 local and 1/2 national). Relief would apply only to areas with a practice expense GPCI less than 1.0. The proposal would hold-harmless any areas negatively impacted by the adjustment. The proposal would direct the Secretary to analyze current methods of establishing practice expense geographic adjustments under the physician fee schedule (PE GPCI) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different Medicare payment localities. Based on the analysis and evaluation, the Secretary would make appropriate adjustments to the PE GPCI to ensure accurate geographic adjustments across payment areas, no later than January 1, 2012. Adjustments made in 2012 would be made without regard to the adjustments made in 2010 and 2011.
Extend special payments for certain hospital based physician pathology services. Current Law: In 1999, the Health Care Financing Administration, now called CMS, proposed terminating an exception to a payment rule that had permitted laboratories to receive direct payment from Medicare when providing technical pathology services that had been outsourced by certain hospitals. Congress enacted provisions in BIPA to delay the termination. The special provision has been periodically extended, most recently through December 31, 2009 by MIPPA.	*H. §1195.* The bill would extend this provision through 2011.	*S. §3104.* This proposal would extend the provision through 2010.
Extend special payment for certain ambulance services. Current Law: Ambulance services are paid on the basis of a national fee schedule, which is being phased in. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. The national fee schedule is fully phased in for air ambulance services. For ground ambulance services, payments through 2009 are equal to the greater of the	*H. §1196.* The provision would maintain the 3% higher payments for ground transports originating in rural areas or rural census tracts before January 1, 2012. The MIPPA provision maintaining the designation of certain areas as rural for the purposes of Medicare's payments for air ambulance services would be maintained until December 31, 2011.	*S. §3105 as modified by S. §10311.* The provision would extend the bonus payments and the increased ground ambulance payments until January 1, 2011. The provision to pay certain urban air ambulance services as rural would be extended until January 1, 2011, as well.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
national fee schedule or a blend of the national and regional fee schedule amounts. The portion of the blend based on national rates is 80% for 2007-2009. In 2010 and subsequently, the payments in all areas will be based on the national fee schedule amount.. The ambulance fee schedule payment equals a base rate for the level of service plus payment for mileage. Geographic adjustments are made to a portion of the base rate. For the period July 2004 to December 2009, mileage payments are increased for ground ambulance services originating in rural low population density areas. For the period July 1, 2004 before January 1, 2009, there was a 25% bonus on the mileage rate for trips of 51 miles and more. Payments for ground transports originating in rural areas or rural census tracts are increased by 3% for the period of October 1, 2008 before January 1, 2010. MIPPA specifies that any area designated as rural for the purposes of making payments for ambulance services on December 31, 2006, will be treated as rural for the purpose of making air ambulance payments during the period July 1, 2008 ending on December 1, 2011.		
Extend Medicare's reasonable cost payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas. Current law: Generally, hospitals that provide clinical diagnostic laboratory services under Part B are reimbursed using a fee schedule. Hospitals with under 50 beds in qualified rural areas (certain rural areas with low population densities) receive 100% of reasonable cost reimbursement for the clinical diagnostic laboratories covered under Part B that are provided as outpatient hospital services. Reasonable cost reimbursement for laboratory services provided by these hospitals ended July 1, 2008.	No provision.	*S. §3122.* Reasonable cost reimbursement for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds would be reinstated from July 1, 2010 and extended for one year, ending July 1, 2011.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Treatment of certain complex diagnostic laboratory tests. Current law: Medicare reimbursement for diagnostic laboratory tests performed on specimens collected from a hospitalized patient is included in the DRG payment.	No provision.	*S. §3113.* The proposal would establish a demonstration project under Medicare Part B that would make separate payments, newly established by the Secretary, for complex diagnostic laboratory tests provided to Medicare beneficiaries. The term "complex diagnostic laboratory test" would mean a diagnostic laboratory test that is (a) an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay, (b) determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics, (c) billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code, (d) approved or cleared by the Food and Drug Administration or is covered under the Medicare program; and (e) described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)). The term "separate payment" would mean direct payment to a laboratory (including a hospital-based or independent laboratory) that performs a complex diagnostic laboratory test on a specimen collected from a hospital patient if the test is performed after the hospitalization and if a separate Medicare payment would not otherwise be made. The demonstration project would run for a 2-year period beginning on July 1, 2011, so long as the cost of the demonstration program does not exceed $100 million. Not later than 2 years after the completion of the demonstration project, the Secretary would submit a report to Congress that would include (1) an assessment of the impact of the demonstration project on access to care, quality of care, health outcomes, and expenditures or savings to the Medicare program, and (2) such recommendations as the Secretary would determine to be appropriate.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Extend the Rural Community Hospital Demonstration Program. Current Law: CMS is conducting a five-year Rural Community Hospital Demonstration Program to test the feasibility and advisability of reasonable cost reimbursement for small rural hospitals (those with fewer than 51 beds) in low population density areas. No more than 15 hospitals can participate in the demonstration. Participants were paid the reasonable costs of providing services for discharges in the first year of the demonstration and the lesser of reasonable costs or a target amount for discharges in subsequent cost reporting years. Currently, there are 10 hospitals participating in the program.	No provision.	*S. §3123 as modified by S. §10313.* This provision would extend the demonstration program for an additional five years, expand the maximum number of participating hospitals to 30 for that period, and specify that the 20 states with low population densities would participate in the demonstration project. The Secretary would provide for the continued participation for those hospitals that are in the demonstration at the end of the initial five-year period during the 5-year extension unless the hospital elects to discontinue such participation. Participants would receive the reasonable cost for discharges occurring in the first cost reporting period beginning on or after the first day of the 5-year extension.
Extend the Medicare-dependent Hospital (MDH) Program. Current Law: Medicare dependent hospitals (MDHs) are small rural hospitals with a high proportion of patients who are Medicare beneficiaries. Specifically, the hospitals have at least 60% of acute inpatient days or discharges attributable to Medicare in FY1987 or in 2 of the 3 most recently audited cost reporting periods. As specified in regulation, they cannot be a sole community hospital and must have 100 or fewer beds. MDHs receive special treatment, including higher payments, under Medicare's inpatient prospective payment system. The sunset date for the MDH classification has been periodically extended by legislation and is presently set to expire September 30, 2011.	No provision.	*S. §3124.* MDH classification would be extended one year, until September 30, 2012.
Require HHS Study on urban Medicare-dependent hospitals (MDHs). Current Law: MDHs receive special treatment, including higher payments, under Medicare's inpatient prospective payment system (IPPS). Certain other hospitals, such as rural referral centers (RRC) and sole community hospitals (SCHs) receive special treatment under IPPS. Other small, limited service critical access hospitals	No provision.	*S. §3142.* This provision would require the Secretary to complete a study within 9 months of enactment on the need for an additional Medicare payment for urban Medicare-dependent hospitals paid under IPPS which receive no additional IPPS payments (have an IME or DSH adjustment) or receive special treatment (as an RRC, SCH, or MDH).

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
(CAHs) are exempt from IPPS and paid 101% of their reasonable costs. IPPS includes certain payment adjustments, such as the indirect medical education (IME) adjustment for teaching hospitals, to compensate hospitals for higher average costs which might not be in their control. The disproportionate share hospital (DSH) adjustment increases payments for hospitals that serve a relatively high proportion of poor Medicare and Medicaid patients.		
Change the Medicare inpatient hospital payment adjustment for low-volume Hospitals. Current Law: Under Medicare's IPPS, certain low-volume hospitals receive a payment adjustment to account for their higher costs per discharge. A low-volume hospital is defined as an acute care hospital that is located more than 25 road miles from another comparable hospital and that has less than 800 total discharges during the fiscal year. Under current law, the Secretary is required to determine an appropriate percentage increase for these low-volume hospitals based on the empirical relationship between the standardized cost-per-case for such hospitals and their total discharges to account for the additional incremental costs (if any) that are associated with such number of discharges. The low-volume adjustment is limited to no more than 25%. Accordingly, under regulations, qualifying hospitals (those located more than 25 road miles from another comparable hospital) with less than 200 total discharges receive a 25% payment increase for every Medicare discharge.	No provision.	*S. §3125 as modified by S. §10314.* A temporary adjustment that would increase payment in FY2011 and FY2012 for certain low-volume hospitals would be created. A low volume hospital could be located more than 15 road miles from another comparable hospital and have fewer than 1,600 discharges of individuals entitled to or enrolled for Medicare Part A benefits. The Secretary would determine the applicable percentage increase using a continuous linear sliding scale ranging from 25% for low-volume hospitals with 200 or fewer discharges of individuals with Medicare Part A benefits to no adjustment for hospitals with greater than 1,600 discharges of individuals with Medicare Part A benefits.
Improvements to the demonstration project on community health integration models in certain rural counties. Current Law: A demonstration project to allow eligible entities to develop and test new models for the delivery of health care services in eligible counties has been required by MMA. Those eligible to participate in the demonstration project are limited to certain entities in	No provision.	*S. §3126.* The provision would eliminate the limit of 6 eligible counties that may participate in the demonstration project within the qualifying states. Rural health clinic services would no longer be one of specified CAH services. Rural health clinic services would be removed from the definition of other essential services and replaced with physician services.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
States with at least 65% of its counties in the State with 6 or fewer residents per square mile. Based on these criteria, the Secretary is instructed to select up to 4 states to participate in the demonstration program, and within those states, up to 6 counties. For a county to be eligible to participate, it must have 6 or fewer residents per square mile and contain a critical access hospital (CAH) that furnished one or more of specified services (home health, hospice, or rural health clinic) and had a daily inpatient census of 5 or less as of date of enactment; skilled nursing facility services must be available in the eligible county. The three-year demonstration project began on October 1, 2009 and be done in a budget neutral manner.		
MedPAC Study on adequacy of Medicare payments for health care providers serving in rural areas. Current Law: No provision.	No provision.	*S. §3127.* MedPAC would be required to review payment adequacy for rural health care providers and suppliers serving the Medicare program and provide a report to Congress by January 1, 2011. MedPAC would analyze rural payment adjustments, beneficiaries' access to care in rural communities, adequacy of Medicare payments to rural providers and suppliers, and quality of care in rural areas.
Technical correction related to critical access hospital services. Current Law: CAHs are limited-service rural facilities that meet certain distance criteria; offer 24-hour emergency care; have no more than 25 acute care inpatient beds and have a 96-hour average length of stay. Generally, a rural hospital designated as a CAH receives 101% reasonable, cost based reimbursement for inpatient and outpatient care rendered to Medicare beneficiaries. A CAH may elect an all-inclusive outpatient payment which is equal to a 101% of reasonable costs for facility services plus 115% of the Medicare physician fee schedule payment for professional services when the physician or practitioner has reassigned his or her billing rights to the CAH. As	No provision.	*S. §3128.* Under this provision, Medicare would pay the facility component of the all-inclusive elective CAH payment for outpatient services at 101% of reasonable costs. Medicare would pay for qualifying ambulance services provided by a CAH or by an entity owned and operated by a CAH at 101% of reasonable cost.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
part of its FY2010 rulemaking process, starting October 1, 2009, CMS will lower the facility component of the all-inclusive, elective payment method from 101% to 100% of the CAH's reasonable costs; the payment for professional services will remain at 115% of the fee schedule amount. Medicare pays for ambulance services provided by a CAH or by an entity owned and operated by a CAH at 100% of reasonable costs, but only if CAH or the entity is the only supplier or provider of ambulance services with a 35-mile drive of the CAH or the entity.		
Extension of and revisions to Medicare Rural Hospital Flexibility Program. Current Law: One component of the Medicare Rural Hospital Flexibility Program is a grant program (FLEX grants) that is administered by the Health Resources and Services Administration (HRSA). Under this program, Flex grants may be awarded to States and to small rural hospital for certain purposes. There are certain limitations imposed on the use of grant funds for administrative expenses, both at the state and Federal level. The FLEX grant program is authorized at $55 million for each fiscal year from 2009 and 2010 and the new rural mental health and other services grants is authorized at $55 million for each of fiscal years 2009 and 2010.	No provision.	*S. §3129.* The FLEX grant program would be extended two years until 2012. Starting January 1, 2010, grant funding would be available until expended to be used to assist small rural hospitals to participate in delivery system reforms made by this Act.

Title II – Medicare Beneficiary Improvements.

Subtitle A – Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Improving assets tests for Medicare Savings Program and Low-income Subsidy program. Current Law: Federal assistance is provided to certain low-income persons to help them meet Medicare Part D premium and cost-sharing charges. To qualify for the Part D low-income subsidy, Medicare beneficiaries must have resources no greater than the income and resource limits established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). In general, beneficiaries may qualify for a subsidy if they have an annual income below 150% of the FPL and if their resources do not exceed a certain limit (in 2009, $12,510 for individuals or $25,010 if married).	*H. §1201.* Under this provision, the maximum resources levels used to determine eligibility for the low-income subsidy would be increased. In 2012, the level would be $17,000 for an individual and $34,000 for a couple. In subsequent years, the asset level would be increased by the annual percent increase in the Consumer Price Index (all items, U.S. city average) as of September of the previous year. These maximum resources levels would also apply for determining eligibility for Medicare Savings Programs, beginning January,1, 2012.	No provision.
Elimination of Part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals. Current Law: Cost-sharing subsides for LIS enrollees are linked to the standard Part D prescription drug coverage. Full-subsidy eligibles have no deductible, minimal cost sharing during the initial coverage period and coverage gap, and no cost-sharing over the catastrophic threshold. Full-benefit dual eligibles who are residents of medical institutions or nursing facilities have no cost-sharing.	*H. §1202.* Under this provision, cost-sharing would not apply to persons who were full-benefit dual eligibles and for whom a determination was made that but for the provision of home and community based care, the individual would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded and such care would be paid for by Medicaid. Such home and community based care would be that provided under Section 1915 or 1932 of the SSA or under a waiver under Section 1115 of the Act. The provision would apply to drugs dispensed on or after January 1, 2011.	*S. §3309.* Similar provision. Under this provision, cost-sharing would not apply to persons who were full-benefit dual eligibles and for whom a determination was made that but for the provision of Medicaid home and community-based care, the individual would require the level of care provided in an institutional setting. Such home and community-based care would include services provide under a home and community-based waiver authorized for a State under section 1115 or subsection (c) or (d) of section 1915 or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a Medicaid managed care organization with a contract under section 1903(m) or

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		under section 1932. The provision would be effective on a date specified by the Secretary, but not earlier than January 1, 2012.
Eliminating barriers to enrollment. Current Law: Under the Medicare Part D low-income subsidy program, dual eligibles, those receiving assistance through Medicare Savings Programs, and recipients of SSI are deemed subsidy-eligible individuals for up to one year; other persons, or their personal representatives, have to apply for assistance either at state Medicaid offices or Social Security offices. Applicants are required to provide information from financial institutions as requested to support information in the application, and to certify as to the accuracy of the information provided.	*H. §1203.* Under this provision, individuals applying for the low-income subsidy under the prescription drug program would be permitted to qualify on the basis of self-certification of income and resources beginning January 1, 2010. The information would be subject to verification; however, and except in extraordinary situations as determined by the Commissioner of SSA, the individual would not be required to provide additional documentation.	No provision.
Enhanced oversight relating to reimbursements for retroactive Low Income Subsidy enrollment. Current Law: Individuals who qualify for Medicaid, a Medicare Savings Program, or SSI are automatically deemed eligible for the low-income subsidy, while other individuals with limited income and resources may apply for the low-income subsidy and have their eligibility determined by either the SSA or their state Medicaid agency. As eligibility is effective the month the application was submitted, LIS status is often applied retroactively. If a beneficiary is already enrolled in a Part D plan, the Part D sponsor must take steps to ensure that the beneficiary has been reimbursed for any premiums or cost-sharing the member had paid that should have been covered by the subsidy	*H. §1204.* This provision would enhance oversight to make sure that low-income beneficiaries who are owed retroactive reimbursement payments from their drug plans receive them. The reimbursement would be made by the Part D sponsor no later than 45 days after the date on which the plan receives appropriate notice that the beneficiary is eligible for assistance, and no further information would need to be submitted to the plan by the beneficiary. A retroactive LIS enrollment beneficiary would be defined as an individual who is enrolled in a Part D plan and subsequently becomes eligible as a full-benefit dual eligible individual, Medicare Savings Program eligible, or eligible for SSI, or is a full-benefit dual eligible individual who is automatically enrolled in such a plan.	No provision.
Intelligent assignment in enrollment. Current Law: Generally, there is a two-step process for low-income persons to gain Part D coverage. First, a determination must be made that they qualify for the assistance; second, they must enroll, or be enrolled, in a specific Part D plan. Full-benefit dual-eligible individuals who have not elected a Part D plan are auto-enrolled into one by CMS using a random assignment process.	*H. §1205.* Under this provision, for contract years beginning with 2012, the Secretary would be given the option to use an "intelligent assignment" process as an alternative to the random assignment process. The intelligent assignment process would be designed to maximize the access of full-benefit dual eligibles to necessary prescription drugs while minimizing costs to the individual and to the	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Because of the random nature of the process, some dual eligibles may be enrolled in plans that may not best meet their needs; for example, necessary drugs may not be covered by the new plan.	program to the greatest extent possible.	
Special enrollment period and automatic enrollment process for certain subsidy eligible individuals. Current Law: In general, a Medicare beneficiary who does not enroll in Part D during his or her initial enrollment period may enroll only during the annual open enrollment period, which occurs from November 15 to December 31 each year. Beneficiaries already enrolled in a Part D plan may change their plans during the annual open enrollment period. There are a few additional, limited occasions when an individual may enroll in or disenroll from a Part D plan or switch from one Part D plan to another, called special enrollment periods.	*H. §1206.* The provision would establish a new special enrollment period for persons deemed to be low-income subsidy eligible individuals for subsidy determination made for months beginning with January 2011. The provision would also require the Secretary to use an automatic assignment process to enroll low-income beneficiaries who failed to enroll in a prescription drug plan or MA-PD plan during the special enrollment period. This assignment process would be identical to that used for full-benefit dual eligibles. The individual would have the option of declining or changing such enrollment.	No provision
Application of MA premiums prior to rebate and quality bonus payments in calculation of Low Income Subsidy benchmark. Current Law: The federal government pays up to 100% of the Part D premiums for low-income subsidy (LIS) beneficiaries who are enrolled in "benchmark" plans. A Part D plan qualifies as a benchmark plan if it offers basic Part D coverage with premiums equal to or lower than the regional low-income premium subsidy amount. MA plans offering prescription drug coverage submit a separate bid for the Part D portion. Payment for the portion of the premium attributable to basic prescription drug benefits is calculated in the same way as that for stand-alone PDPs, however an MA plan may choose to apply some of its Part C rebate payments to lower the Part D premium. If an MA plan uses rebate payments to reduce its Part D premium, this reduced amount is factored into the calculation of the regional low-income benchmark. This has the effect of lowering the benchmark and potentially of reducing the number	*H. §1207.* This provision would exclude the Medicare Advantage rebate amounts and MA quality bonus payments, as defined in Section 1161 of this Act, from the MA-PDP premium bids when calculating the low-income regional benchmark for subsidy determinations made for months beginning with January 2011.	*S. § 3302.* Substantially similar provision. This provision would require the Secretary to exclude Medicare Advantage rebates and performance bonus payments from the MA-PDP premium amount when calculating the regional LIS benchmark amounts. The provision would apply to premiums for months beginning on or after January 1, 2011.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
of plans that qualify as low-income plans. MedPAC has noted that the number of plans that qualify as low-income benchmark plans has been decreasing in recent years, resulting in fewer options for LIS enrollees.		
Voluntary de minimus policy for subsidy eligible individuals under Prescription Drug Plans and MA-PD plans. Current Law: The federal government pays up to 100% of the Part D premiums for low-income subsidy (LIS) beneficiaries who are enrolled in "benchmark" plans. A Part D plan qualifies as a benchmark plan if it offers basic Part D coverage with premiums equal to or lower than the regional low-income premium subsidy amount.	No provision.	*S. § 3303.* To help maintain plans that wish to serve LIS beneficiaries at fully subsidized or $0 premiums, this provision would authorize a policy, beginning in 2011, through which plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark amount could choose to absorb the cost of the small difference between their bid and the LIS benchmark in order to qualify as a LIS-eligible plan. The Secretary would be given discretion to auto-enroll LIS beneficiaries into these plans in order to maintain adequate LIS plan choices. The de minimus threshold amount would be established by the Secretary.
Special rule for widows and widowers regarding eligibility for low-income assistance. Current Law: To qualify for financial assistance under the Part D low-income subsidy (LIS) program, Medicare beneficiaries must have resources no greater than the income and resource limits established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). Each year, the Secretary conducts a redeeming process to determine whether those who automatically qualified for the full subsidy in a given year continue to meet the criteria for eligibility in the following year. For those who have qualified for the full or partial subsidy through the application process, the agency that made the determination decision (SSA or an individual state) is responsible for monitoring a recipient's eligibility. For example, for cases in which eligibility has been established through an application with SSA, a report of a subsidy-changing event, such as marriage, divorce, or death of a spouse, will trigger a redetermination of subsidy eligibility during the calendar year. This can result in changes to the individual's	No provision.	*S. §3304.* The proposal would require that, beginning in 2011, the surviving spouse of an LIS-eligible couple undergo a redetermination of his or her eligibility status no earlier than one year from the next redetermination that would have occurred after the death of a spouse. Subsequently, the LIS widow/widower would be determined or redetermined, as appropriate, for LIS on the same basis as other LIS-eligible beneficiaries.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
deductible, premium and cost sharing subsidy, or even termination of his or her LIS eligibility status. In the case of the death of a spouse, it is possible that the surviving spouse, as the sole owner of the previously combined resources, may exceed the resource limit for an individual and may no longer qualify for the LIS program.		
Improved information for subsidy eligible individuals reassigned to Prescription Drug Plans and MA-PD Plans. Current Law: Low-income subsidy (LIS) beneficiaries who are enrolled in plans with premiums below the low-income regional benchmark amount receive assistance with premiums and cost sharing. Those who are enrolled in LIS-eligible plans whose plan bids exceed the regional benchmark amount for the next benefit year are randomly reassigned by the Secretary of HHS to new plans whose bids are at or below the regional benchmark amount in order to ensure that these beneficiaries continue to receive a subsidy of plan premiums. It is possible that the new plan's exceptions, appeals and grievance mechanisms could differ from the old plan and that some covered drug(s) a beneficiary is currently taking would not be covered by the new plan.	No provision.	*S. §3305.* In the case of an LIS beneficiary who has been reassigned to another LIS plan, the provision would require the Secretary, beginning in 2011 to transmit within 30 days of the reassignment, information to the beneficiary about formulary differences between the former plan and the new plan with respect to the beneficiary's drug regimen, as well as a description of the beneficiary's rights to request a coverage determination, exception or reconsideration, or to resolve a grievance.
Funding outreach and assistance for low-income programs. Current Law: Section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) provided $25 million for fiscal years 2008 and 2009 for beneficiary outreach and education activities related to low-income programs related to the Medicare through State Health Insurance Counseling and Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the Administration on Aging (AoA).	No provision.	*S. §3306.* This provision would extend MIPPA Section 119 and provide an additional $45 million for outreach and education activities related to Medicare low-income assistance programs, including the Part D low-income subsidy (LIS) program and the Medicare Savings Program (MSP). Funds would be allocated to SHIPs, AAAs, ADRCs, and the National Center for Benefits Outreach and Enrollment in the same proportion as under MIPPA and would be available for obligation through 2012. The Secretary would also be provided the authority to enlist the support of these entities to conduct outreach activities aimed at preventing disease and promoting wellness as an additional use of these funds.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Sec. 3313. Office of the Inspector General studies and reports. Current Law: According to Section 1860D-14 of the SSA, full-benefit dual-eligible individuals who have not elected a Part D plan are to be auto-enrolled into one by CMS. Because plans vary in the formularies they offer, some dual eligibles could find that they have been auto-enrolled in a plan that may not best meet their needs. Additionally, when the Medicare prescription drug program was created, it was expected that drug plan sponsors would negotiate with drug manufacturers to obtain price concessions on drugs covered under Part D, and thus reduce total costs to the government and to beneficiaries. Some studies have suggested that Part D plans are not obtaining rebates equivalent to those required under Medicaid.	No provision.	*S. §3313.* The proposal would require the Office of Inspector General of HHS (OIG) to report annually, beginning July 1, 2011, on the extent to which formularies used by prescription drug plans and MA-PD plans under Part D include drugs commonly used by full-benefit dual eligible individuals. OIG would also be required to complete a study by October 1, 2011 that would compare covered prescription drug prices paid under the Medicare Part D program to those negotiated by state Medicaid plans for the top 200 drugs determined by both volume and expenditures including all rebates and discounts received by the Medicaid and Part D plans. The report would not disclose information that is deemed proprietary or likely to negatively impact a Medicaid program or Part D plans' ability to negotiate drug prices.

Subtitle B – Reducing Health Disparities

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Ensuring effective communication in Medicare. Current Law: Congress passed Title VI of the Civil Rights Act of 1964 to ensure that federal money is not used to support programs or activities that discriminate on the basis of race, color, or national origin. The U.S. Supreme Court has treated discrimination based on language as national origin discrimination. Therefore, recipients of federal funds (including hospitals, nursing homes, state Medicaid agencies, managed care organizations, home health agencies, health service providers, human service organizations, and any other health or human services federal fund recipient, as well as subcontractors, vendors, and subrecipients) are	*H. §1221-1224.* These sections would require the Secretary to conduct a study to examine the extent to which Medicare providers utilize, offer, or make available language services for LEP, and the ways that Medicare should develop payment systems for language services. The Secretary would be required to submit a report on the study not later than 12 months after the date of enactment. The Secretary would be authorized to use $2 million from the Supplementary Medical Insurance Trust Fund to pay for the study and report. Additionally, section 1857(g)(1) of the SSA would be amended to provide the Secretary authority to apply sanctions, such	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
required to take reasonable steps to ensure that persons with limited English proficiency (LEP) have meaningful access to programs and activities. The Department of Health and Human Services has issued guidance on the types of language services that should be offered, including oral and written interpretation services.	as civil money penalties, suspension of enrollment, and suspension of payments, to Medicare Advantage organizations that fail to provide required language services to LEP beneficiaries enrolled in their plans. Within six months of the completion of the above study, the Secretary would be required to carry out a demonstration program under which the Secretary would award no fewer than 24 three-year grants to eligible Medicare providers to improve effective communication between providers and Medicare beneficiaries living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to such services. Grantees would be required to provide the Secretary with annual reports. No grant under this program could exceed $500,000 for the three-year period. The Secretary would be required to conduct an evaluation of the demonstration program and submit a report to Congress not later than one year after the completion of the program. An amount of $16 million would be authorized to be appropriated for each fiscal year of the demonstration program. The Secretary would also be required to contract a study with the Institute of Medicine on the impact of language access services on the health and health care of LEP populations and report the findings within three years of enactment. Based on the study's findings, the Secretary, in consultation with patients, providers, and organizations representing the interests of LEP individuals, may opt to designate one or more training or accreditation organizations to oversee translation services being provided to Medicare beneficiaries.	

Subtitle C – Miscellaneous Improvements.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Extension of therapy caps exceptions process. Current law: Medicare beneficiaries face two annual payment limits for all outpatient therapy services provided by non-hospital providers. For 2009, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is $1,840, and there is a separate limit for occupational therapy of $1,840. The Secretary was required to implement an exceptions process for 2006, 2007, and the first half of 2008 for cases in which the provision of additional therapy services was determined to be medically necessary. Section 141 of MIPPA extended the exceptions process for therapy caps through December 31, 2009.	*H. §1231.* The provision would extend the exceptions process for therapy caps for two years, through December 31, 2011.	*S. §3103.* The provision would extend the exceptions process for therapy caps for one year, through December 31, 2010.
Extended months of coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions. Current Law: Medicare coverage for beneficiaries with end-stage renal disease (ESRD) generally begins in the fourth month of dialysis treatments or the month of a kidney transplant. After receiving a kidney transplant, individuals are prescribed immunosuppressive drugs to reduce the risk of their immune system rejecting the new organ. If a beneficiary already had Medicare because of age or disability before the onset of end-stage renal disease, or if an individual became eligible for Medicare because of age or disability after receiving a transplant paid for by Medicare, Medicare will continue to pay for immunosuppressive drugs with no time limit. However, if a beneficiary qualifies for Medicare only because of kidney failure, Medicare, together with coverage of the immunosuppressive drugs, ends 36 months after the month of the successful transplant.	*H. §1232.* This provision would amend SSA title II (Old Age, Survivors and Disability Insurance) to (1) continue entitlement to prescription drugs used in immunosuppressive therapy furnished to an individual who receives a kidney transplant for which payment is made under Medicare, and (2) extend Medicare secondary payer requirements for ESRD beneficiaries. It would also amend title XVIII (Medicare) of SSA to apply special rules to kidney transplant recipients who receive additional coverage for immunosuppressive drugs whose eligibility for benefits would have ended on or after January 1, 2012, except for the coverage of immunosuppressive drugs. Such individuals would be deemed to be enrolled under Medicare Part B and would be responsible for the full amount of the applicable premiums, deductibles, and co-insurance payments that are not covered under the Medicare savings program.	*S. §10336* This provision would require the Comptroller General to conduct a study and submit a report, within a year of enactment, on the impact on Medicare beneficiary access to high-quality dialysis services of including specified oral drugs that are furnished to beneficiaries for the treatment of ESRD and included in the ESRD bundled prospective payment system. The study would include an analysis of (1) the ability of providers of services and renal dialysis facilities to furnish specified oral drugs; (2) the ability of providers of services and renal dialysis facilities to comply with applicable State laws, such as State pharmacy licensure requirements in order to furnish such drugs; (3) whether appropriate quality measures exist to safeguard care for Medicare beneficiaries being furnished specified oral drugs by providers of services and renal dialysis facilities; and (4) other areas determined appropriate by the Comptroller General.

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Under Medicare Secondary Payer (MSP) rules, Medicare is prohibited from making payments for any item or service when payment has been made or can reasonably be expected to be made by a third party payer. For individuals with Medicare entitlement based solely on ESRD, MSP rules apply for those covered by an employer-sponsored group plan, regardless of the employer size or current employment status. Any group health plan coverage these beneficiaries receive through their employer or their spouse's employer is the primary payer for the first 30 months of ESRD benefit eligibility. After 30 months, Medicare becomes the primary insurer. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) requires the Secretary to implement a bundled payment system, making a single payment for Medicare renal dialysis services, to be phased in over 4 years beginning January 1, 2011. The bundled payment will include (1) items and services included in the composite rate as of December 31, 2010; (2) erythropoiesis stimulating agents for the treatment of ESRD; (3) injectable biologicals and medications that were paid for separately under Part B, (before bundling) and any oral equivalent to such medications; and (4) diagnostic laboratory tests and other items and services furnished to individuals for the treatment of ESRD. Dialysis facilities will have the opportunity to opt out of the phase-in and be paid under the new bundled system starting in 2011. The new law also creates a quality incentive payment program that ties payments to certain quality measures including anemia management, dialysis adequacy, patient satisfaction, and bone mineral metabolism.	The provision also makes several changes to Medicare coverage for ESRD patients under Section 1881 of the SSA. The provision specifies that oral drugs that are not the oral equivalent of an intravenous drug would be included in the drugs and biologicals provided as part of the renal dialysis services covered by Medicare. The provision also would allow providers of renal dialysis services to make an election with respect to 2011, 2012, or 2013, prior to the first date of such year, to be excluded from the phase in of the prospective rate (or the remainder of the phase in) and be paid entirely based on the prospective rate. Additionally, the provision changes the performance standards of ESRD providers from the "lesser of" to the "greater of" the performance of such provider or facility or a performance standard based on the national performance rates for such measures in a period determined by the Secretary.	
Voluntary advance care planning consultation. Current Law: Sec. 101 of MIPPA of 2008 (P.L. 110-275) added "end-of-life planning" to the initial preventive physical exam that Medicare beneficiaries receive upon	*S. §1233.* The provision would add voluntary advance care planning consultations as a new covered service for eligible Medicare beneficiaries under Part B and provide	No provision.

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enrollment. MIPPA also defines "end-of-life planning" to mean verbal or written information regarding: an individual's ability to prepare an advance directive in the case that an injury or illness causes the individual to be unable to make health care decisions, and whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.	payment to physicians for such consultations. These optional consultations would be conducted by a practitioner, as described, if they have not occurred within the last 5 years. Consultations could be conducted more frequently if there is a significant change in an individual's health. Nothing in this section would require an individual to complete an advance directive, an order for life sustaining treatment, or other advance care planning document; require an individual to consent to restrictions on the amount, duration, or scope of medical benefits as entitled to under Medicare; or encourage the promotion of suicide or assisted suicide. These provisions would take effect on January 1, 2011.	
Part B Special Enrollment Period and waiver of limited enrollment penalty for TRICARE beneficiaries. Current Law: TRICARE beneficiaries who are eligible for Medicare Part A must accept and pay for voluntary Medicare Part B in order to retain their TRICARE Coverage. Medicare functions as the primary payer and TRICARE serves as a supplement. This requirement is the result of many changes in the law the last of which came in the National Defense Authorization Act of 2001 (P.L. 106–386) which created the TRICARE for Life program. With the establishment of TRICARE for Life and the concomitant need to enroll in Medicare Part B, there became concern about coordination between the two programs and the potential for penalties for late enrollment in Part B. To address this concern, section 625 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108–173) waived the Part B enrollment penalty for eligible retirees who enrolled in Part B prior to December 31,2004.	*H. §1234.* *Special Enrollment Period*: This section creates a special 12 month enrollment period in which military retirees who are eligible for Medicare by reason of disability or End Stage Renal Disease (ESRD) who have not yet enrolled in Medicare Part B can enroll in Part B, thus becoming eligible for TRICARE for Life, without incurring a Medicare late enrollment penalty. The Special Enrollment Period (SEP) and waiver of the late enrollment penalty provisions (Sec. 1234 (a&b)) would apply to elections made on or after the date of enactment of the Act. This provision would also require the Secretary of Defense to establish a method for identifying individuals eligible for the SEP and provide them notice of their eligibility for enrollment during the SEP (Sec. 1234(a)(4)). *Rebates.* Additionally, this provision would require the Secretary of HHS to establish a method for providing rebates for late enrollment penalties that were charged to certain disabled and End Stage Renal Disease (ESRD) beneficiaries who enrolled during or after January 2005 and before the month of enactment of this Act. (Sec.	*S. § 3110* *Special Enrollment Period:* The Senate provision uses identical language to create the special enrollment period and identify those eligible for the SEP (Sec. 3110(a)(1-3), and to waive the late enrollment penalty (Sec. 3110(b)). The House and Senate sections differ in the wording and inclusion of effective dates. Specifically, in the Senate version, the provision related to the creation of the SEP would apply to elections made with respect to initial enrollment periods that end after the date of enactment of this Act; no effective date is provided for the waiver of penalty provision. The Senate section includes an additional limitation that stipulates that the twelve-month special enrollment period (SEP) would only be available to individuals once in the individual's lifetime (Sec. 3110(a)(4)). The Senate version would also require that the materials that are provided to individuals prior to their initial enrollment periods contain information on the impact of not enrolling, including the impact on health care benefits under the TRICARE program (Sec. 3110(a)(5)). Similar to the House version, the Senate section also requires the identification of eligible individuals by the Secretary of Defense, but adds additional requirements

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	1242(b)(2).	for the Defense Secretary to consult with the Secretaries of HHS and SSA to assist in identification of individuals and to ensure appropriate follow up after the individuals have been notified.(Sec. 3110(a)(6)) The Secretary of Defense would be required to identify and notify individuals of their eligibility for the SEP; the Secretary of Health and Human Services and the Commissioner for Social Security would support these efforts. *Rebates.* The Senate version does not contain a requirement for the Secretary to establish a method for providing rebates.
Exception for use of more recent tax year in case of gains from sale of primary residence in computing Part B income-related premium. Current law: Medicare beneficiaries have out-of-pocket cost-sharing requirements that differ according to the services they receive. Physician and outpatient services provided under Part B are financed through a combination of beneficiary premiums, deductibles, and federal general revenues. In general, Part B beneficiary premiums equal 25% of estimated program costs for the aged, with federal general revenues accounting for the remaining 75%. Beginning in 2007, higher-income enrollees pay a higher percentage of Part B costs.	*H. §1235.* The provision would exclude income from the gains attributable to the sale of a primary residence from the beneficiary's modified adjusted gross income in determining the Part B income-related premium. This modification would apply to premiums and payments for years beginning with 2011.	No provision. However, see next row (*S. § 3402)* for related issue.
Temporary adjustment to the calculation of Part B premiums. Current law: Medicare Part B finances coverage for physicians' and other outpatient services, in part through premiums paid by beneficiaries who enroll in the voluntary program. Before January 2007, the Part B premium was set at 25 percent of the program's costs per aged enrollee (enrollees who were age 65 or older) and was applied universally to all enrollees. Since then, under a provision of the Medicare Modernization Act, approximately 1.7 million higher-income beneficiaries have faced progressively greater shares of those costs—	No provision. However, see previous row (*H. §1235)* for related issue.	*S. §3402.* The provision would freeze the income thresholds for 2011 through 2019 at the 2010 levels.

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35 percent, 50 percent, 65 percent, or 80 percent, depending on income. The income categories that those shares apply to are based on enrollees' modified adjusted gross income. In 2009, the income thresholds for those premium shares are $85,000, $107,000, $160,000, and $213,000, respectively. (For married couples, the corresponding income thresholds are twice those values.) The income thresholds rise each year with changes in the consumer price index.		
Demonstration program on use of patient decision aids Current Law: No provision.	*H. §1236.* This section would require the Secretary, acting through the Center for Medicare and Medicaid Innovation (established under Sec. 1115A), to establish a Medicare shared decisionmaking demonstration program using patient decision aids to help beneficiaries understand their treatment options. A patient decision aid is defined as an educational tool that helps patients and caregivers decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences. Not more than 30 eligible providers (as defined) would be enrolled in the program. Preference would be given to providers trained in and with documented experience using patient decision aids and shared decisionmaking. Participating providers would be required to schedule a follow-up counseling visit after a beneficiary views the patient decision aid to answer questions about their medical care. The Secretary would be required to establish a payment for such counseling visits. Providers would be responsible for the costs of selecting, purchasing, and incorporating patient decision aids into their practice, and for reporting data on quality and outcome measures under the program. The Secretary would be required to transfer from the Part B Trust Fund such funds as are necessary to carry out the demonstration program, and would be authorized to waive any necessary requirements of SSA Titles XI and XVIII. Within 12 months of completion of the program,	*S. §3506.* This section would also promote the use of patient decision aids, but the focus would be on the development and certification of standards for such aids and the dissemination of best practices. It would add a new Public Health Service Act Sec. 936 requiring the Secretary to enter into a contract with the consensus-based organization with a contract under SSA Sec. 1890 to develop and identify standards for patient decision aids, review patient decision aids, and develop a certification process for determining whether patient decision aids meet those standards. As in the House bill, a patient decision aid is defined as an educational tool that helps patients and caregivers decide with their health care provider what treatments are best for them based on their treatment options, scientific evidence, circumstances, beliefs, and preferences. The Secretary, acting through the Director of AHRQ, would be required to award grants or contracts to develop, update, and produce patient decision aids, to test such materials to ensure they are balanced and evidence-based, and to educate providers on their use. Further, the Secretary would be required to award grants for establishing Shared Decision Making Resource Centers to develop and disseminate best practices to speed adoption and effective use of patient decisions aids and shared decisionmaking. The Secretary also would be required to award grants to providers for the development and implementation of shared

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	the Secretary would be required to evaluate the program and report to Congress with recommendations for legislation and administrative action.	decisionmaking techniques and to assess the use of such techniques. Funds may be used to purchase certified patient decision aids. There would be authorized to be appropriated such sums as may be necessary for FY2010 and each subsequent fiscal year to carry out this section.

Title III – Promoting Primary Care, Mental Health Services, and Coordinated Care.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Establish accountable care organization (ACO) pilot program. Current Law : No current provision. In April 2005, CMS initiated the Physician Group Practice demonstration, which offers 10 large practices the opportunity to earn performance payments for improving the quality and cost-efficiency of health care delivered to Medicare fee-for-service beneficiaries.	*H. §1301.* A new section 1866E would be added to the SSA to establish the accountable care organization pilot program. This pilot program would test different payment incentive models intended to reduce Medicare's expenditure growth and improve health outcomes; promote accountability and coordinate Part A and B items and services, encourage infrastructure investment and process redesign, and reward high quality, efficient physician practices.	*S. §3022 as modified by S §10307.* A new section 1899 would be added to the SSA to establish a shared savings program for the same general purposes as the ACO program in H.R. 3962.
Scope of initial ACO pilot program. Current law: No provision.	*H. §1301.* Specific goals would be set for the number of ACOs, participating practitioners, and patients served under the pilot program initially to ensure there is sufficient size and scope to test the approach in a variety of settings, including urban, rural and underserved areas and, subject to certain qualifications, disseminate the approach rapidly under a national basis. To the extent ACO models are found to be successful, the Secretary would seek to implement such models on as large a	No provision.

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	geographic scale as practical and economical.	
Establish specific payment models. Current Law: No provision.	*H. §1301.* Specific payment incentive models to be tested include: the performance target model, the partial capitation model, and other payment models. Under the performance target model, a qualifying ACO would receive an incentive payment if expenditures for applicable beneficiaries are less than a target spending level or a target rate of growth. The incentive payment would be made only if savings are greater than would result from normal variation in Medicare expenditures for Part A and B items and services (and may include Part D). In general the Secretary would establish a base amount increased to the current year by an adjustment factor. The target may be established on a per capita basis or adjusted for risk. The base amount would equal the average total payments (or allowed charges) under Parts A and B (and may include those under Part D) for applicable beneficiaries for whom the qualifying ACO furnishes items and services. The base amount may determined on a per capita basis or adjusted for risk. The adjustment factor would equal an annual per capita amount that reflects changes in expenditures from the base period to the current year. The base amount would be periodically recalculated. A qualifying ACO that meets or exceeds annual quality and performance targets for a year would receive an incentive payment equal to an appropriate portion of the amount by which Medicare payments are estimated to be below the performance target. The Secretary could establish a cap on incentive payments for a year for a qualifying ACO. In any case, incentive payments to qualifying ACOs would be limited to ensure that the aggregate expenditures (including the incentive payments) do not exceed the amount that the Secretary estimates would be expended for such ACO for such beneficiaries if the pilot program were not implemented.	*S. §3022 as modified by S §10307.* Payments for Part A and Part B services would be made to ACO participating providers and supplies in the same manner as in fee-for-service (FFS) Medicare except an ACO is eligible to receive a shared savings payment if it meets established quality performance and program savings standards. In each year of the 3-year agreement period, an ACO would be eligible for a shared savings payment only if the estimated average per capita Medicare expenditures for Parts A and B services, adjusted for beneficiary characteristics is at least the specified percentage below the applicable benchmark. This appropriate percentage would account for the normal variation in expenditures base on the number of beneficiaries assigned to the ACO. The ACO's benchmark for each agreement period would be based on the most recent available 3 years of per beneficiary Part A and B spending for its assigned beneficiaries. This benchmark would be adjusted for beneficiary characteristics and updated by the projected absolute growth in national per capital expenditures for Part A and B FFS Medicare services, as estimated by the Secretary. The benchmark would be reset at the start of each agreement period. Subject to attaining quality performance standards, an ACO would receive a percent of the difference between the estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and the ACO's benchmark. The remainder of the difference would be retained by the program. The Secretary would establish limits on the total amount of shared savings that may be paid to an ACO. The Secretary could use a partial capitation model or other payment models. As with the H.R. 3962, under the partial capitation model, a qualifying ACO would be at financial risk for some, but not all, of the Part A and B

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	Under the partial capitation model, a qualifying ACO would be at financial risk for some, but not all, of the Part A and B items and services (and may include Part D services as well). The Secretary would be able to limit a partial capitation model to ACOs that are highly integrated systems of care and to ACOs capable of bearing risk. Payments under the partial capitation model would be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended if the pilot were not implemented. The Secretary may develop other payment models that meet the goals of this pilot program to improve quality and efficiency. Payments under these models would be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended if the pilot were not implemented.	items and services. There is no mention of Part D services. The Secretary could limit participation in this model in highly integrated systems capable of bearing risk. Also, spending under this model could not result in greater spending than would otherwise be expended if the model were not implemented. The same general provisions are established for the development of other payment models.
Establish annual quality targets for ACOs. Current law: No provision.	*H. §1301.* An ACO would have to meet annual quality targets in order to receive incentive payments, operate at financial risk or participate in alternative financing models. A process to establish annual targets based on ACO reporting of multiple quality measures would be established. ACOs would be required to report a starter set of measures concerning clinical care, care coordination and patient care experience in years one and two of its participation. In each subsequent year, a more comprehensive set of measures would be required to be reported. To the extent feasible, these measures would reflect national priorities for quality improvement and patient-centered care established elsewhere in the bill.	*S. §3022 as modified by S §10307.* The Secretary would determine appropriate measures to assess the quality of care furnished by the ACO such as measures of clinical processes and outcomes; patient, and where appropriate, caregiver experience of care; and utilization (such as rates of hospital admissions for ambulatory care sensitive conditions). An ACO would submit required data specified by the Secretary in order to evaluate its quality of care. This data could include that on care transition across setting and post hospital followup care. The Secretary would establish quality performance standards and would specify higher standards, new measures or both over time. The Secretary would be able to terminate an agreement with an ACO if it does not meet specified quality performance standards.
Qualifying ACO. Current Law : No current provision.	*H. §1301.* A qualifying ACO would be a group of physicians who are organized, at least in part, for the purpose of	*S. §3022 as modified by S §10307.* An eligible ACO would be defined as a group of providers and suppliers which have an established

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	providing physician services and meet other specified standards, but could include a hospital or any other Medicare provider or supplier that is affiliated with the ACO under an arrangement where the entity participates in the pilot program and shares in any incentive payments. A qualifying ACO would meet the following requirements: (1) have a legal structure that would allow the group to receive and distribute incentive payments; (2) include a sufficient number of primary care physicians (as determined by the Secretary); (3) report on required quality measures in the specified form, manner, and frequency (which may be for the group, for providers of services, and suppliers or both); (4) report required data to monitor and evaluate the pilot program; (5) provide notice to applicable beneficiaries regarding the pilot program; (6) contribute to a best practices network or website to share strategies on quality improvement, care coordination, and efficiency; (7) utilize patient-centered processes of care, and (8) meet other criteria determined to be appropriate by the Secretary.	mechanism for shared governance including (1) ACO professionals in group practice arrangements; (2) networks of individual practices of ACO professionals; (3) partnerships or joint ventures arrangements between hospitals and ACO professionals; (4) hospitals employing ACO professionals and (5) other appropriate groups of providers of services and suppliers. An ACO would be required to (1) be willing to be accountable for the quality, costs, and overall care of assigned Medicare FFS beneficiaries; (2) enter into an 3-year participation agreement; (3) have a formal legal structure to receive and distribute payments; (4) include sufficient primary care ACO professionals to provide care to at least 5,000 beneficiaries (the minimum number assigned to an ACO); (5) provide necessary information to the Secretary to support beneficiary assignment to an ACO, implement quality and reporting requirements, and determine shared savings payments.; (6) have a leadership and management structure including clinical and administrative systems; (7) define processes to promote evidenced based medicine and patient engagement, report on quality and cost measures and coordinate care: and (8) demonstrate that it meets patient centeredness criteria. An ACO professional is a physician or practitioner as defined by statute.
Coordinate ACO pilot program with the physician quality reporting initiative (PQRI) and other physician requirements. Current law: No provision.	*H. §1301.* The Secretary would be able to incorporate reporting requirements, incentive payments, and penalties related to PQRI, electronic prescribing, electronic health records, and other similar physician payment initiatives under section 1848 of the SSA. Alternative criteria than would otherwise apply could be used when determining whether to make these payments. Also, these incentive payments would not be included in the aggregate expenditure test described previously or in the performance target model.	*S. §3022 as modified by S §10307.* Same general provisions.
Define eligible beneficiary; monitor services to beneficiaries who disenroll in ACO pilot.	*H. §1301.* An applicable beneficiary would be an individual who is	*S. §3022 as modified by S §10307.* Same general provision with respect to limiting

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Current law: No provision.	enrolled under part B and entitled to Part A benefits; is not enrolled in a Medicare Advantage plan under part C or a PACE program under Section 1894 of the SSA; and meets other appropriate criteria which may include criteria relating to frequency of contact with an ACO's physicians. The Secretary would be able to monitor data on Medicare expenditures and quality of services after an applicable beneficiary discontinues receiving services through a qualifying ACO.	participants to FFS beneficiaries except enrollment in an eligible organization under Section 1876 (which establishes payments to health management organizations and competitive medical plans) is included. No inclusion of appropriate criteria. No provision with respect to monitoring utilization after disenrollment.
Assign Medicare beneficiaries to ACO	No provision.	*S. §3022 as modified by S §10307.* The Secretary would determine an appropriate method to assign Medicare FFS beneficiaries to an ACO based on their utilization of primary care services by an ACO professional.
Establish start date and duration of ACO agreement. Current law: No provision.	*H. §1301.* The pilot program would begin no later than January 1, 2012. An agreement with a qualifying ACO under this pilot would cover a multi-year period of between 3 and 5 years.	*S. §3022 as modified by S §10307.* The shared savings program would be established no later than January 1, 2012.
Waive other program requirements. Current law: No provision.	*H. §1301.* The Secretary would be able to waive Medicare provisions and the general provisions established under Title XI of the SSA as necessary. Also, Chapter 35 of Title 44 of the United States Code (concerning the coordination of Federal information policy) would not apply to this pilot.	*S. §3022 as modified by S §10307.* The Secretary would be able to waive Medicare requirements and sections 1128A and 1128B of the SSA as necessary. Same waiver with respect to Chapter 35 of Title 44 of the USC.
Require annual performance reports. Current law: No provision.	*H. §1301.* The Secretary would be required to report performance results to qualifying ACOs under the pilot program at least annually.	No provision.
Establish limits on administrative and judicial review of certain aspects of the ACO program. Current law: No provision.	*H. §1301.* There would be no administrative or judicial review of the (1) elements, parameters, scope, and duration of the pilot program; (2) the selection of qualifying ACOs for the pilot program; (3) the establishment of targets, measurement of performance, determinations with respect to whether savings have been achieved and the	*S. §3022 as modified by S §10307.* There would be no administrative or judicial review of the specification of criteria with respect to ACOs that are eligible for shared savings payments, the assessment of the quality of care furnished by an ACO and the establishment of quality performance standards, the assignment of Medicare FFS beneficiaries to an ACO, the

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	amount of savings; (4) determinations regarding whether, to whom, and in what amounts incentive payments are paid; and (5) decisions about the extension of the program with successful ACOs, expansion of the program to additional ACOs or transitional extension of the existing physician group practice demonstration project.	determinations of whether an ACO is eligible for shared savings payments or the amount of such payment (including the determination of the average per capita expenditures and average benchmark for the ACO); the percent of shared savings provided to the ACO and any limit to the shared savings amount; and the termination of an ACO from the program.
Establish evaluation and monitoring requirements for ACO program. Current law: No provision.	*H. §1301.* The Secretary would evaluate the payment incentive model for each qualifying ACO to assess the pilot's impact on beneficiaries, providers, and, suppliers. The evaluation would be publicly available within 60 days of the date of completion of such report. The OIG would be responsible for monitoring of the operation of ACOs under the pilot program with regard to violations of the Stark self referral prohibition (Section 1877 of the SSA).	No provision.
Extend pilot program with successful ACOs. Current law: No provision.	*H. §1301.* No later than 2 years after the date the first pilot agreement is established, and every 2 years thereafter for six years, the Secretary would report to Congress on the use of authorities under the pilot program and its impact on expenditures, access, and quality. Subject to monitoring of the qualifying ACO, the Secretary would be able to extend the duration of the agreement if (1) the ACO receives incentive payments with respect to any of the first 4 years of the pilot agreement and is consistently meeting quality standards or (2) the ACO is consistently exceeding quality standards and is not increasing spending under the program. The Secretary would be able to terminate an agreement if the ACO did not receive incentive payments or consistently failed to meet quality standards in any of the first 3 years under the program.	*S. §3022 as modified by S §10307.* The Secretary would be able to terminate an agreement with an ACO if it does not meet specified quality performance standards.
Expand ACO program to additional organizations. Current law: No provision.	*H. §1301.* Subject to the evaluation of the pilot, the Secretary would be able to enter into agreements with additional qualifying ACOs to further test and refine payment incentive models.	No provision.

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Implement ACO program. Current law: No provision.	*H. §1301.* The Secretary would be able issue regulations to implement on a permanent basis the components of the pilot program that are beneficial to Medicare. However, to do so, the Chief Actuary of the CMS would be required to certify that the expansion of the program's components would result in estimated spending that would be less than what spending would otherwise be estimated to be in the absence of such expansion.	No provision.
Incorporate existing physician group practice demonstration into ACO pilot project. Current law: No provision.	*H. §1301.* The Secretary would be able to enter into an agreement with an organization participating in the physician group practice demonstration as a qualifying ACO under the demonstration under section 1866A established by this section. Participation as a qualifying ACO would be subject to rebasing and other appropriate modifications, until the pilot program under this section is operational.	*S. §3022 as modified by S §10307* During the period beginning on enactment and ending on the date the program is established the Secretary could enter an agreement with an ACO as a demonstration, subject to rebasing and other appropriate modification.
Provide authority for different incentive arrangements and arrangements to encourage participation of smaller ACOs. Current law: No provision.	*H. §1301.* The Secretary would be able to create separate incentive arrangements (including using multiple years of data, varying thresholds, varying shared savings amounts, and varying shared savings limits) for different categories of qualifying ACOs to reflect natural variations in data availability, variation in average annual attributable expenditures, and other matters the Secretary deems appropriate. The Secretary would be able to limit a qualifying ACO's exposure to high cost patients in order to encourage the participation of smaller accountable care organizations in the pilot.	No provision.
Give preference to experienced ACOs. Current law: No provision.	*H. §1301.* The Secretary would be able to give preference to ACOs who are participating in similar arrangements with other payers.	*S. §3022 as modified by S §10307.* Same provision.
Forbid discrimination against beneficiaries with certain health conditions. Current law: No provision.	*H. §1301.* All participating entities would be required to guarantee that it will not deny, limit, or condition the coverage or provision of benefits for eligible individuals based on any health status-related factor described in section 2702(a)(1) of the PHSA, including health status, medical	*S. §3022 as modified by S §10307.* If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO, the Secretary would be able to impose appropriate sanctions on the ACO, including termination from the program.

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	condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.	
Provide funding to administer ACO pilot program. Current law: No provision.	*H. §1301.* Funding of $25 million for each of FY2010 through FY2014 and of $20 million for FY2015 would be appropriated to the Program Management account of CMS.	No provision.
Forbid duplicate payments. Current law: No provision.	*H. §1301.* The Secretary would not make payments to any physician group that is paid for participation in the medical home project (established in Section 1302) or in the independence at home project (established in Section 1312).	*S. §3022 as modified by S §10307.* Same general provisions forbidding duplication of participation in this demonstration and those involving shared savings and the independence at home medical practice project.
Medical home pilot program. Current Law: Sec. 204 of Division B of the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432), as amended by Sec. 133 of MIPPA of 2008, requires the Secretary to establish a 3-year demonstration in up to 8 states with urban, rural, and underserved areas, to redesign the health care delivery system to provide targeted, accessible, continuous, and coordinated family-centered care to high need Medicare populations with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment. Under the demonstration, care management fees are paid to persons performing services as personal physicians, as described, and incentive payments are paid to physicians participating in practices that provide services as a medical home.	*H. §1302.* The provision would establish the Medical Home Pilot Program for the purpose of evaluating Medicare payments to qualified patient-centered medical homes for furnishing medical home services to beneficiaries and to targeted beneficiaries, as specified. The pilot program would evaluate 2 medical home models: (1) the independent patient-centered medical home model; and (2) the community-based medical home model. Beginning no later than 12 months after enactment and operating for up to 5 years, the Secretary would be required to establish a methodology for payment of a monthly fee, paid prospectively, for each targeted high need beneficiary who consents to receive services under the independent patient-centered medical home model, as described. Beginning no later than 2 years after enactment and operating for 5 years, the Secretary would be required to establish a methodology for payment for medical home services furnished under the community based medical home (CBMH) model to a high need beneficiary, as described. Under such methodology, the Secretary would be required to make two separate prospective monthly payments for each high need beneficiary who consents to receive medical	No provision.

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	home services: one to a community-based or State-based organization or State, and the other to the primary or principal care practice. The Secretary would be required to evaluate the pilot program with respect to the cost and quality of such care, as specified. No later than 60 days after the evaluation is completed, the Secretary would be required to submit a report to Congress and the public on the findings of the evaluation and the extent to which standards for the certification of medical homes need to be updated. Subject to the evaluation, the Secretary would be authorized to issue regulations to implement one or more models on a permanent basis, to the extent that such models are beneficial to Medicare, but only if the Chief Actuary of CMS were to first certify that the expansion would not result in higher estimated Medicare spending than otherwise estimated in the absence of such expansion. The provision would include certain administrative provisions including prohibiting duplication in payments for individuals in medical homes, among others. For the purposes of carrying out the pilot program, $6 million would be transferred from the Federal Supplementary Medical Insurance Trust Fund (Part B Trust Fund) to the CMS Program Management Account for each of FYs 2010 through 2014, in addition to funds otherwise available. Also, the following would be available to CMS from the Part B Trust Fund, in addition to funds otherwise available: $200 million for each of FYs 2010 through 2014 for payments for independent patient-centered medical home services; and $125 million for each of FYs 2012 through 2016 for CBMH services. In addition to funds otherwise available, $2.5 million would be available to CMS from the Part B Trust Fund for initial implementation costs for each of FYs 2010 through 2012, which would remain available until expended. In addition to funds otherwise available, $100 million established by the TRHCA for the existing Medicare Medical Home Demonstration would be available to the independent patient-centered medical	

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	home pilot program. The provision would require that amendments made by this section apply to services furnished on or after the date of enactment. The authority for the Medicare Medical Home Demonstration project would be repealed.	
Community health teams to support medical homes. Current Law: See current law under the "Medical Home Pilot Program," H §1302, above.	No provision.	*S. §3502, as amended by S. §10321.* The provision would require the Secretary to establish a program to fund certain eligible entities, as specified, that establish community-based health teams to support primary care providers and provide capitated payments to such providers, as determined by the Secretary. Health teams would be required to carry out certain specified activities, including establishing contractual agreements with primary care providers to provide support services; supporting patient-centered medical homes, as defined; and developing plans that integrate preventive services for patients; and others. It would also require contracted primary care providers to provide care plans for participants, access to health records, and regular meetings with the care team. This section would require a funded entity to submit a report to the Secretary, as requested.
Payment incentive for selected primary care services. Current law: Medicare uses a fee schedule to reimburse physicians for the services they provide. In certain circumstances, physicians receive an additional payment to encourage targeted activities. These bonuses, typically a percentage increase above the Medicare fee schedule amounts, can be awarded for a number of activities including demonstrating quality achievements, participating in electronic prescribing, or practicing in underserved areas. For instance, Section 1833(m) of the Social Security Act provides bonus payments (10% of what would otherwise be paid under the fee schedule) for physicians who furnish medical care services in geographic areas that are designated by the Health Resources and Services Administration (HRSA) as	*H. §1303.* The provision would establish payment incentives for primary care services furnished on or after January 1, 2011 by a primary care practitioner. The amount of the payment incentive would be 5% (or 10% if the practitioner provides the services predominately in an area that is designated as a primary care health professional shortage area) and would be paid from the Part B Trust Fund. Primary care services would be defined as evaluation and management services and preventive services, regardless of the specialty of the physician providing the service. The primary care services incentive payments would not be taken into account in determining the additional payments for physicians in health professions shortage areas or in physician scarcity areas.	*S. § 5501.* The provision would establish a new 10% bonus on select evaluation & management and general surgery codes under the Medicare fee schedule for five years, beginning January 1, 2011. The primary care service codes to which this bonus would apply would be office visits, nursing facility visits, and home visits. The bonus would be available to primary care practitioners who (1) are physicians who have a specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine, or are nurse practitioners, clinical nurse specialists, or physician assistants, and (2) furnish 60 percent of their services in the select codes. Practitioners providing major surgical procedures in health professional shortage areas would also be eligible for a bonus under this provision. Over the same five

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primary medical care health professional shortage areas (HPSAs) under section 332 (a)(1)(A) of the Public Health Service (PHS) Act.		year period beginning January 1, 2011, general surgeons providing care in a HPSA would also be eligible for a ten percent bonus on major surgical procedure codes, defined as surgical procedures for which a 10-day or 90-day global period is used for payment under the Medicare fee schedule. The review and adjustment of RVUs (under Section 1848(c)(2)(B)) would be adjusted for these incentives; only half (50 percent) of the cost of the bonuses would be taken into consideration in the budget neutrality calculation in 2011 and in subsequent years, with an across-the-board reduction to all codes (through a modification of the conversion factor) accounting for the adjustment, except for physicians who primarily provide services in health professionals shortage areas.
Increased reimbursement rate for certified nurse-midwives. *Current Law:* Section 1833 of the SSA provides for Medicare payments for services received by covered individuals. For certified nurse-midwife services, the amount required to be paid is 80% of the lesser of either (1) the actual charge for the services, or (2) the amount determined by a fee schedule established by the Secretary. The fee schedule is not allowed to exceed 65% of the prevailing charge that would be allowed for the same services performed by a physician.	*H. §1304.* The proposal would amend section 1833(a)(1)(K) of SSA to remove the 65% restriction for Medicare payments to certified nurse-midwives. The modification would apply to services furnished on or after January 1, 2011.	*S. §3114.* Similar provision. This provision would amend Section 1833(a)(1)(K) of the SSA by stipulating that for services provided on or after January 1, 2011, the fee schedule for certified-midwife services would not be allowed to exceed 100% of the fee schedule amount provided under Section 1848 for the same service performed by a physician.
Coverage and waiver of cost-sharing for preventive services Current Law: Under several subsections of SSA§1861, Medicare Part B covers a number of clinical preventive services, including a one-time comprehensive examination, certain periodic cancer screenings, certain vaccines, and other services. Congress has waived cost-sharing for some but not all of these services under SSA§1833(a) re: coinsurance, and/or SSA§1833(b) re: application of the deductible. Sec. 101 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275, SSA§1861(ddd)) provided	*H. §1305.* The bill would amend SSA§1861 to define "Medicare covered preventive services" as a specified list of currently covered services, and any services subsequently covered under the Secretary's administrative authority. Coverage would be subject to conditions and limitations that currently apply to each listed service, except that SSA§1833(a) and 1833(b) would be amended to waive any cost-sharing (coinsurance and/or deductible) that currently applies. This provision would apply to services furnished on or after January 1, 2011.	*S. §4104.* The bill would amend SSA§1861 to define preventive services covered by Medicare as a specified list of currently covered services. Coverage would be subject to conditions and limitations that currently apply to each listed service, except that SSA§1833(a) and 1833(b) would be amended to waive, for most services, any cost-sharing (coinsurance and/or deductible) that currently applies. Services for which no coinsurance would be required are the one-time comprehensive examination, personalized prevention plan services (as under Sec. 4103 of this bill), additional preventive service covered

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administrative authority for the Secretary to add Part B coverage of additional preventive services under specified conditions. Among other conditions, a preventive service that may be covered under this authority must be recommended (i.e., with a grade of A or B) by the United States Preventive Services Task Force (USPSTF). Medicare Advantage (Part C) is an alternative way for Medicare beneficiaries to receive covered benefits through private health plans. Medicare Advantage plans must cover benefits covered under Part B, but have considerable flexibility in how they apply or waive cost-sharing. Many of these plans waive cost-sharing for preventive services.		under the Secretary's administrative authority, and any currently covered preventive service (including medical nutrition therapy and excluding electrocardiograms) if it is recommended (i.e., with a grade of A or B) by the USPSTF. Section 4104 would generally waive the deductible for the same preventive services noted above for which coinsurance would be waived. It would not, however, waive the deductible for additional preventive service covered under the Secretary's administrative authority. This provision would apply to services furnished on or after January 1, 2011.
Coverage and waiver of cost-sharing for preventive services – Abdominal aortic aneurysm (AAA) screening. Current Law: Under SSA§1861(s)(AA), Medicare Part B covers AAA screening for certain beneficiaries based on risk and/or physician referral.	*H. §1305.* The bill would require the Secretary, to the extent practical, to identify and implement policies promoting proper use of AAA screening among Medicare beneficiaries at risk for such aneurysms.	No provision.
Coverage and waiver of cost-sharing for preventive services – Reports. Current Law: No provision.	*H. §1305.* The bill would require the Secretary, within 12 months of enactment, to report to Congress on barriers, if any, facing Medicare beneficiaries in accessing the benefit to abdominal aortic aneurysm screening (see below) and other preventive services through the Welcome to Medicare Physical Exam.	No comparable provision. However, as noted elsewhere, *S. §4204(e).* would require GAO to study, and report by June 1, 2011, regarding the impact of vaccine coverage under Medicare Part D on access to those vaccines by beneficiaries who are 65 years of age or older. It would appropriate $1 million for FY2010 for this study.
Waiver of deductible for colorectal cancer screening test regardless of coding, subsequent diagnosis, or ancillary tissue removal. Current Law: SSA§1861(pp) provides Medicare Part B coverage of colorectal cancer screening tests, defined as "procedures furnished to an individual for the purpose of early detection of colorectal cancer...." The law does not explicitly address the situation in which the screening test may detect abnormalities which result in diagnostic and/or treatment procedures during the same	*H. §1306.* The bill would amend SSA§1833 to clarify that cost sharing would be waived for colorectal cancer screening services regardless of the code applied, of the establishment of a diagnosis, or of the removal of tissue or other matter or other procedure that is performed in connection with and as a result of the screening, in the same clinical encounter. This provision would apply to services furnished on or after January 1, 2011.	*S. §4104.* Though bill language is not identical, the policy is the same.

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visit. Under SSA§1833(b), the deductible does not apply to colorectal cancer screening services. Coinsurance, however, is required.		
Excluding clinical social worker services from coverage under the Medicare skilled nursing facility prospective payment system and consolidated payment. Current Law: The majority of services provided to beneficiaries in a Medicare covered SNF stay are included in the bundled prospective payment made to the SNF. Certain services have been specifically excluded from SNF consolidated billing. In these instances, Medicare will pay the entity providing the service directly. Currently, the items and services provided by a clinical social worker are included in the SNF consolidated billing.	*H. §1307.* The provision would exclude items and services provided by clinical social workers to Medicare beneficiaries in a SNF from SNF consolidated billing and would establish a separate Medicare payment on or after October 1, 2010.	No provision.
Coverage of marriage and family therapist services and mental health counselor services. Current Law: Section 1861(s)(2) of the SSA defines "medical and other health services" as including medical supplies, hospital services, diagnostic services, outpatient physical therapy services, rural health clinic services, home dialysis services and supplies, antigens and physician assistant and nurse practitioner services. Marriage and family therapists and mental health counselors are not included under current law.	*H. §1308.* The provision would add two subcategories of services to be covered under the term "medical and health services." These are (1) marriage and family therapists, and (2) mental health counselors. The provision would stipulate the required qualifications for a marriage and family therapist, and mental health counselor. It would define these providers' services as the diagnosis and treatment of mental illnesses, as permitted by his or her state license, if no other provider or facility is also paid for those services. The provision would also add a payment provision for marriage and family therapists, and mental health counselors. The amount paid would be 80% of the lesser of the actual charge for services or 75% of the amount that would be paid for a psychologist's services. The provision would require the Secretary to consider confidentiality issues while developing criteria allowing for direct payment of the therapist and medical information sharing with the patient's primary care physician. The provision would exclude marriage and family therapists and mental health counselors from the prospective payment system for	No provision.

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	skilled nursing facilities. The provision would include marriage and family therapists and mental health counselors as providers in rural health clinics and federally qualified health centers. The provision would also include marriage and family therapists and mental health counselors as one of the practitioner categories who can file claims for services provided.	
Extension of physician fee schedule mental health add-on. *Current Law:* By law, every five years CMS examines Medicare billing codes under the physician fee schedule to determine whether they are overvalued or undervalued. Subsequent to the most recent evaluation, Medicare increased the rates for the codes used by physicians to bill for "evaluation and management" (E/M) services (face-to-face visits with patients), effective January 1, 2007. To maintain budget neutrality, rates for certain other codes, including some used to bill for psychotherapy services, were reduced. MIPPA increased Medicare payments under the fee-schedule for psychotherapy services by 5% beginning on July 1, 2008 and ending on December 31, 2009.	*H. §1309.* The provision would extend the increased payments for psychotherapy services for two additional years (ending December 31, 2011).	*S. §3107.* The Senate provision would extend the add-on payment provision for one additional year (ending December 31, 2010.)
Expanding access to vaccines. Current Law: Under SSA§1861, Medicare Part B covers three vaccines and the cost of their administration. Covered vaccines are those against influenza, pneumococcus, and, for individuals at increased risk, hepatitis B. Medicare Part D covers any FDA-licensed vaccine, and the cost of its administration, when prescribed by a recognized provider.	*H. §1310.* The bill would provide Medicare Part B coverage for all federally recommended vaccines, defined as any FDA-approved vaccine that is recommended for use by the CDC. Generally, provisions in this section would apply to services furnished on or after January 1, 2011.	*S. §4204(e).* The bill would require GAO to study, and report by June 1, 2011, regarding the impact of vaccine coverage under Medicare Part D on access to those vaccines by beneficiaries who are 65 years of age or older. It would appropriate $1 million for FY2010 for this study.
Expansion of Medicare-covered preventive services at Federally Qualified Health Centers. Current Law: Under SSA§1861(aa)(3)(A), FQHCs may receive Medicare reimbursement for services furnished to covered beneficiaries by physicians and other specified providers, and for the three vaccines currently covered under Medicare Part B, as noted above.	*H. §1311.* The bill would amend SSA§1861(aa)(3)(A) to provide that FQHCs may receive reimbursement for Medicare covered preventive services, as defined in Section 1305 of this bill. This amendment would be effective not later than January 1, 2011.	*S. §5502(a).* The bill would amend SSA§1861(aa)(3)(A) to provide that FQHCs may receive reimbursement for Medicare covered preventive services, as defined in Sec. 4104 of this bill, furnished on or after January 1, 2011.

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Independence at Home demonstration program. Current Law: No provision.	*H. §1312* Adds new SSA§1866G(a). The Secretary would be required to conduct a Medicare demonstration program, beginning no later than January 1, 2012, to test a payment incentive and service delivery model that uses physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services to certain chronically ill Medicare beneficiaries. The demonstration would also be required to test whether a model, which is accountable for providing comprehensive, coordinated, continuous, and accessible care to a high-need populations at home and coordinating health care across all treatment settings, results in (A) reducing preventable readmissions; (B) preventing hospital readmissions; (C) reducing emergency room visits; (D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness; (E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests; (F) reducing the cost of health care services covered under Medicare; and (G) achieving beneficiary and family caregiver satisfaction.	*S. §3024* Adds new SSA§1866D(a). In general, the Senate bill is the same as the House bill with respect to the Independence at Home demonstration program unless otherwise stated. For this subsection, the provisions are the same.
Independence at Home demonstration programs – Medical practices. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(b)(1).* The Secretary would enter into agreements, of no more than 3 years, with qualifying independence at home medical practices, legal entities comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provide care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff, as appropriate. No more than 10,000 people could participate in the demonstration. These practice staff would have experience providing home-based primary care services to applicable beneficiaries. Practice staff would, among other requirements, make in-home visits and be available 24	*S. §3024 – Adds new SSA§1866D(b)(1).* The provision is similar except that the Senate bill clarifies that Independence at Home medical practice entities would *furnish services* to at least 200 applicable beneficiaries each year (rather than "include" at least 200 applicable beneficiaries, as stated in the House bill.)

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	hours per day, 7 days per week to carry out care plans tailored to the individual beneficiary's chronic conditions, among others. These entities would also be organized at least in part for the purpose of providing physicians' services; have documented experience in providing home-based primary care services to high cost chronically ill beneficiaries, as determined appropriate by the Secretary; *include* at least 200 applicable beneficiaries; have entered into an agreement with the Secretary; use electronic health information systems, remote monitoring, and mobile diagnostic technology; and meet such other criteria as the Secretary determines to be appropriate. Physicians would include, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physician services and has the medical training or experience to fulfill the physician's role.	
Independence at Home demonstration programs – Medical practices, continued. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(b)(2) and (3), and SSA§1866G(e)(4).* *SSA§1866G(b)(2) and (3).* Nurse practitioners or physician assistants would not be prohibited from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if (A) all the requirements of this provision are met: (B) the nurse practitioner or physician assistant is acting consistent with state laws; (C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role. Independence at home medical practices would not be prohibited from including providers of services or participating practitioners that are affiliated with the practice so that such providers or practitioners could participate in the demonstration's shared savings. *SSA§1866G(e)(4).* In approving an independence at home medical practice, the Secretary would be required to give preference to practices that are located in high-cost areas of the country; have experience in furnishing	*S. §3024 – Adds new SSA§1866D(b)(2) and (3), and SSA§1866D(e)(4).* Same provision.

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	health care services to applicable beneficiaries in the home; and use electronic medical records, health information technology, and individualized care plans.	
Independence at Home demonstration programs – Number of practices. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(e)(5).* The Secretary would be required to enter into agreements with as many independence at home medical practices as practicable and consistent to test the potential of this model to achieve results across practices serving varying numbers of beneficiaries.	No provision.
Independence at Home demonstration programs – No physician duplication in demonstration participation. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(e)(2).* The Secretary would be prohibited from paying an independence at home medical practice that participates in the Acute Care Episode pilot program (*H. §1152(f)*which adds a new *SSA§1866D*) or in an Accountable Care Organization Pilot Program (*H. §1301*which adds a new *SSA§1866E*).	*S. §3024 – Adds new SSA§1866D(e)(2).* The Secretary would be prohibited from paying an Independence at home medical practice that participates in The Medicare Shared Savings Program as added by *S. §3022*.
Independence at Home demonstration programs – Beneficiary participation. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(d).* Applicable Medicare beneficiaries would be entitled to Medicare Part A, enrolled in Medicare Part B, and not enrolled in a Medicare Advantage plan or a Program for the All-Inclusive Care for the Elderly (PACE). Eligible individuals would be determined by a practice to have 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high Medicare costs; have had a nonelective hospital admissions within the past 12 months; have received acute or subacute rehabilitation services, within the past 12 months; have 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and meet such other criteria as the Secretary determines	*S. §3024 – Adds new SSA§1866D(d).* The same provision.

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	appropriate. The Secretary would be required to determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program would be required to be voluntary. Nothing in this provision should encourage physicians or nurse practitioners from limiting applicable beneficiary access to services covered under Medicare and applicable beneficiaries would not be required to relinquish access to any Medicare benefit as a condition to receiving services from an independence at home medical practice.	
Independence at Home demonstration programs – No beneficiary duplication in demonstration participation. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(e)(3).* The Secretary would be required to ensure that no applicable beneficiary enrolled in an independence at home medical practice is participating in Accountable Care Organization programs created in section 1866E or the Acute Care Episode Pilot under section 1866D.	*S. §3024 – Adds new SSA§1866D(e)(3).* The Secretary would be required to ensure that no applicable beneficiary enrolled in an independence at home medical practice is participating in the Medicare Shared Savings program under section 1899.
Independence at Home demonstration programs – Shared savings payment methodology. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(c)(1).* The Secretary would be required to establish a methodology for sharing savings with independence at home medical practices for annual expenditures less than a target spending level for items and services covered under parts A and B. Target spending levels, which would account for normal variation in expenditures for items and services covered under parts A and B, could be set for either all qualifying practices or for groups of practices or a single practice.	*S. §3024 – Adds new SSA§1866D(c)(1).* Different from H.R. 3962. The Secretary would be required to establish an estimated annual spending target, for the amount the Secretary estimates would have been spent in the absence of the demonstration for items and services under Medicare parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice. Such spending targets would be required to be determined on a per capita basis and would include a risk corridor that takes into account normal variation in expenditures for items and services covered under Medicare parts A and B furnished to such beneficiaries. The size of the corridor would be related to the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets could also be adjusted for other factors as the Secretary determines appropriate.

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Independence at Home demonstration programs – Shared savings amounts. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(c)(2) and (3).* Practices with annual aggregate expenditures for applicable beneficiaries less than the target spending level would be eligible for an incentive payment. The Secretary would determine how savings beyond the first 5% (relative to set target spending levels) are to be apportioned among practices, taking into account the number of beneficiaries served by each practice, the characteristics of the individuals enrolled in each practice, the practices' performance on quality performance measures, and other factors as the Secretary determines appropriate. The Secretary must limit payments for shared savings to each practice so that aggregate expenditures for applicable beneficiaries would not exceed the amount that the Secretary estimates, less 5 percent, would be expended for such services for such beneficiaries enrolled in an independence at home medical practice if the demonstration program had not been implemented.	*S. §3024 – Adds new SSA§1866D(c)(2).* Incentive payments would be designed as follows. Subject to performance on quality measures, a qualifying independence at home medical practice would be eligible for an incentive payment if actual expenditures for a year for the applicable beneficiaries enrolled by that practice are less than the estimated spending target for such year. An incentive payment for such year would be equal to a portion, as determined by the Secretary, of the amount by which actual expenditures for applicable beneficiaries under Medicare parts A and B for such year are estimated to be less than 5 percent less than the estimated spending target for such year.
Independence at Home demonstration programs – Quality and performance standards. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(b)(4).* In general, an independence at home medical practice participating in the demonstration program would be required to report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determine appropriate to monitor and evaluate the demonstration program. The Secretary would be required to develop quality performance standards for participating independence at home medical practices.	*S. §3024 – Adds new SSA§1866D(b)(4).* The Secretary would be required to develop quality performance standards for participating independence at home medical practices.
Independence at Home demonstration programs – Antidiscrimination limitation. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(i).* The Secretary is required to ensure that an entity entering into an agreement under the demonstration project guarantees it will not deny, limit, or condition the coverage or provision of benefits that a participating	No provision.

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	beneficiary would have otherwise been entitled to on the basis of health status if not included in this program.	
Independence at Home demonstration programs – Termination. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(j).* The Secretary could terminate an agreement with an independence at home medical practice if such practice does not receive incentive payments or consistently fails to meet quality standards.	*S. §3024 – Adds new SSA§1866D(i).* Same and adds that the Secretary would be required to terminate an agreement with an independence at home medical practice if the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program or such practice fails to meet quality standards during any year of the demonstration.
Independence at Home demonstration programs – Evaluation. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(f).* The Secretary would be required to evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the demonstration's desired results. The Secretary could monitor data on expenditures and quality of services under Medicare after an applicable beneficiary discontinues receiving services under Medicare through a qualifying independence at home medical practice. The Secretary would be required to conduct an independent evaluation and submit to Congress a final report on the demonstration's best practices and the impact of the demonstration program on coordination of care, expenditures under this title, beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.	*S. §3024 – Adds new SSA§1866D(f).* The same provision.
Independence at Home demonstration programs – Funding. Current Law: No provision.	*H. §1312 – Adds new SSA§1866G(h).* In addition to funds otherwise appropriated, other than for incentive payments, the provision would transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medicaid Insurance Trust Fund $5 million for each of fiscal years 2010 through 2015 to the Secretary for CMS to administer the demonstration program. Funds would be available until expended.	*S. §3024 – Adds new SSA§1866D(h).* Similar but provision specifies that the proportion of amounts transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medicaid Insurance Trust Fund would be determined by the Secretary.

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Recognition of certified diabetes educators as certified providers for purposes of Medicare diabetes outpatient self-management training services. Current Law: SSA§1861(qq) provides Medicare coverage of diabetes outpatient self-management training (DSMT) services provided by a certified provider, defined as a physician or other provider who provides other items or services, in addition to DSMT services, that are reimbursed under Medicare.	*H. §1313.* The bill would amend SSA§1861(qq) to designate certain certified diabetes educators as Medicare-certified providers of covered DSMT services. A "certified diabetes educator" would be defined as an individual who meets specified criteria including certification by a "recognized certifying body," which also would be defined. This section would be effective for services furnished on or after the first day of the first calendar year that is at least 6 months after the date of enactment.	No provision.
Community-based care transitions program. Current Law: No provision.	No provision.	*S. §3026.* Community-Based Care Transitions Program. Beginning January 1, 2011, the provision would establish a five-year Community Care Transitions Program under Medicare. Under this program, the Secretary would fund eligible acute care hospitals located in one of the fifty states identified as having high readmission rates as defined in Section 3025 of the bill and certain community-based organizations that provide care transition services across a continuum of care to certain high-risk Medicare beneficiaries. These community-based organizations would provide services through arrangements with IPPS hospitals (acute care hospital) and whose governing body includes sufficient representation of multiple health care stakeholders (including consumers). High-risk Medicare beneficiaries would mean beneficiaries entitled to Medicare part A and enrolled in Medicare part B (but not enrolled in Medicare Advantage). More specifically, they would have attained a minimum hierarchical condition category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care. Such diagnoses or risk factors could include cognitive impairment, depression, a history of multiple readmissions, and any other chronic disease or risk factors determined by the

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		Secretary. A readmission would conform to the new statutory definition established in Section 1886(q)(5)(E) of the SSA as added by Section 3025 of the bill. Applications to the Secretary by hospitals and their community-based organization partners to participate in this program would be required to include a detailed proposal for at least one care transition intervention. This intervention could include, other than discharge planning process already paid for by Medicare: (i) initiating care transition services for high-risk Medicare beneficiaries no later than 24 hours prior to the hospital discharge. (ii) arranging timely post-discharge follow-up services to provide the beneficiary (and, as appropriate, the primary caregiver) with information regarding symptoms that may indicate additional health programs or a deteriorating condition. (iii) providing beneficiaries with assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers. (iv) assessing and actively engaging with a high-risk Medicare beneficiary through the provision of self-management support and relevant information. (v) conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support). In selecting participating entities, the Secretary would be required to prioritize those entities that participate in a program administered by the Administration on Aging to provide current care transitions interventions with multiple hospitals and practitioner; or provide services to medically underserved populations, small communities, and rural areas. A total of $500 million for FYs 2011 through 2015 would be transferred by the Secretary from the Federal Hospital Insurance Trust Fund and the Federal

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		Supplementary Medical Insurance Trust Fund for this program in such proportion as the Secretary determines appropriate. Amounts transferred would be required to remain available until expended. The Secretary would have the authority to expand the scope and duration of the program if the Secretary (and the CMS' Chief Actuary) determines Medicare spending would be reduced without reducing quality.
Annual wellness visit. Current Law: Medicare does not cover routine visits to assess beneficiaries who do not have symptoms of an illness, or to develop prevention plans. In 2003, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress required Medicare to cover a one-time Initial Preventive Physical Examination (IPPE) and health risk appraisal (the "Welcome to Medicare" exam) for new Part B enrollees.	No provision.	*S. §4103 as amended by S.§10402(b).* The bill would amend SSA§1861to require that Medicare Part B cover, without cost sharing, beginning on January 1, 2011, "personalized prevention plan services," including a comprehensive health risk assessment. The personalized plan could include several specified elements, including medical and family history; identification of health risk factors; and a plan for preventive screenings. All enrolled beneficiaries would be eligible for personalized prevention plan services once every year without any cost sharing. During the first year of Part B enrollment, beneficiaries could receive only the IPPE. Beneficiaries would be eligible to receive personalized prevention plan services each year thereafter provided that the beneficiary has not received either an IPPE or personalized prevention plan services within the preceding 12 months. The Secretary would be required to develop appropriate guidance and conduct outreach and related activities with respect to personalized prevention plan services and health risk assessments. These services would be included in the list of Medicare covered preventive services under Sec. 4104 of this bill.
Authority to modify coverage of currently covered preventive services. Current Law: In general, Medicare law authorizes the Secretary to cover services for the diagnosis and treatment of illness, while coverage of preventive services (i.e., services provided in the absence of symptoms) has required legislation. As noted earlier,	No provision.	*S. §4105.* The bill would authorize the Secretary, effective January 1, 2010, to modify the coverage of any currently covered preventive service (including services included in the IPPE, but not the IPPE itself) to the extent that the modification is consistent with USPSTF recommendations. This section also would allow the

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authority provided in MIPPA allows the Secretary to cover additional preventive services if specified conditions are met. However, the Secretary is not authorized to modify the coverage of those preventive services currently covered through statute.		Secretary to withhold payment for any currently covered preventive service graded D (i.e., recommended against) by the USPSTF. The enhanced authority would not apply to services furnished for the purposes of diagnosis or treatment (rather than as preventive services furnished to asymptomatic patients).
Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries. Current Law: No provision.	No provision.	*S. §4202* Sec. 4202(b) would require the Secretary to conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries, and report to Congress by September 30, 2013. $50 million in total from the Medicare Part A and Part B Trust Funds would be used to pay for this activity.

Title IV – Quality.

Subtitle A – Comparative Effectiveness Research.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Comparative effectiveness research/patient-centered outcomes research Current law: The Institute of Medicine (IOM) defines comparative effectiveness research (CER) as the "the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition, and improve the delivery of care" with the aim of tailoring	*H. §1401* The proposal would establish a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality under title XI of the Social Security Act. The Center would conduct, support, and synthesize research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which	*S. §6301, as modified by §10602.* The proposal would modify title XI of the Social Security Act to authorize the establishment of a private, non-profit, tax-exempt corporation, which would be neither an agency nor establishment of the United States government, that would be known as the "Patient-Centered Outcomes Research Institute." The Institute would be subject to the provisions of this section and, to

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decisions to the needs of individual patients. CBO has referred to CER as "a comparison of the impact of different options that are available for treating a given medical condition for a particular set of patients." MedPAC has referred to "comparative-effectiveness" as "analysis [that] compares the clinical effectiveness of a service (drugs, devices, diagnostic and surgical procedures, diagnostic tests, and medical services) with its alternatives." The phrase "patient-centered outcomes research" has also been used as an alternate term. Recently, comparative effectiveness research has been addressed in current law by the Medicare Modernization Act of 2003 (MMA, P.L. 108-173) and the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5). Section 1013 of the MMA authorizes the Agency for Healthcare Research and Quality (AHRQ) to conduct and support research on outcomes, comparative clinical effectiveness, and appropriateness of pharmaceuticals, devices, and health care services. The section also prohibits the Centers for Medicare and Medicaid Services (CMS) from using the data to withhold coverage of a prescription drug. The ARRA provided $1.1 billion in funds to support the development and dissemination of CER. ARRA also asked the Institute of Medicine to recommend national priorities for the research to be addressed by ARRA funds.	diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.	the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act. The purpose of the Institute would be to assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient sub-populations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items.
Duties and powers	The duties of the Center would be to (1) conduct, support, and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services, and systems, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions; (2) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment; (3) continuously develop rigorous scientific methodologies for conducting comparative effectiveness studies, and	The duties of the Institute would be to (1) identify research priorities and establish a research agenda, (2) carry out the research project agenda, (3) collect relevant data from CMS and other sources, (4) appoint expert advisory panels, (5) support patient and consumer representatives, (6) establish a methodology committee, (7) provide for a peer-review process for primary research, (8) release research findings, (9) adopt the national priorities identified in (1), and (10) provide annual reports to Congress and the President. The Board of the Institute (see below) would carry out the

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	use such methodologies appropriately; (4) submit to the Comparative Effectiveness Research Commission (see below), the Secretary, and Congress appropriate relevant reports; and (5) enter into an arrangement under which the Institute of Medicine (IOM) would conduct an evaluation and report on standards of evidence for highly credible research, (6) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post-marketing drug and medical device surveillance efforts, and other forms of electronic health data, and (7) appoint clinical perspective advisory panels for CER research priorities, which would consult with patients and other stakeholders and advise the Center on research questions, methods, and evidence gaps in terms of clinical outcomes for the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research would be clinically relevant to decisions made by clinicians and patients at the point of care. The Center could secure information (data) necessary to enable it to carry out its duties directly from any department or agency of the United States. Upon request of the Center, the head of that department or agency would furnish the information to the Center on an agreed upon schedule. The duties of the Commission (see below) would include the following: (1) Determine national priorities for research that would take into account (i) disease incidence, prevalence, and burden in the U.S.; (ii) evidence gaps in terms of clinical outcomes; (iii) variations in practice, delivery, and outcomes by geography, treatment site, provider type, disability, variation in age group (including children, adolescents, adults, and seniors), racial and ethnic background, gender, genetic and molecular subtypes, and other appropriate populations or	duties of the institute, and duties (1) and (9) are non-delegable responsibilities of the Board.

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	subpopulations; and (iv) the potential for new evidence concerning certain categories, health care services, or treatments to improve patient health and well-being, and the quality of care. In making such determinations, the Commission would consult with a broad array of public and private stakeholders, including patients and health care providers and payers. (2) Monitor the appropriateness of use of the Comparative Effectiveness Research Trust Fund (CERTF), described below, with respect to the timely production of CER determined to be a national priority. (3) Identify highly credible research methods and standards of evidence for such research to be considered by the Center. (4) Review the methodologies developed by the Center as described below. (5) Support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Center to advance methods and standards that promote highly credible research. (7) Make recommendations to the Center for policies that would allow for public access of data produced under this section, in accordance with appropriate privacy and proprietary practices, while ensuring that the information produced through such data is timely and credible. (8) Review the processes of the Center and make reports to Congress and the President at least annually regarding research conducted, supported, or synthesized by the Center to confirm that the information produced by such research is objective, credible, consistent with standards of evidence developed under this section, and developed through a transparent process that includes consultations with appropriate stakeholders. These reports would not be submitted to the OMB or to any other federal agency or executive department for any purpose prior to transmittal to Congress and the	

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	President, and the reports would be published on the Commission's public Internet website after the date of transmittal. (9) Make recommendations to the Center for the broad dissemination of the findings of research conducted and supported under this section that enables clinicians, patients, consumers, and payers to make more informed health care decisions that improve quality and value. (10) Hold a public meeting with an opportunity for stakeholder input at least twice a year.	
Governance and oversight	An independent Comparative Effectiveness Research Commission would be established to advise the Center and evaluate its activities to ensure that the activities result in highly credible research and information. The members of the Commission would consist of the Director of the AHRQ, the Chief Medical Officer of the CMS, and the Director of the NIH or their designees, as well as 16 additional members who would represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, and consumers of federal and state beneficiary programs. Of such members, at least 10 would be practicing physicians, health care practitioners, consumers, or patients. The members of the Commission would represent a broad range of perspectives and collectively would have experience in epidemiology, health services research, bioethics, decision sciences, health disparities, and health economics. To ensure a diverse representation of the health care community, at least one member would represent each of the following: (1) patients, (2) health care consumers, (3) practicing physicians, including surgeons, (4) other health care practitioners engaged in clinical care, (5) organizations with proven expertise in racial and ethnic minority health research, (6) employers, (7) public payers, (8) insurance plans, and (9) clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers. No more than 3 of the members of the Commission could be	The proposal would establish a Board of Governors for the Institute, which would be responsible for carrying out the duties of the Institute. The Institute's Board would consist of the Directors of AHRQ and the NIH (or their designee) and 17 other members appointed not later than 6 months after enactment by the Comptroller General. The Board would include (i) 3 members representing patients and health care consumers; (ii) 7 members representing physicians and providers, including 4 physicians with at least one surgeon, 1 nurse, and 1 state-licensed integrative health care practitioner and 1 representative of a hospital; (iii) 3 members representing private payers, of whom at least 1 member would represent health insurance issuers and at least 1 member would represent employers who self-insure employee benefits; (iv) 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers; (v) 1 member representing quality improvement or independent health service researchers; and (vi) 2 members representing the federal government or the states, including at least 1 member representing a federal health program or agency. The Board would represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research including epidemiology, decision sciences, health economics, and statistics. Board members would be appointed for a term of 6

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	representatives of pharmaceutical or device manufacturers and these representatives would be clinical researchers as described in (9). The Comptroller General (CG) would appoint the members of the Commission. The CG would designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the CG could designate another member for the remainder of that member's term. The Chairman would serve as an ex officio member of the National Advisory Council of the AHRQ. Of the members first appointed, 8 would be appointed for a term of 4 years and 8 would be appointed for a term of three years. Subsequently, each member of the Commission would be appointed for a term of four years. While serving on the business of the Commission (including travel time), members would be entitled to compensation at a per diem equivalent of the rate provided for level IV of the Executive Schedule. While serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Director of the Commission. Subject to review as the CG would deem necessary to assure the efficient administration of the Commission, the Commission could (1) appoint an executive director (subject to the approval of the CG) and other personnel as Federal employees under §2105 of Title 5 USC as may be necessary to carry out its duties (without regard to the provisions of Title 5 USC, governing appointments in the competitive service); (2) seek assistance and support from appropriate federal departments and agencies as might be required in the performance of its duties; (3) enter into contracts or make other arrangements for the conduct of the work of the Commission, as may be necessary without regard to §3709 of the Revised Statutes (41 USC 5) on competitive bids; (4) make	years except for the members first appointed, whose terms would be staggered evenly over 2-year increments. No individual would be appointed to the Board for more than 2 terms. Vacancies would be filled in the same manner as the original appointment. The CG would designate a Chairperson and Vice Chairperson from among the members of the Board; these members would serve in such capacity for a period of 3 years. Each member of the Board who is not an officer or employee of the federal government would be entitled to compensation equivalent to the rate provided for level IV of the Executive Schedule as well as for expenses incurred while performing the duties of the Board. An officer or employee of the federal government who is a member of the Board would be exempt from compensation. The Board could employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Institute and could seek such assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute. The Board would meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel would be advertised at least 7 days in advance and open to the public. A majority of the Board members would constitute a quorum, but a lesser number of members could meet and hold hearings. The Institute would provide for the conduct of financial audits of the Institute on a annual basis by a private entity with expertise in conducting financial audits. The CG would review the following: (1) the financial audits (at least annually); (2) the processes established by the Institute, including the research priorities and the conduct of research projects, in order to determine

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	advance, progress, and other payments that relate to the work of the Commission; (5) provide transportation and subsistence for persons serving without compensation; and (6) prescribe such rules and regulations as it were to deem necessary with respect to the internal organization and operation of the Commission.	whether information produced by such research projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process (at least every 5 years); (3) the dissemination and training activities and data networks established under section 937 of the Public Health Service Act, including the methods and products used to disseminate research, the types of training conducted and supported and the types and functions of the data networks established, in order to determine whether the activities and data are produced in a manner consistent with the requirements under the section (at least every 5 years); (4) the overall effectiveness of activities conducted under this section and the dissemination, training, and capacity building activities conducted under section 937 of the Public Health Service Act. Such review shall include an analysis of the extent to which research findings are used by health care decision-makers, the effect of the dissemination of such findings on reducing practice variation and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States (at least every 5 years); (5) the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization of research findings by public and private payers, funding sources for the PCORTF are appropriate and whether such sources of funding should be continued or adjusted (not later than 8 years after the date of enactment). The CG would submit an annual report to Congress not later than April 1 of each year containing the results of the above review conducted with respect to the proceeding year (or years), together with recommendations for legislation and administrative action as the CB determines appropriate.

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Conflict of Interest	In appointing the members of the Commission or a clinical perspective advisory panel (described below), the CG or the Secretary, respectively, would take into consideration any financial interest (defined below) and develop a plan for managing any identified conflicts. When considering an appointment to the Commission or a clinical perspective advisory panel, the CG or the Secretary, respectively, would review the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual would later require a written determination, certification, or waiver with respect to Title 18, USC. Prior to a meeting of the Commission or a clinical perspective advisory panel, each member of the Commission or the clinical perspective advisory panel who is a full-time government employee or special government employee would disclose any relevant financial interests to the CG or the Secretary. A member of the Commission or a clinical perspective advisory panel could not participate with respect to a particular matter considered in a meeting of the Commission or the clinical perspective advisory panel if the member were to have a financial interest that could be affected by the advice given to the Secretary regarding the matter, excluding interests exempted in regulations issued by the Director of the Office of Government Ethics as too remote or inconsequential to affect the integrity of the services of the government officers or employees to which such regulations apply. The Secretary could grant a waiver if the Secretary were to determine it necessary to afford the Commission or a clinical perspective advisory panel the essential expertise of the member. The waiver would permit such a member to participate as a non-voting member with respect to a particular matter under consideration in a	In appointing the Board, the CG would consider and disclose any conflicts of interest in accordance with the requirements below. Members of the Board would be recused from relevant Institute activities in the case where the member (or an immediate family member) were to have a real conflict of interest directly related to the research project or the matter that could affect or be affected by the member's participation. In general, a conflict of interest would be disclosed (1) by the Institute when appointing members to an expert advisory panel, in selecting individuals to contribute to any peer-review process, and for employment as executive staff of the Institute, (2) by the CG in appointing members of the methodology committee, and (3) by the Institute in the annual report, except that, in the case of individuals contributing to any peer review process, the description would be in a manner such that those individuals cannot be identified with a particular research project. Conflicts of interest would be disclosed as soon as practicable on the Internet web site of the Institute and of the GAO. The information disclosed would include the type, nature, and magnitude of the interest of the individual involved, except to the extent that the individual recuses himself or herself from participating in the consideration of or any other activity with respect to the study as to which the potential conflict exists. The Institute, its Board, and its staff would be prohibited from accepting gifts, bequeaths, or donations of services or property. In addition, the Institute would be prohibited from establishing a corporation or generating revenues from activities other than as provided under this section.

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	Commission or a clinical perspective advisory panel meeting, or as a voting member with respect to a particular matter considered in a meeting of the Commission. The number of waivers granted to members of the Commission could not exceed one-half of the total number of members for the Commission. However, no voting member of any clinical perspective advisory panel would be in receipt of a waiver, and no more than two nonvoting members of any clinical perspective advisory panel would be serving under waiver. For purposes of determining conflict of interest under this section, the term "financial interest" would mean a financial interest under section 208(a) of title 18, United States Code.	
Coordination	To enhance effectiveness and coordination, the Secretary would be encouraged to seek coordination between the Commission and the National Advisory Council of the AHRQ, to the greatest extent possible.	No provision.
Federal Advisory Committee Act	The Federal Advisory Committee Act (FACA) would apply to the Commission, with the exception of section 14 regarding termination, renewal and continuation of advisory committees.	No provision
Research capacity and requirements	The establishment of the Center's research agenda would be informed by the national priorities for research as recommended by the Commission and would be insulated from inappropriate political or stakeholder influence. The methods of conducting the research would be scientifically based. Consistent with applicable law, all aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research would be transparent to all stakeholders. The Center would provide opportunities for all stakeholders involved to review and provide public comment on the methods and findings throughout the process of research. The research would consider advice given to the Center by the clinical perspective advisory panel for the particular national	The Institute would give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health in the awarding of contracts to conduct the research, if the organizations are so authorized in their governing statutes.

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	research priority. The Commission would consult with patients, health care providers, health care consumer representatives, and other appropriate stakeholders with an interest in the research through a transparent process recommended by the Commission. Where deemed appropriate by the Commission, the consultation would include (i) recommending research priorities and questions, (ii) recommending research methodologies, and (iii) advising on and assisting with efforts to disseminate research findings. The Secretary would designate a patient ombudsman who would (i) serve as an available point of contact for any patients with an interest in proposed comparative effectiveness studies by the Center, and (ii) ensure that any comments from patients regarding proposed comparative effectiveness studies are reviewed by the Center.	
Consultation with relevant expert organizations	Prior to recommending priorities or initiating research described in this section, the Commission or the Center would consult with the relevant expert organizations responsible for standards and protocols of clinical excellence. Such consultation would be consistent with processes established for ensuring stakeholder input as described above. Any dissemination of research from and findings made by the Commission or the Center would be consistent with processes established per the research requirements above. In addition, any dissemination would (1) be based upon evidence-based medicine, and (2) would take into consideration standards and protocols of clinical excellence developed by relevant expert organizations. For purposes of this subsection, the following definitions would apply. (a) A "relevant expert organization" would mean an organization with expertise in the rigorous application of evidence-based scientific methods for the design of clinical studies, the interpretation of clinical	No provision.

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	data, and the development of national clinical practice guidelines, including a voluntary health organization, clinical specialty, or other professional organization that represents physicians based on the field of medicine in which each such physician practices or is board certified. (b) "Standards and protocols of clinical excellence" would mean clinical or practice guidelines that consist of a set of directions or principles that is based on evidence and is designed to assist a health care practitioner with decisions about appropriate diagnostic, therapeutic, or other clinical procedures for specific clinical circumstances.	
Limitations on use of the research	None of the reports submitted under this section or research findings disseminated by the Center or Commission would be construed as mandates for payment, coverage, or treatment. Nothing in this section would be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine. Nothing in this section would be construed to make more stringent or otherwise change the standards or requirements for coverage of items and services under the Medicare program.	A rule of construction specifies that the Institute is not to be permitted to mandate coverage, reimbursement or other policies for any public or private payer nor is the Secretary to be prevented from covering the routine costs of clinical care received by Medicare, Medicaid, or CHIP beneficiaries in the case where the individual is participating in a clinical trial where the costs otherwise would be covered by the program. In addition, the Secretary could only use evidence and findings from CCER research to make a Medicare coverage determination if the process is iterative and transparent and includes public comment and considers the effect on subpopulations. The Secretary would not use CCER evidence and findings in determining Medicare coverage, reimbursement, or incentive programs in a manner that would preclude or have the intent to discourage individuals from choosing health care treatments based on how the individual values the tradeoff between extending the length of life and the risk of disability. Nor would the Institute be allowed to develop or employ a dollars-per-quality adjusted life year or similar measure that discounts value of life because of disability as a threshold to establish what type of care is cost effective or recommended.
Accounting for potential differences	Research would be designed, as appropriate, to take into	See language above regarding subpopulations.

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	account the potential for differences in the effectiveness of health care items, services, and systems used with various subpopulations such as racial and ethnic minorities, women, different age groups (including children, adolescents, adults, and seniors), individuals with disabilities, and individuals with different co-morbidities and genetic and molecular subtypes. The research would seek to include members of such subpopulations as subjects in the research, as feasible and appropriate.	
Public access and transparency	The appropriate information contained in relevant reports made by the Center, Commission, or clinical perspective advisory panel would be posted on the official public Internet site of the Center and Commission within 90 days. For purposes of providing information, a relevant report would be any interim or progress reports as deemed appropriate by the Secretary, stakeholder comments, or final reports submitted by the Center or a grantee or contractor of the Center.	The Institute would establish procedures to ensure that certain requirements for ensuring transparency, credibility, and access are met. (1) The Institute would provide for a public comment period of not less than 45 days and not more than 60 days prior to the adoption of the national priorities, the research project agenda, the methodological standards developed and updated by the methodology committee, and the peer-review process, and after the release of draft findings with respect to systematic reviews of existing research and evidence. (2) The Institute would support forums to increase public awareness and obtain and incorporate public input and feedback through media (such as an Internet website) on research priorities, research findings, and other duties, activities, or processes the Institute determines appropriate. (3) The Institute would make available to the public and disclose through the official public Internet website of the Institute the following: (a) information contained in research findings; (b) the process and methods for the conduct of research, including the identity of the entity and the investigators conducting such research and any conflicts of interest of such parties, any direct or indirect links the entity has to industry, and research protocols (including measures taken, methods of research and analysis, research results, and such other information the

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		Institute determines appropriate) concurrent with release of research findings; (c) notice of public comment periods, including deadlines for public comments; (d) subsequent comments received during each of the public comment periods; (e) the proceedings of the Institute, in accordance with applicable laws and processes and as the Institute determines appropriate. (4) Disclosure of conflicts of interest (see section above for details).
Dissemination requirements	The Center would provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, relevant expert organizations, federal and private health plans, and other relevant stakeholders. In disseminating such findings the Center would (1) convey findings of research so that they are comprehensible and useful to patients and providers in making health care decisions; (2) discuss findings and other considerations specific to certain sub-populations, risk factors, and co-morbidities as appropriate; (3) include considerations such as limitations of research and what further research may be needed, as appropriate; (4) not include any data that the dissemination of which would violate the privacy of research participants or violate any confidentiality agreements made with respect to the use of data under this section; and (5) assist the users of health information technology focused on clinical decision support to promote the timely incorporation of such findings into clinical practices and promote the ease of use of such incorporation. The Center would develop protocols and strategies for the appropriate dissemination of research findings in order to ensure effective communication of the findings and the use and incorporation of the findings into relevant activities for the purpose of informing higher quality and more effective and efficient decisions	The Office of Communication and Knowledge Transfer (Office) at the AHRQ (or any other relevant office designated by AHRQ), in consultation with the NIH, would broadly disseminate the research findings that are published by the PCOR Institute and other government-funded research relevant to comparative clinical effectiveness research. The Office would create informational tools that organize and disseminate research findings for physicians, health care providers, patients, payers, and policy makers. The Office would also develop a publicly available resource database that would collect and contain government-funded evidence and research from public, private, not-for profit, and academic sources. The Office would provide for the dissemination of the Institute's research findings and government-funded research relevant to CCER to physicians, health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and federal and private health plans. Materials, forums, and media used to disseminate the findings, informational tools, and resource databases would (a) include a description of considerations for specific subpopulations, the research methodology, and the limitations of the research, and the names of the entities, agencies, instrumentalities, and individuals who conducted any research which was published by the Institute; and (b) not be construed as mandates, guidelines, or recommendations for payment, coverage,

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	regarding medical items and services. In developing and adopting the protocols and strategies, the Center would consult with stakeholders concerning the types of dissemination that would be most useful to the end users of information and could provide for the utilization of multiple formats for conveying findings to different audiences, including dissemination to individuals with limited English proficiency.	or treatment. The Office, in consultation with relevant medical and clinical associations, would assist users of health information technology focused on clinical decision support to promote the timely incorporation of research findings disseminated as above into clinical practices and to promote the ease of use of such incorporation. The Office would establish a process to receive feedback from physicians, health care providers, patients, and vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans about the value of the information disseminated and the assistance provided under this section.
Reports to Congress	The provision would establish a number of reporting requirements. (1) Beginning not later than one year after the date of the enactment, the Director of the AHRQ would submit an annual report on the activities of the Center and the Commission and research conducted under this section to Congress. Each report would include a discussion of the Center's compliance with the requirement to include, as feasible and appropriate, members of the subpopulations described above as research subjects, including any reasons for lack of compliance with this requirement. (2) Not later than December 31, 2011, the Secretary would submit to Congress an annual recommendation for a fair share per capita amount (described below) for purposes of funding the CER through the Comparative Effectiveness Research Trust Fund (CERTF). (3) Not later than December 31, 2013, the Secretary, in consultation with the Commission, would submit to Congress a report on all activities conducted or supported under this section as of such date. The report would include an evaluation of the overall costs of such activities and an analysis of the backlog of any research proposals approved by the	See detail under "duties and powers."

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	Center but not funded.	
Funding	The proposal would establish the Comparative Effectiveness Research Trust Fund (CERTF) under section 9511 of the Internal Revenue Code of 1986 (the Code) to carry out the provisions relating to comparative effectiveness research. For fiscal year 2010 and in each subsequent fiscal year, amounts in the CERTF would be available to carry out this section without the need for further appropriations and without fiscal year limitation. However, nothing in this section would be construed to permit the Center or Commission to mandate coverage, reimbursement, or other policies for any public or private payer, nor to prevent the Secretary from covering the routine costs of clinical care received by an individual entitled to or enrolled for benefits under the Medicare, Medicaid, or SCHIP programs in the case where such an individual would be participating in a clinical trial and where such costs would otherwise be covered under such title with respect to the beneficiary.	The proposal would create a new trust fund, the Patient-Centered Outcomes Research Trust Fund (the 'PCORTF') in the U.S. Treasury to fund the Institute and its activities. Monies would be directed to this fund from the general fund of the Treasury as well as the Medicare Trust Funds and from fees imposed on health insurance and self-insured plans. For fiscal year 2013, the Secretary would transfer amounts from the Medicare Federal Hospital Insurance and the Federal Supplemental Medical Trust Funds to the PCORTF in proportion to total Medicare expenditures that come from each Fund for a given year. In FY2013, the amount would be equivalent to $1 multiplied by the average number of individuals entitled to benefits under Part A or enrolled under Part B of Medicare during the year. In FY2014 through FY2019, the amounts would be equivalent to $2, adjusted for increases in health care spending FY2014, multiplied by the average number of such individuals for the given year. In years 2010, 2011, and 2012, $10 million, $50 million, and $150 million would be appropriated from Treasury to the fund. In addition, beginning in 2013, the PCORTF would also be financed from fees on insured and self-insured health plans. For fiscal years 2014 through 2019, the proposal would require a transfer of $150 million from the Treasury as well as the net revenues from a fee of $1 in FY2013 and $2 (adjusted for health care spending increases) in FY2014 through FY2019, on each health insurance policy in the United States multiplied by the number of lives covered under that policy. Insurance policies that primarily provide non-health benefits would be exempt. This fee would sunset after FY2019 (plan years ending after September 30, 2019). For fiscal year 2010 and in each subsequent fiscal year, amounts in the PCORTF would be available to the Institute to carry out this section without further

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		appropriation.
Federal Coordinating Council for Comparative Effectiveness Research. Current law: The American Recovery and Reinvestment Act of 2009 established an interagency advisory panel, the Federal Coordinating Council for Comparative Effectiveness Research, to help coordinate and support CER activities across federal agencies and departments. Composed of senior officials from federal agencies with health-related programs, the Council published its initial report on June 30, 2009 with recommendations on (1) the importance of disseminating CER findings to doctors and patients, (2) targeting CER on the needs of priority populations such as racial and ethnic minorities, and persons with multiple chronic conditions, (3) researching high-impact health arenas such as medical and assistive devices, surgical procedures, and behavioral interventions and prevention, and (4) electronic data networks and exchange.	No provision.	*S. §6302.* The proposal would terminate the Council effective the date of enactment.
Clinical practice guidelines. Current Law: Sec. 304(b) of the Medicare Improvements for Patients and Providers Act of 2008 requires the Secretary to enter into a contract with the Institute of Medicine (IOM) which would require the IOM to conduct a study on the best methods used in developing clinical practice guidelines in order to ensure that organizations developing such guidelines have information on approaches that are objective, scientifically valid, and consistent. In addition, this section requires the IOM to submit to the Secretary and the appropriate committees of jurisdiction of Congress a report containing the results of this study and recommendations for legislation and administrative action. Finally, this section requires stakeholders with expertise in making clinical recommendations to participate on the panel responsible for conducting this study and preparing the report.	No provision.	*S. §10303(c).* This section would require the Secretary, following receipt of the report required under MIPPA Sec. 304(b), and not less than every three years thereafter, to contract with the IOM to employ the results of the study and the best methods identified for the purpose of identifying existing and new clinical practice guidelines that were developed using such best methods, including guidelines listed in the National Guideline Clearinghouse. This section would require the Secretary, in carrying out this identification process, to allow for consultation with professional societies, voluntary health care organizations, and expert panels.

Subtitle B – Nursing Home Transparency.

Part 1 – Improving Transparency of Information on Skilled Nursing Facilities, Nursing Facilities, and Other Long-Term Care Facilities.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Required disclosure of ownership and additional disclosable parties information. Current Law: In general, Medicare and Medicaid require skilled nursing facilities (SNF) and nursing facilities (NFs) to be administered in a manner that maintains residents' well being, including the administration of the facilities. To ensure residents' safety, SNF and NFs are required to report changes in the following: in ownership or controlling interest; in the individuals who are officers, directors, agents or managing employees; in the corporation, association or other company responsible for facility management, or when information on a new SNF or NF administrator or director is provided to state licensing agencies.	*H. §1411* H. §1411 (a) — New SSA §1124(c). SSA Sec. 1124 would be amended by adding a new section that would require SNFs and NFs to disclose ownership and additional parties' information.	*S. §6101* S. §6101(a) — New SSA §1124(c). Same as H.R. 3962.
Required Disclosure of Ownership and Additional Disclosable Parties Information—Disclosure of Additional Parties. Current Law: SSA Section 1124 requires participating entities in Medicare, Medicaid and other HHS programs to disclose full and complete information for each person with ownership or control interest as a condition for participation, certification, or re-certification. Individuals are considered to have ownership or control interests when directly or indirectly: (1) they own 5% or more of an entity; or they hold a whole or part of any mortgage, deed of trust, note or other obligation secured by the entity (SNF) or any property or assets that equal 5% of the total property; (2) is an officer or director of the entity,	*H. §1411 (a) —* *New SSA §1124(c)(1)(A) and (B).* Between the date of enactment of H.R. 3962 until final regulations were issued by the Secretary, upon request by (1) the Secretary, (2) the HHS Office of the Inspector General (OIG), (3) the state where a SNF or NF is located, and (4) the state long-term care (LTC) ombudsman, SNFs and NFs would be required to provide disclosable party information. After final regulations covering disclosable parties were issued, SNFs and NFs would be required to have disclosable party information also available upon request to the public. After final regulations were issued, SNFs and NFs would not be authorized to dispose of information that had been available upon request only to the Secretary, the HHS OIG, the state	*S. §6101(a) —* *New SSA §1124(c)(1)(A) and (B).* Same as H.R. 3962.

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if the entity is organized as a corporation; or (3) is a partner in the entity if it is organized as a partnership. In addition, SSA Sec. 1819(d) requires SNFs to be administered in a manner that maintains residents' well being. Changes in the following parties must be provided to the state licensing agency: (1) ownership or controlling interest; (2) the officers, directors, agents or managing employees; (3) the corporation, association or other company responsible for facility management, or (4) the SNF administrator or director. Administrators must meet standards established by the Secretary of the Department of Health and Human Services (HHS).	where a SNF or NF was located, and the state LTC ombudsman, while final regulations were pending.	
Required Disclosure of Ownership and Additional Disclosable Parties Information—Public Availability of Information. Current Law: See above.	*H. §1411 (a) —* *New SSA §1124(c)(2)(A) and (B).* During the period before final regulations were issued, SNFs and NFs would be required to (A) make disclosable party information (see below) available on request and update this information as necessary to reflect changes; and (B) post a prominent notice in the lobby of each SNF or NF that disclosable party information is available.	No provision.
Required Disclosure of Ownership and Additional Disclosable Parties Information—Information Described. Current Law: See above.	*H. §1411 (a) —* *New SSA §1124(c)(3)(A).* SNFs and NFs would be required to disclose the identity of and information on (1) each member of a facility's governing body including their name, title, and period of service for each SNF or NF; (2) each person or entity who is an officer, director, member, partner, trustee, or managing employee, including the name, title, and date of start of service; (3) each person or entity who is an additional disclosable party; and (4) the organizational structure and relationship of the organizational entities to each SNF or NF and each other for each ownership and governing individual or	*S. §6101(a) —* *New SSA §1124(c)(2)(A).* Same as H.R. 3962.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	entity.	
Required Disclosure of Ownership and Additional Disclosable Parties Information—Special Rule Where Information is Already Reported or Submitted Current Law: See above.	*H. §1411 (a) —* *New SSA §1124(c)(3)(B).* To the extent practicable, and as long as it contained the specified disclosable party information, the Secretary would be authorized to permit SNFs and NFs to submit information using existing reporting mechanisms on ownership interest, governance, and organizational structure if they already report such information to other oversight agencies including: the Internal Revenue Services (IRS), on Form 990; the Securities and Exchange Commission; the Secretary; or through information otherwise submitted to any other federal agency.	*S. §6101(a) —* *New SSA §1124(c)(2)(B).* Same as H.R. 3962.
Required Disclosure of Ownership and Additional Disclosable Parties Information—Special Rule Current Law: See above.	*H. §1411 (a) —* *New SSA §1124(c)(3)(C).* Ownership or controlling interest would include direct or indirect interests through any number of intermediate entities; and would include owners of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the entity's property or assets, if the ownership interest was at least 5%.	*S. §6101(a) —* *New SSA §1124(c)(2)(C).* Same as H.R. 3962.
Required Disclosure of Ownership and Additional Disclosable Parties Information—Reporting Current Law: See above.	*H. §1411(a) —* *New SSA §1124(c)(4)(A) and (B).* Within two years after this provision takes effect, the Secretary would be required to issue final regulations requiring SNFs and NFs to report to the Secretary in standardized format disclosable party information. The Secretary would specify in the final regulations that the reporting requirements would commence first day of the first quarter which begins 90 days after the final regulations appeared in the *Federal Register*. The final regulations would require that as a condition of participation and payment, SNFs and NFs certify that	*S. §6101(a) —* *New SSA §1124(c)(3)(A).* Same as H.R. 3962.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	reported information is current and accurate. The Secretary would be required to provide technical assistance and guidance to states on how to adopt and implement the reporting requirements in the standardized format.	
Required Disclosure of Ownership and Additional Disclosable Parties Information—No Effect on Existing Reporting Requirements Current Law: See above.	*H. §1411(a) —* *New SSA §1124(c)(5).* This provision would not reduce, diminish, or alter any existing facility reporting requirements.	*S. §6101(a) —* *New SSA §1124(c)(4).* Same as H.R. 3962.
Required Disclosure of Ownership and Additional Disclosable Parties Information—Additional Disclosable Party Definition Current Law: See above.	*H. §1411(a) —* *New SSA §1124(c)(6)(A).* The following definitions would apply to this provision: (A) An additional disclosable party would be any individual or entity who as follows: (i) Exercises operational, financial, or managerial control over the facility or any part of the facility. Provides policies or procedures for any facility operations or provides financial or cash management services to the facility; (ii) Leases or subleases real property to the facility, or owns a whole or part interest of at least 5% of the total value of such real property; (iii) Lends funds or provides a financial guarantee to the facility of at least $50,000; (iv) Provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.	*S. §6101(a) —* *New SSA §1124(c)(5)(A).* Similar to H.R. 3962, except does not include (iii) Lends funds or provides a financial guarantee to the facility of at least $50,000.
Required Disclosure of Ownership and Additional Disclosable Parties Information—Facility and Managing Employee Definition Current Law: See above.	*H. §1411 (a) —* *New SSA §1124(c)(6)(B) and (C).* A facility is a disclosing entity operating as a Medicare certified SNF or a Medicaid certified NF. Managing employees include any employees, such as a general manager, business manager, administrator, director, or consultant, who directly or indirectly	*S. §6101(a) —* *New SSA §1124(c)(5)(B) and (C).* Same as H.R. 3962.

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	manages, advises, or supervises any element of a SNF or NF's practices, finances, or operations.	
Required Disclosure of Ownership and Additional Disclosable Parties Information—Organizational Structure Definition Current Law: See above.	*H. §1411 (a) —* *New SSA §1124(c)(6)(D).* Organizational Structure consists of the following: (1) in the case of a corporation, the officers, directors, and shareholders of corporations, who own at least 5% of the corporation; (2) in the case of a limited liability company, the ownership interest of members and managers of limited liability companies (including, the percentage owned by each member and manager); (3) in the case of a general partnership, the partners of a general partnership; (4) in the case of a limited partnership, the general and limited partners who own at least 10% of the partnership; (5) in the case of a trust, the trustees of the trust; (6) in the case of an individual, contact information for the individual; and (7) in the case of any other person or entity, as the Secretary determines appropriate.	*S. §6101(a) —* *New SSA §1124(c)(5)(D).* Same as H.R. 3962.
Required Disclosure of Ownership and Additional Disclosable Parties Information—Public Availability of Information Current Law: See above.	*H. §1411(b).* Within one year of the publication of final regulations, the Secretary would be required to make ownership disclosure and additional disclosable party information for SNFs and NFs available to the public following procedures to be determined by the Secretary.	*S. §6101(b).* Same as H.R. 3962.
Required Disclosure of Ownership and Additional Disclosable Parties Information—Conforming Amendment Current Law: SNF and NF must report the following changes to state licensing entities: (i) individuals with ownership or control interests, (ii) officers, directors, agents, or managing employees,	*H. §1411(a)(1) and (2). Duplicate subsection (a), probably should be subsection (c).* Requirements for SNFs and NFs to report ownership and other changes to state licensing entities would be removed from the Medicare and Medicaid sections.	*S. §6101(c)(1) and (2).* Same as H.R. 3962.

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(iii) corporations, associations, or other companies responsible for the facilities' management, or (iv) SNF's or NF's administrators or directors of nursing.		
Accountability requirements *Effective Compliance and Ethics Programs, Skilled Nursing Facilities* Current Law: There are no specific accountability requirements in current law for SNFs and NFs to implement compliance and ethics programs.	*H. §1412* H. §1412(a)(1) — New SSA §1819(d)(1). SSA Sec. 1819(d)(1) would be amended to add a new requirement that SNFs implement compliance and ethics programs.	*S. §6102* New SSA §1128I. Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs.
Accountability Requirements for Facility—Definition Current Law: None.	No provision.	*S. §6102 —* *New SSA §1128I(a)(1) and (2).* Facilities include both SNF and NFs.
Accountability Requirements—Effective Compliance and Ethics Programs, Skilled Nursing Facilities—Requirement Current Law: None.	*H. §1412(a)(1) —* *New SSA §1819(d)(1)(C)(i).* By the first quarter one year after final regulations were published in the Federal Register became final; the entity that operates or controls SNFs (operating organization) would have compliance and ethics programs that were effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care.	*S. §6102 —* *New SSA §1128I(b)(1).* Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs. Within 36 months of enactment, operating organizations would be required to have implemented compliance and ethics programs that were effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care.
Accountability Requirements—Effective Compliance and Ethics Programs, Skilled Nursing Facilities—Development of Regulations; In General Current Law: None.	*H. §1412(a)(1) —* *New SSA §1819(d)(1)(C)(ii)(I).* Within two years of the effective date of this provision, the Secretary, in consultation with the HHS OIG would issue effective compliance and ethics program regulations for operating organizations. These regulations may include a model compliance program.	*S. §6102 —* *New SSA §1128I(b)(2)(A).* Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs.
Accountability Requirements—Effective Compliance and Ethics Programs, Skilled Nursing Facilities—Development of Regulations; Design of Regulations	*H. §1412(a)(1) —* *New SSA §1819(d)(1)(C)(ii)(II).* Design of the compliance and ethics programs	*S. §6102 —* *New SSA §1128I(b)(2)(B).* Same as H.R. 3962 except the regulations would specify

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Current Law: None.	regulations may vary depending on an organization's size. Larger operating organizations should have more formal programs with established written policies and procedures to guide employees. Regulations also would specifically address requirements for employees and managers of multi-nursing home corporations.	that the design of compliance and ethics programs would be required to be more formal for organizations that operate five or more facilities.
Accountability Requirements—Effective Compliance and Ethics Programs, Skilled Nursing Facilities—Development of Regulations; Evaluation Current Law: None.	*H. §1412(a)(1) —* *New SSA §1819(d)(1)(C)(ii)(III).* Within three years after final regulations were issued, the Secretary would evaluate the compliance and ethics programs and submit a report to Congress. The Secretary's evaluation would determine if the compliance and ethics programs led to changes in deficiency citations, quality performance, or changes in other patient care quality metrics. The Secretary's report to Congress would include recommendations to change the requirements of the compliance and ethics program.	*S. §6102 —* *New SSA §1128I(b)(2)(C).* Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs.
Accountability Requirements—Effective Compliance and Ethics Programs, Skilled Nursing Facilities—Requirements for Compliance and Ethics Programs Current Law: None.	*H. §1412(a)(1) —* *New SSA §1819(d)(1)(C)(iii)(I) and (II).* SNF operating organizations' (entities that operate SNFs) compliance and ethics programs would need to be (I) reasonably designed, implemented, and enforced to be generally effective in preventing and detecting civil, criminal, and administrative violations as well as in promoting quality of care; and (II) would include at least the following required components.	*S. §6102 —* *New SSA §1128I(b)(3)(A) and (B).* Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs.
Accountability Requirements—Effective Compliance and Ethics Programs, Skilled Nursing Facilities—Required Components of Program Current Law: None.	*H. §1412(a)(1) —* *New SSA §1819(d)(1)(C)(iv)(I)-(VIII).* (I) Operating organizations would be required to have established compliance standards and procedures that would guide employees, contractors, and other agents and would be reasonably capable of reducing criminal, civil, and administrative violations. (II) Specific high-level individuals within operating	*S. §6102 —* *New SSA §1128I(b)(4)(A)-(H).* Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs.

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	organizations would be required to be responsible for compliance with the standards and procedures the entity establishes for their compliance and ethics program. These supervisors also must have resources and authority to assure compliance. (III) Operating organizations would be required to show they were diligent in ensuring that individuals who were at risk for engaging in criminal, civil, or administrative violations under this provision were not delegated responsibility for implementing or monitoring the organization's compliance and ethics program. (IV) Operating organizations would be required to effectively communicate their standards and procedures to employees (and other agents), such as through training programs or explanatory publications that practically illustrate what is required. (V) Operating organizations would be required to have taken reasonable steps to ensure that the standards for their compliance and ethics programs were met by using procedures to detect criminal, civil, and administrative violations of this provision. Organizations could use procedures such as monitoring and auditing systems as well as installing a reporting system that enables employees and agents to report violations by others without fear of retribution. (VI) Operating organizations would be required to have appropriate disciplinary mechanisms that have consistently been followed to enforce the compliance and ethics program standards. Organizations also must demonstrate that they have used, where appropriate, disciplinary measures on individuals for failing to detect offenses. (VII) After violations were detected, organizations would be required to demonstrate that they had responded appropriately to these offenses and have mechanisms to prevent future similar offenses, including repayment of any funds to which it was not entitled and	

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	any necessary modification of their compliance and ethics programs. (VIII) Operating organizations would be required to periodically reassess their compliance and ethics program standards to ensure that the programs continue to be effective as the organization and facilities change.	
Accountability Requirements—Effective Compliance and Ethics Programs, Skilled Nursing Facilities—Coordination Current Law: Under Medicare, as a condition of participation, providers must agree to certain terms, including participation in the Federal Payment Levy Program (FPLP). FPLP permits the Internal Revenue Services to collect overdue taxes through federal payments, such as Medicare provider and supplier payments.	*H. §1412(a)(1) —* *New SSA §1819(d)(1)(C)(v).* Requirements for SNFs to participate in compliance and ethics programs would apply in lieu of the requirement for SNFs to participate in the Federal Payment Levy Program.	No Provision.
Accountability Requirements—Effective Compliance and Ethics Programs, Nursing Facilities—Requirement Current Law: None.	*H. §1412(a)(2) —* *New SSA §1919(d)(1)(C)(i).* By the first quarter one year after regulations were published in the *Federal Register* became final; the entity that operates or controls NFs (operating organization) would have compliance and ethics programs that were effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care.	*S. §6102 —* *New SSA §1128I(b)(1).* Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs.
Accountability Requirements—Effective Compliance and Ethics Programs, Nursing Facilities—Development of Regulations, In General Current Law: None.	*H. §1412(a)(2) —* *New SSA §1919(d)(1)(C)(iii)(I).* Within two years of the effective date of this provision, the Secretary, in consultation with the HHS OIG would issue effective compliance and ethics program regulations for operating organizations. These regulations may include a model compliance program.	*S. §6102 —* *New SSA §1128I(b)(2)(A).* Similar to H.R. 3962, except that the regulations would specify that the design of compliance and ethics programs would be required to be more formal for organizations that operate five or more facilities.
Accountability Requirements—Effective Compliance and Ethics Programs, Nursing Facilities— Development	*H. §1412(a)(2) —*	*S. §6102 —*

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
of Regulations, Design of Regulations Current Law: None.	*New SSA §1919(d)(1)(C)(iii)(II).* Design of Regulations—The design of the compliance and ethics programs regulations may vary depending on an organization's size. Larger operating organizations should have more formal programs with established written policies and procedures to guide employees. Regulations also would specifically address requirements for employees and managers of multi-nursing home corporations.	*New SSA §1128I(b)(2)(B).* Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs.
Accountability Requirements—Effective Compliance and Ethics Programs, Nursing Facilities— Development of Regulations, Evaluation Current Law: None.	*H. §1412(a)(2) —* *New SSA §1919(d)(1)(C)(iii)(III).* Within three years after final regulations were issued, the Secretary would evaluate the compliance and ethics programs and submit a report to Congress. The Secretary's evaluation would determine if the compliance and ethics programs led to changes in deficiency citations, quality performance, or changes in other patient care quality metrics. The Secretary's report to Congress would include recommendations to change the requirements of the compliance and ethics program.	*S. §6102 —* *New SSA §1128I(b)(2)(C).* Similar to H.R. 3962, except that the Senate bill. would apply to SNFs and NFs.
Accountability Requirements—Effective Compliance and Ethics Programs, Nursing Facilities—Requirements for Compliance and Ethics Programs Current Law: None.	*H. §1412(a)(2) —* *New SSA §1919(d)(1)(C)(v)(I) and(II).* NF operating organizations' (entities that operate NFs) compliance and ethics programs would need to be (I) reasonably designed, implemented, and enforced to be generally effective in preventing and detecting civil, criminal, and administrative violations as well as in promoting quality of care; and (II) would include at least the following required components.	*S. §6102 —* *New SSA §1128I(b)(3)(A) and (B).* Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs.
Accountability Requirements—Effective Compliance and Ethics Programs, Nursing Facilities—Required Components of Program Current Law: None.	*H. §1412(a)(2) —* *New SSA §1919(d)(1)(C)(vi)(I)-(VIII).* (I) Operating organizations would be required to have established compliance standards and procedures that would guide employees, contractors, and other agents	*S. §6102 —* *New SSA §1128I(b)(4)(A)-(H).* Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs.

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	and would be reasonably capable of reducing criminal, civil, and administrative violations. (II) Specific high-level individuals within operating organizations would be required to be responsible for compliance with the standards and procedures the entity establishes for their compliance and ethics program. These supervisors also must have resources and authority to assure compliance. (III) Operating organizations would be required to show they were diligent in ensuring that individuals who were at risk for engaging in criminal, civil, or administrative violations under this provision were not delegated responsibility for implementing or monitoring the organization's compliance and ethics program. (IV) Operating organizations would be required to effectively communicate their standards and procedures to employees (and other agents), such as through training programs or explanatory publications that practically illustrate what is required. (V) Operating organizations would be required to have taken reasonable steps to ensure that the standards for their compliance and ethics programs were met by using procedures to detect criminal, civil, and administrative violations of this provision. Organizations could use procedures such as monitoring and auditing systems as well as installing a reporting system that enables employees and agents to report violations by others without fear of retribution. (VI) Operating organizations would be required to have appropriate disciplinary mechanisms that have consistently been followed to enforce the compliance and ethics program standards. Organizations also must demonstrate that they have used, where appropriate, disciplinary measures on individuals for failing to detect offenses. (VII) After violations were detected, organizations would be required to demonstrate that they had	

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	responded appropriately to these offenses and have mechanisms to prevent future similar offenses, including repayment of any funds to which it was not entitled and any necessary modification of their compliance and ethics programs. (VIII) Operating organizations would be required to periodically reassess their compliance and ethics program standards to ensure that the programs continue to be effective as the organization and facilities change.	
Accountability Requirements—Effective Compliance and Ethics Programs, Nursing Facilities—Coordination. Current Law: None.	*H. §1412(a)(2) —* *New SSA §1919(d)(1)(C)(vii).* This effective compliance and ethics program requirement would be in effect in lieu of other Medicaid requirements established under other sections of H.R. 3962 (Sec. 1753) applicable to nursing facilities.	No provision.
Accountability Requirements—Quality Assurance and Performance Improvement Program—Skilled Nursing Facilities. Current Law: None.	*H. §1412(b)(1) —* *New SSA §1819(b)(1)(B)(ii).* SSA Sec. 1819(b) would be amended to add the following requirements for a quality assurance improvement program (QAPI) for SNFs: (I) Before December 31, 2011, the Secretary would be required to establish and implement a quality assurance and performance improvement (QAPI) program for SNFs. The QAPI program would include multi-unit SNF chains. Under the QAPI program, the Secretary would be required to establish facility standards and provide technical assistance on the development of best practices for SNFs to meet the QAPI standards. Within 1 year after the Secretary issued regulations to establish and implement the QAPI program, SNFs would be required to submit plans to the Secretary identifying how they will meet the QAPI standards and implement best practices, including how to coordinate	*S. §6102 —* *New SSA §1128I(c)(1).* Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs – H.R. 3962 amends SSA Sec. 1819, which is applicable to Medicare, while the Senate bill amends SSA Sec. 1128, which is applicable to both Medicare and Medicaid.

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	the implementation of the facility plans. (II) Regulations—The Secretary would be required to issue regulations to establish and implement a QAPI program for SNFs.	
Accountability Requirements—Quality Assurance and Performance Improvement Program—Nursing Facilities Current Law: None applicable to NFs.	*H. §1412(b)(2) —* *New SSA §1919(b)(1)(B)(ii).* SSA Sec. 1919(b) would be amended to add the following requirements for a QAPI program for NFs: (I) Before December 31, 2011, the Secretary would be required to establish and implement a QAPI program for NFs. The QAPI program would include multi-unit NF chains. Under the QAPI program, the Secretary would be required to establish facility standards and provide technical assistance on the development of best practices for NFs to meet the QAPI standards. Within 1 year after the Secretary issued regulations to establish and implement the QAPI program, NFs would be required to submit plans to the Secretary identifying how they will meet the QAPI standards and implement best practices, including how to coordinate the implementation of the facility plans. (II) Regulations—The Secretary would be required to issue regulations to establish and implement a QAPI program for NFs.	*S. §6102 —* *New SSA §1128I(c)(1).* Similar to H.R. 3962, except that the Senate bill would apply to SNFs and NFs – H.R. 3962 amends SSA Sec. 1919, which is applicable to Medicaid, while the Senate bill amends SSA Sec. 1128, which is applicable to both Medicare and Medicaid.
Accountability Requirements—Proposal to Revise Quality Assurance and Performance Improvement Programs Current Law: None.	*H. §1412(b)(3)* The Secretary would be required to include in the Medicare SNF prospective payment system proposed rule or other statutory or regulatory authority for Medicaid, one or more proposals for SNFs and NFs to modify and strengthen QAPI programs at these facilities.	No provision.
Accountability Requirements—Facility Plan Current Law: None.	*H. §1412(b)(4)* Within one year of the Secretary issuing these regulations, facilities must submit to the Secretary a plan for the facility to meet the QAPI regulatory	No provision.

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	standards and to implement best practices, including how to coordinate implementation of the plan with quality assessment and assurance activities.	
Accountability Requirements—GAO Study on Nursing Facility Under-Capitalization Current Law: None.	*H. §1412(c)(1)-(3)* The Comptroller General and the Government Accountability Office (GAO) would be required to conduct a study that examined the following: (A) the extent to which corporations that operate NFs and SNFs are undercapitalized taking into account ownership type (including private equity and control interests) that are undercapitalizing SNFs and NFs; (B) the effects of undercapitalization on quality of care, including staffing and food costs; and (C) options to address under-capitalization issues, such as requirements for surety bonds, liability insurance, or minimum capitalization. Within 18 months after this provision became effective, GAO would submit to Congress a report on nursing facility under-capitalization. The term nursing facility would include both SNFs and NFs.	No provision.
Nursing Home Compare Medicare website Current Law: There are no requirements in current law for Medicare's Nursing Home Compare website. The Nursing Home Compare (NH Compare) website was developed by the Centers for Medicare and Medicaid Services (CMS) and launched in November 2002. The website was intended to bolster the agency's efforts to improve SNF and NF quality of care and to make information on nursing home quality more accessible for long-term care consumers and their families. Since its launch, CMS has enhanced the website by adding or improving quality measures and website navigation. Medicare's NH Compare website includes national data on all nursing facilities that participate in Medicare and Medicaid. The data in Medicare NH Compare website include facility ratings, selected results from survey and certification inspections, staffing information on all Medicare and Medicaid SNFs and nursing facilities.	*H. §1413* H. §1413(a)(1) — New SSA §1819(i). SSA Sec. 1819 would be amended to add a new requirement for the Secretary to ensure that Medicare's Nursing Home (NH) Compare website (or a successor website) would contain additional information for SNFs that is searchable and displayed in a manner that is prominent, easily accessible, and clearly understandable for LTC consumers.	*S. §6103* S. §6103(a)(1)— New SSA §1819(i). Same as H.R. 3962.

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Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Inclusion of Additional Information; Ownership and Additional Disclosable Parties Current Law: See above.	*H. §1413(a)(1) —* *New SSA §1819(i)(1)(A)(i).* The Secretary would ensure that the official HHS website for Medicare beneficiaries, NH Compare, would display the following information: (i) information on ownership and additional disclosable parties as would be required under H.R. 3962 Sec. 1411, that identifies SNFs and SNF facility chains' ownership, governing boards, and organizational structure;	*S. §6103(a)(1)—* No provision.
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Inclusion of Additional Information, Special Focus Facilities Current Law: See above.	*H. §1413(a)(1) —* *New SSA §1819(i)(1)(A)(ii).* (ii) according to procedures established by the Secretary, information on CMS' Special Focus Facilities (or a successor program), including the names and locations of facilities that, since the previous quarter were, (I) newly enrolled in the program, (II) enrolled but failed to significantly improve, (III) enrolled and significantly improved, (IV) graduated from the program, and (V) have closed voluntarily or been terminated by the Secretary;	*S. §6103(a)(1)—* No provision.
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Inclusion of Additional Information, Staffing Data. Current Law: See above.	*H. §1413(a)(1) —* *New SSA §1819(i)(1)(A)(iii).* (iii) staffing data for each facility including resident census, hours of care provided per resident per day, staff turnover, and tenure. These data would need to be submitted in formats that are clearly understandable to LTC consumers and would permit consumers to compare staffing differences among facilities. This staffing information would need to enable consumers to compare staffing differences with state and national facility averages as follows: (I) concise explanations of how to interpret data (i.e.,	*S. §6103(a)(1)—* *New SSA §1819(i)(1)(A)(i).* Same as H.R. 3962.

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	nursing home staff hours per resident day), (II) staff type differences, such as different training requirements, (III) relationship between nurse staff levels and quality of care, and (IV) an explanation that appropriate staff levels vary based on patient case mix.	
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Inclusion of Additional Information, Links to State Internet Websites with Survey and Certification Information. Current Law: See above.	*H. §1413(a)(1) —* *New SSA §1819(i)(1)(A)(iv).* (iv) links to state internet websites where state survey and certification program information can be found; Form 2567, state inspection reports—or successor forms—programs; and facility correction plans or other facility responses, along with information to guide consumers in interpreting and understanding survey and certification reports;	*S. §6103(a)(1)—* *New SSA §1819(i)(1)(A)(ii).* Similar to H.R. 3962, except the Senate bill requires links to be posted on a timely basis.
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Inclusion of Additional Information, Standardized Complaint Form. Current Law: See above.	*H. §1413(a)(1) —* *New SSA §1819(i)(1)(A)(v).* (v) the standardized complaint form developed by the Secretary under Sec. 1415, Standardized Complaint Form, which includes an explanation of how complaint forms are used and how to file a complaint with states' LTC ombudsman programs and survey and certification programs;	*S. §6103(a)(1)—* *New SSA §1819(i)(1)(A)(iii).* Same as H.R. 3962..
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Inclusion of Additional Information, Complaint Summary. Current Law: See above.	*H. §1413(a)(1) —* *New SSA §1819(i)(1)(A)(vi).* (vi) summary information on the number, type, severity, and outcome of complaints;	*S. §6103(a)(1)—* *New SSA §1819(i)(1)(A)(iv).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Inclusion of Additional Information, Criminal Violations and Other Information. Current Law: See above.	*H. §1413(a)(1) —* *New SSA §1819(i)(1)(A)(vii).* (vii) the number of adjudicated criminal violations by the nursing facility or crimes committed by nursing facility staff, (I) that were committed inside a facility, and	*S. §6103(a)(1)—* *New SSA §1819(i)(1)(A)(v).* Similar to H.R. 3962, except, the Senate bill excludes item (ix), "any other information determined appropriate by the Secretary."

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	(II) for crimes or violations committed outside a facility, the instances where these were: elder abuse, neglect, exploitation, criminal sexual abuse of an elder, or other violations that resulted in serious bodily injury; (viii) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents; and (ix) any other information determined appropriate by the Secretary.	
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Inclusion of Additional Information, Deadline for Provision of Information. Current Law: See above.	*H. §1413(a)(1) —* *New SSA §1819(i)(1)(B)(i) and (ii).* (i) Within one year after enactment of H.R. 3962, the Secretary would ensure that the information described in this subsection would be available. (ii) Exception—the Secretary would ensure that ownership and additional disclosable party information as described in H.R. 3962 Sec. 1411, would be included on the NH Compare website within one year after those data are submitted to the Secretary.	*S. §6103 (a)(1)—* *New SSA §1819(i)(1)(B)(i) and (ii).* Same as H.R. 3962
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Inclusion of Additional Information, Review and Modification of Website. Current Law: See above.	*H. §1413(a)(1) —* *New SSA §1819(i)(1)(B)(2)(A).* The Secretary would establish a NH Compare website review and modification process that would (i) address the accuracy, clarity of presentation, timeliness, and comprehensiveness of the information reported on the Medicare NH compare website as of the day before enactment of this subsection; and (ii) within one year after the effective date of implementation of the Medicare NH Compare website, review process, modify or revamp the website in accordance with the findings of the review process.	*S. §6103 (a)(1)—* *New SSA §1819(i)(1)(B)(2)(A).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Inclusion of Additional Information, Consultation.	*H. §1413(a)(1) —* *New SSA §1819(i)(1)(B)(2)(B).*	*S. §6103 (a)(1)—* *New SSA §1819(i)(1)(B)(2)(B).*

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Current Law: See above.	In conducting the Medicare NH compare website review process, the Secretary would be required to consult with the following organizations: (i) state LTC Ombudsman programs, (ii) consumer advocacy groups, (iii) provider stakeholder groups, and (iv) any representatives of programs or groups the Secretary determines would be appropriate.	Same as H.R. 3962.
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Inclusion of Additional Information, Timeliness of Submission of Survey and Certification Information. Current Law: See above.	*H. §1413(a)(2)(A) —* *New SSA §1819(g)(5)(E).* SSA Sec. 1819(g) would be amended by adding a new subparagraph. To improve the public's access to timely information on state survey and certification inspections, states would be required to submit information, including any enforcement actions, to the Secretary at the same time or before the state nursing home surveyors sent that information to facilities. Corrections to prior information submitted to the state also would need to be submitted to the Secretary in a timely manner. The Secretary would be required to update Medicare's NH Compare website with the information from states' survey and certification inspections as expeditiously as practicable, but at least quarterly.	*S. §6103(a)(2)(A) —* *New SSA §1819(g)(5)(E).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Effective Date. Current Law: See above.	*H. §1413(a)(2)(B).* Submission of new additional information would be required within one year after the effective date of H.R. 3962.	*S. §6103(a)(2)(B).* *Same as H.R. 3962.*
Nursing Home Compare Medicare Website—Skilled Nursing Facilities—Special Focus Facility Program. Current Law: See above.	*H. §1413(a)(3) —* *New SSA §1819(f)(8).* SSA Sec. 1819(f) would be amended by adding a new paragraph that would require the Secretary to (A) conduct a special focus facility program for enforcing requirements for SNFs identified as having substantially failed to meet applicable requirements of this provision	*S. §6103(a)(3) —* *New SSA §1819(f)(8).* Same as H.R. 3962.

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	of H.R. 3962; and (B) to conduct periodic surveys of each facility in the program at least every six months.	
Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information; In General. Current Law: See above.	*H. §1413(b)(1) —* *New SSA §1919(i)(1)(A).* SSA Sec. 1919 would be amended to add a new requirement for the Secretary to ensure that Medicare's NH Compare website (or a successor website) would contain additional information for NFs that is searchable and displayed in a manner that is prominent, easily accessible, and clearly understandable for LTC consumers:	*S. §6103(b)(1) —* *New SSA §1919(i)(1)(A).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information, Ownership and Additional Disclosable Parties. Current Law: See above.	*H. §1413(b)(1) —* *New SSA §1919(i)(1)(A).* The Secretary would ensure that the official HHS website for Medicare beneficiaries, NH Compare, would display the following information: (i) information on ownership and additional disclosable parties as would be required under H.R. 3962 Sec. 1411, (SSA Sec. 1124(c)(4)) that identifies NFs and NF facility chains' ownership, governing boards, and organizational structure;	No provision.
Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information, Special Focus Facilities. Current Law: There are no requirements in current law for the Special Focus Facility program. CMS initiated the special focus facility program to help identify and monitor facilities that consistently had higher numbers of and more severe deficiencies.	*H. §1413(b)(1) —* *New SSA §1919(i)(1)(A)(ii).* (ii) according to procedures established by the Secretary, information on CMS' Special Focus Facility facilities (or a successor program), including the names and locations of facilities that were, since the previous quarter: (I) newly enrolled in the program, (II) enrolled but failed to significantly improve, (III) enrolled and significantly improved, (IV) graduated from the program, and (V) have closed voluntarily or been terminated by the Secretary;	No provision.

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Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information, Staffing Data Current Law: See above.	*H. §1413(b)(1) —* *New SSA §1919(i)(1)(A)(iii).* (iii) staffing data for each facility including resident census, hours of care provided per resident per day, staff turnover, and tenure. These data would need to be submitted in formats that are clearly understandable to LTC consumers and would permit consumers to compare staffing differences among facilities. This staffing information would need to enable consumers to compare staffing differences with state and national facility averages as follows: (I) concise explanations of how to interpret data (i.e., nursing home staff hours per resident day), (II) staff type differences, such as different training requirements, (III) relationship between nurse staff levels and quality of care, and (IV) an explanation that appropriate staff levels vary based on patient case mix.	*S. §6103(b)(1) —* *New SSA §1919(i)(1)(A)(i).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information, Links to State Internet Websites with Survey and Certification Information Current Law: See above.	*H. §1413(b)(1) —* *New SSA §1919(i)(1)(A)(iv).* (iv) links to state internet websites where state survey and certification program information can be found; Form 2567, state inspection reports—or successor forms—programs; and facility correction plans or other facility responses, along with information to guide consumers in interpreting and understanding survey and certification reports;	*S. §6103(b)(1) —* *New SSA §1919(i)(1)(A)(ii).* Similar to H.R. 3962 except internet website links would be required to be posted on a timely basis.
Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information, Standardized Complaint Form Current Law: See above.	*H. §1413(b)(1) —* *New SSA §1919(i)(1)(A)(v).* (v) the standardized complaint form developed by the Secretary under Sec. 1415, Standardized Complaint Form, which includes an explanation of how complaint forms are used and how to file a complaint with states' LTC ombudsman programs and survey and certification	S. *§6103(b)(1) —* *New SSA §1919(i)(1)(A)(iii).* Same as H.R. 3962.

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	programs;	
Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information, Complaint Summary Current Law: See above.	*H. §1413(b)(1) —* *New SSA §1919(i)(1)(A)(vi).* (vi) summary information on the number, type, severity, and outcome of complaints;	*S. §6103(b)(1) —* *New SSA §1919(i)(1)(A)(iv).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information, Criminal Violations and Other Information. Current Law: See above.	*H. §1413(b)(1) —* *New SSA §1919(i)(1)(A)(vii)-(ix).* (vii) the number of adjudicated criminal violations by the nursing facility or crimes committed by nursing facility staff, (I) that were committed inside a facility, and (II) for crimes or violations committed outside a facility, the instances where these were: elder abuse, neglect, exploitation, criminal sexual abuse of an elder, or other violations that resulted in serious bodily injury; (viii) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents; and (ix) any other information determined appropriate by the Secretary.	*S. §6103(b)(1) —* *New SSA §1919(i)(1)(A)(v).* Similar to H.R. 3962, with the following exceptions: No provision. No provision.
Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information, Deadline for Provision of Information. Current Law: See above.	*H. §1413(b)(1) —* *New SSA §1919(i)(1)(B)(i) and (ii).* (i) Within one year after enactment of H.R. 3962, the Secretary would ensure that the information described in this subsection would be available. (ii) Exception—the Secretary would ensure that ownership and additional disclosable party information as described in H.R. 3962 Sec. 1411, would be included on the NH Compare website within one year after those data are submitted to the Secretary.	*S. §6103(b)(1) —* *New SSA §1919(i)(1)(B)(i) and (ii).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information, Review	*H. §1413(b)(1) —* *New SSA §1919(i)(2)(A).*	*S. §6103(b)(1) —* *New SSA §1919(i)(2)(A).*

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and Modification of Website. Current Law: See above.	The Secretary would establish a NH Compare website review and modification process that would (i) address the accuracy, clarity of presentation, timeliness, and comprehensiveness of the information reported on the Medicare NH compare website as of the day before enactment of this subsection; and (ii) within one year after the effective date of implementation of the Medicare NH Compare website, review process, modify or revamp the website in accordance with the findings of the review process.	Same as H.R. 3962.
Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information, Consultation. Current Law: See above.	*H. §1413(b)(1) —* *New SSA §1919(i)(2)(B).* Consultation—In conducting the Medicare NH compare website review process, the Secretary would be required to consult with the following organizations: (i) state LTC Ombudsman programs, (ii) consumer advocacy groups, (iii) provider stakeholder groups, and (iv) any representatives of programs or groups determined appropriate by the Secretary.	*S. §6103(b)(1) —* *New SSA §1919(i)(2)(B).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Nursing Facilities—Inclusion of Additional Information, Timeliness of Submission of Survey and Certification Information. Current Law: See above.	*H. §1413(b)(2)(A) —* *New SSA §1919(g)(5)(E).* SSA Sec. 1919(g)(5) would be amended by adding a new subparagraph. To improve the public's access to timely information on state survey and certification inspections, states would be required to submit information, including any enforcement actions, to the Secretary at the same time or before the state nursing home surveyors sent that information to facilities. Corrections to prior information submitted to the state also would need to be submitted to the Secretary in a timely manner. The Secretary would be required to update Medicare's NH Compare website with the information from states' survey and certification inspections as expeditiously as	*S. §6103(b)(2)(A)—* *New SSA §1919(g)(5)(E).* Same as H.R. 3962.

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	practicable, but at least quarterly.	
Nursing Home Compare Medicare Website—Nursing Facilities—Effective Date. Current Law: See above.	*H. §1413(b)(2)(B).* Submission of new additional information would be required within one year after the effective date of H.R. 3962.	*S. §6103(b)(2)(B).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Nursing Facilities—Special Focus Facility Program. Current Law: See above.	*H. §1413(b)(3) —* *New SSA §1919(f)(10).* SSA Sec. 1919 would be amended by adding a new paragraph that would require the Secretary to (A) conduct a special focus facility program for enforcing requirements for NFs identified as having substantially failed to meet applicable requirements of this provision of H.R. 3962; and (B) to conduct periodic surveys of each facility in the program at least every six months.	*S. §6103(b)(3) —* *New SSA §1919(f)(10).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Availability of Reports on Surveys and Certifications, and Complaint Investigations—Skilled Nursing Facilities. Current Law: See above.	*H. §1413(c)(1) —* *New SSA §1819(d)(i)(C).* SSA Sec. 1819(d)(i) would be amended to add a new subparagraph that would require SNFs to (i) make available for any individual's review reports on surveys, certifications, and complaint investigations for the past three years and (ii) to post notices in prominent and accessible facility areas that these reports are available for inspection. These reports would need to exclude information identifying complainants or residents.	*S. §6103(c)(1) —* *New SSA §1819(d)(i)(C).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Availability of Reports on Surveys and Certifications, and Complaint Investigations—Nursing Facilities. Current Law: See above.	*H. §1413(c)(2) —* *New SSA §1919(d).* SSA Sec. 1919(d)(i) would be amended to add a new subparagraph that would require NFs to (i) make available for any individual's review reports on surveys, certifications, and complaint investigations for the past three years and (ii) to post notices in prominent and accessible facility areas that these reports are available for inspection.	*S. §6103(c)(2) —* *New SSA §1919(d).* Same as H.R. 3962.

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	These reports would need to exclude information identifying complainants or residents.	
Nursing Home Compare Medicare Website—Availability of Reports on Surveys and Certifications, and Complaint Investigations—Effective Date. Current Law: See above.	*H. §1413(c)(3).* SNFs and NF would be required to make the report on surveys and certifications, and complaint investigations available within one year of enactment of H.R. 3962.	*S. §6103(c)(3).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Guidance to States on Form 2567 State Inspection Reports and Complaint Investigation Reports. Current Law: See above.	*H. §1413(d)(1).* The Secretary would be required to provide guidance to states on how to establish internet links to Form 2567 (state inspection reports or successor forms), complaint investigation reports, and facilities' correction plans or other responses to Form 2567. These reports also would be available on state websites displaying information on SNFs and NFs. The Secretary would be required, if possible to include information from these reports on the Medicare NH Compare website. These reports would be required to exclude information that identifies complainants or residents.	*S. §6103(d)(1).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Guidance to States on Form 2567 State Inspection Reports and Complaint Investigation Reports—Requirement. Current Law: See above.	*H. §1413(d)(2) —* *New SSA §1902(a)(9).* SSA Sec. 1902(a)(9) would be amended by adding a new subparagraph that would require (D) states to maintain consumer-oriented websites that provided useful information to consumers on all SNF and NFs in the state, including for each facility, form 2567 inspection reports, facilities' correction plans, and other information the Secretary considers useful in assisting the public to assess the quality of LTC options and the quality of care provided by individual facilities.	*S. §6103(d)(2) —* *New SSA §1902(a)(9).* Same as H.R. 3962.
Nursing Home Compare Medicare Website—Development of Consumer Rights Information Page on Nursing Home Compare Website. Current Law: See above.	No provision.	*S. §6103(e).* Within one year of enactment of the Senate bill, the Secretary would be required to ensure that the Medicare NH Compare Website included a consumer rights information page that contains links to

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		descriptions of, and the following information: (1) documentation available to the public on NFs; (2) general information and tips on choosing a NF that meets an individual's needs; (3) general information on consumers' rights with respect to NFs; (4) the NF survey process (on a national and state-specific basis); and (5) on a state-specific basis, services available through the state LTC ombudsman.
Reporting of expenditures Current Law: SNFs or NFs are not required under current law to report expenditures.	*H. §1414* SSA Sec. 1888 would be amended by adding a new subsection at the end to require SNFs to report direct care expenditures.	*S. §6104* Same as H.R. 3962.
Reporting of Direct Care Expenditures Current Law: See above.	*H. §1414 — New SSA §1888(f)(1).* Beginning with cost reports submitted two years after the date of the redesign of the Medicare cost report (see H.R. 3962 Sec. 1414) SNFs would be required as follows to report: (A) direct care staff wages and benefits separately (at least breaking out): (1) registered nurses, (2) licensed professional nurses, (3) certified nurse assistants, and (4) other medical and therapy staff. (B) account for agency and contract staff in a manner to be determined by the Administrator.	*S. §6104 — New SSA §1888(f)(1).* Same as H.R. 3962, except SNFs would be required to report direct care staffing expenditures two years after the date of enactment of the Senate bill, rather than two years after the redesign of the cost report forms.
Reporting of Expenditures—Modification of Form Current Law: See above.	*H. §1414 —* *New SSA §1888(f)(2).* Within two years of the effective date of H.R. 3962, the Secretary would be required to consult with private sector accountants experienced with SNF cost reports to re-design cost report forms to separately capture	*S. §6104 —* *New SSA §1888(f)(2).* Similar, but language is different—consultation would be required with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports. In addition, the effective date

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	wages and benefit expenditures for direct care staff.	would be shorter--Secretary would be required to redesign reporting forms within one year from the date of enactment of the Senate bill.
Reporting of Expenditures— Categorization by Functional Accounts Current Law: See above.	*H. §1414 —* *New SSA §1888(f)(3).* Beginning with expenditure data from the newly redesigned cost reports, the Secretary, in consultation with Medicare Payment Advisory Commission (MedPAC), HHS OIG, and other experts identified by the Secretary, would be required to annually categorize SNFs' newly collected annual expenditure from the redesign cost reports for each SNF, regardless of payment source, into the following functional accounts: (A) spending on direct care services, including nursing, therapy, and medical services; (B) spending on indirect care, including housekeeping and dietary services; (C) capital assets, including building and land costs; and (D) administrative services costs.	*S. §6104 —* *New SSA §1888(f)(3).* The same as H.R. 3962, except for the effective date--the Secretary would be required to categorize expenditures within 30 months from the date of enactment of the Senate bill.
Reporting of Expenditures—Availability of Information Submitted. Current Law: See above.	*H. §1414 —* *New SSA §1888(f)(4).* The Secretary would be required to establish procedures to make the expenditure data readily available to interested parties upon request, subject to requirements established by the Secretary.	*S. §6104 —* *New SSA §1888(f)(4).* Same as H.R. 3962.
Standardized complaint form Current Law: There are no provisions in current law requiring use of a standardized complaint form. Oversight of nursing homes is a shared federal-state responsibility. Based on statutory requirements, CMS defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to assess whether homes meet these standards through annual surveys and complaint investigations. A range of	*H. §1415* H. §1415(a)(1) — New SSA §1819(f)(9). SSA Sec. 1819(f) would be amended by adding a new paragraph to require SNFs to use a standardized complaint form. The Secretary would be required to develop a standardized complaint form for SNF residents or their	*S. §6105* S. §6105(a) — New SSA §1128I(f)(1). Similar to H.R. 3962, except that the Senate bill changes SSA Sec. 1128 which would apply to both SNFs and NFs, whereas H.R. 3962 modifies first Sec. 1819(f) for SNFs and then SSA Sec. 1919(f) for NFs. Same as H.R. 3962.

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statutorily defined sanctions is available to CMS and the states to help ensure that homes maintain compliance with federal quality requirements. CMS also is responsible for monitoring the adequacy of state survey activities. Every nursing home receiving Medicare or Medicaid payment must undergo a standard survey not less than once every 15 months, and the statewide average interval for these surveys must not exceed 12 months. During a standard survey, separate teams of surveyors conduct a comprehensive assessment of federal quality-of-care and fire safety requirements. In contrast, complaint investigations generally focus on a specific allegation regarding resident care or safety. The quality-of-care component of a survey focuses on determining whether (1) the care and services provided meet the assessed needs of the residents and (2) the home is providing adequate quality care, including preventing avoidable pressure sores, weight loss, and accidents. Nursing homes that participate in Medicare and Medicaid are required to periodically assess residents' care needs in 17 areas, such as mood and behavior, physical functioning, and skin conditions, in order to develop an appropriate plan of care. Such resident assessment data are known as the minimum data set. To assess the care provided by SNF and nursing facilities, surveyors select a sample of residents and (1) review data derived from the residents' MDS assessments and medical records; (2) interview nursing home staff, residents, and family members; and (3) observe care provided to residents during the course of the survey. CMS establishes specific investigative protocols for state survey teams—generally consisting of RNs, social workers, dieticians, and other specialists—to use in conducting surveys. These procedural instructions are intended to make the on-site surveys thorough and consistent across states. The fire safety component of a survey focuses on a home's compliance with federal standards for health care facilities. The fire safety standards cover 18 categories ranging from building construction to furnishings. Examples of specific requirements include the use of fire- or smoke-resistant	representatives to use, in filing complaints on SNFs to state survey and certification agencies and state LTC ombudsman programs.	

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construction materials, the installation and testing of fire alarms and smoke detectors, and the development and routine testing of a fire emergency plan. Most states use fire safety specialists within the same department as the state survey agency to conduct fire safety inspections, but about one-third of states contract with their state fire marshal's office.		
Skilled Nursing Facilities—Complaint Processes and Whistle Blower Protection, State Requirements, Complaint Forms. Current Law: See above.	*H. §1415(a)(2) —* *New SSA §1819(e)(6)(A).* For use in filing complaints on SNFs, SSA Sec. 1819(e) would be amended by adding a new paragraph at the end that would require states to make available the new standardized complaint form available on request to (i) SNF residents, (ii) individuals acting on behalf of SNF residents, and (iii) SNF employees or representatives of SNF employees.	*S. §6105(a) —* *New SSA §1128I(f)(2)(A).* Complaint Forms and Resolution Processes— In filing complaints on facilities (SNFs and NFs) with state survey and certification agencies or state LTC ombudsmen programs, states would be required to make the standardized complaint form available on request to (i) facility (SNF or NF) residents, and (ii) individuals acting on behalf of (SNF or NF) residents.
Skilled Nursing Facilities—Complaint Processes and Whistle Blower Protection, Complaint Resolution Process. Current Law: See above.	*H. §1415(a)(2) —* *New SSA §1819(e)(6)(B).* States would be required to establish a complaint resolution process that ensures that SNF residents, their legal representatives, or SNF employees are not denied access to SNF residents or retaliated against **for complaining, in good faith**, about quality of care or other issues in a facility, regardless of whether residents, their representatives or employees used the standardized form or some other method to submit their complaint. The state complaint resolution procedures would be required to include the following: (i) procedures to assure accurate tracking of complaints; (ii) procedures to determine the likely severity of the complaint and procedures to investigate complaints; (iii) deadlines for responding to complaints and	*S. §6105(a) —* *New SSA §1128I(f)(2)(B).* Similar to H.R. 3962, except that the Senate bill changes SSA Sec. 1128I which would apply to both SNFs and NFs, whereas H.R. 3962 modifies first Sec. 1819 for SNFs and then SSA Sec. 1919 for NFs. In addition, residents (their legal representatives are assured access to the resident) and employees are not included in the list of individuals protected by the complaint resolution process. The Senate bill does not define "**good faith**" complaints.

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	procedures that would enable a complainant to track the complaint and investigation; and (iv) procedures to ensure that the identity of complainants would be kept confidential.	The Senate bill does not require procedures to ensure the identity of complainants would be kept confidential.
Skilled Nursing Facilities—Complaint Processes and Whistle Blower Protection, Whistleblower Protection, Prohibition Against Retaliation. Current Law: See above.	*H. §1415(a)(2) —* *New SSA §1819(e)(6)(C)(i).* The complaint resolution process would be required to include prohibitions against retaliation that would ensure that SNF employees would not be penalized, discriminated, or retaliated against because they or anyone they requested to act on their behalf, in good faith, complained about the quality of care, services provided, or other issues related to quality of care or service in a SNF. This retaliatory prohibition would apply regardless of whether employees used the new standardized form or some other complaint method. Retaliatory actions would not affect any aspect of complainants' employment, including: discharge, promotion, compensation, terms, conditions, or employment privileges, or termination of a contract for services.	No provision.
Skilled Nursing Facilities—Complaint Processes and Whistle Blower Protection, Whistleblower Protection, Retaliatory Reporting. Current Law: See above.	*H. §1415(a)(2) —* *New SSA §1819(e)(6)(C)(ii).* SNFs would not be permitted to file complaints or reports with state professional disciplinary agencies against current or former employees because they, or their agents, acting in good faith, submitted complaints about quality of care or services in their employers' facility.	No provision.
Skilled Nursing Facilities—Complaint Processes and Whistle Blower Protection, Whistleblower Protection, Relief. Current Law: See above.	*H. §1415(a)(2) —* *New SSA §1819(e)(6)(C)(iii).* SNF employees who believed they were penalized, discriminated, or retaliated against, or lost service	No provision.

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	contracts because they submitted a quality of care complaint against a SNF, would be able to seek all appropriate relief through a civil action including reinstatement, reimbursement of lost wages and benefits, and exemplary damages where warranted, and such other relief as a court deems appropriate, as well as reasonable attorney and expert witness fees.	
Skilled Nursing Facilities—Complaint Processes and Whistle Blower Protection, Whistleblower Protection, Rights Not Waivable. Current Law: See above.	*H. §1415(a)(2) —* *New SSA §1819(e)(6)(C)(iv).* SNF employees' rights under this provision would not be diminished by contract or other agreement and would not diminish any greater or additional protection provided by federal or state laws, contracts, or agreements.	No provision.
Skilled Nursing Facilities—Complaint Processes and Whistle Blower Protection, Whistleblower Protection, Requirement to Post Notice of Employee Rights. Current Law: See above.	*H. §1415(a)(2) —* *New SSA §1819(e)(6)(C)(v).* SNFs would be required to conspicuously post in an appropriate location a sign as specified by the Secretary that identifies employees' rights to bring complaints against the facility, including a statement that employees may file a complaint with the Secretary against a SNF.	No provision.
Skilled Nursing Facilities—Complaint Processes and Whistle Blower Protection, Rule of Construction. Current Law: See above.	*H. §1415(a)(2) —* *New SSA §1819(e)(6)(D).* Nothing in this provision would prevent a SNF resident, or someone acting on their behalf, from submitting a complaint in any or format other than the standardized complaint form.	*S. §6105(a) — New SSA §1128I(f)(3).* Similar to H.R. 3962, except that the Senate bill changes SSA Sec. 1128 which would apply to both SNFs and NFs, whereas H.R. 3962 modifies first Sec. 1819(f) for SNFs and then SSA Sec. 1919(f) for NFs.
Skilled Nursing Facilities—Complaint Processes and Whistle Blower Protection, Good Faith Defined. Current Law: See above.	*H. §1415(a)(2) —* *New SSA §1819(e)(6)(E).* Individuals would be considered to be acting in "good faith" when submitting complaints if they believe: (1) their complaint is true, and (2) a violation has or may have occurred related to SSA Medicare provisions.	No provision.

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Nursing Facilities—Complaint Processes and Whistle Blower Protection, Development by the Secretary. Current Law: Complaint investigations provide an opportunity for state surveyors to intervene promptly if problems arise between standard surveys. Complaints may be filed against a home by a resident, the resident's family, or a nursing home employee either verbally, via a complaint hotline, or in writing. Surveyors generally follow state procedures when investigating complaints but must comply with certain federal guidelines and time frames. In cases involving resident abuse, such as pushing, slapping, beating, or otherwise assaulting a resident by individuals to whom their care has been entrusted, state survey agencies may notify state or local law enforcement agencies that can initiate criminal investigations. States must maintain a registry of qualified nurse aides, the primary caregivers in nursing homes, that includes any findings that an aide has been responsible for abuse, neglect, or theft of a resident's property. The inclusion of such a finding constitutes a ban on nursing home employment.	*H. §1415(b)(1) —* *New SSA §1919(f)(11).* SSA Sec. 1919(f) would be amended by adding a new paragraph at the end to require NFs to use a standardized complaint form. The Secretary would be required to develop a standardized complaint form for NF residents or their representatives to use, in filing complaints on NFs to state survey and certification agencies and state LTC ombudsman programs.	Similar to H.R. 3962, except that the Senate bill changes SSA Sec. 1128 which would apply to both SNFs and NFs, whereas H.R. 3962 modifies first Sec. 1819(f) for SNFs and then SSA Sec. 1919(f) for NFs.
Nursing Facilities—Complaint Processes and Whistle Blower Protection, State Requirements, Complaint Forms. Current Law: See above.	*H. §1415(b)(2) —* *New SSA §1919(e)(8)(A).* For use in filing complaints on NFs, SSA Sec. 1919(e) would be amended by adding a new paragraph at the end that would require states to make the standardized complaint form available on request to (i) NF residents, (ii) people acting on behalf of NF residents, and (iii) NF employees or representatives of NF employees.	*S. §6105(a) — New SSA §1128I(f)(2)(A).* Similar to H.R. 3962, except in filing complaints on facilities (SNFs and NFs) with state survey and certification agencies or state LTC ombudsmen programs, states would be required to make the standardized complaint form available on request to (i) facility (SNF or NF) residents, and (ii) individuals acting on behalf of (SNF or NF) residents
Nursing Facilities—Complaint Processes and Whistle Blower Protection, State Requirements, Complaint Resolution Process.	*H. §1415(b)(2) —* *New SSA §1919(e)(8)(B)).* States would be required to establish a complaint	*S. §6105(a) —* *New SSA §1128I(f)(2)(A).* Similar to H.R. 3962, except that the Senate bill

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Current Law: See above.	resolution process that ensures that NF residents, their legal representatives, or NF employees are not denied access to NF residents or retaliated against for complaining, in *good faith*, about quality of care or other issues in a facility, regardless of whether residents, their representatives or employees used the standardized form or some other method to submit their complaint. The state complaint resolution procedures would be required to include: (i) procedures to assure accurate tracking of complaints; (ii) procedures to determine the likely severity of the complaint and procedures to investigate complaints; (iii) deadlines for responding to complaints and procedures that would enable a complainant to track the complaint and investigation; and (iv) procedures to ensure that the identity of complainants would be kept confidential.	changes SSA Sec. 1128I which would apply to both SNFs and NFs, whereas H.R. 3962 modifies first Sec. 1819 for SNFs and then SSA Sec. 1919 for NFs. In addition, residents (their legal representatives are assured access to the resident) and employees are not included in the list of individuals protected by the complaint resolution process. The Senate Bill does not define *good faith* complaints. The Senate bill does not require procedures to ensure the identity of complainants would be kept confidential.
Nursing Facilities—Complaint Processes and Whistle Blower Protection, State Requirements, Prohibition Against Retaliation. Current Law: See above.	*H. §1415(b)(2) —* *New SSA §1919(e)(8)(C)(i).* The complaint resolution process would be required to include prohibitions against retaliation that would ensure that NF employees would not be penalized, discriminated, or retaliated against because they or anyone they requested to act on their behalf, in good faith, complained about the quality of care, services provided, or other issues related to quality of care or service in a nursing facility. This retaliatory prohibition would apply regardless of whether employees used the new standardized form or some other complaint method. Retaliatory actions would not affect any aspect of complainants' employment, including: discharge, promotion, compensation, terms, conditions, or employment privileges, or termination of a contract for services.	No provision.

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Nursing Facilities—Complaint Processes and Whistle Blower Protection, State Requirements, Retaliatory Reporting. Current Law: See above.	*H. §1415(b)(2) —* *New SSA §1919(e)(8)(C)(ii).* NFs would not be permitted to file complaints or reports with state professional disciplinary agencies against current or former employees because they, or their agents, acting in good faith, submitted complaints about quality of care or services in their employers' facility.	No provision.
Nursing Facilities—Complaint Processes and Whistle Blower Protection, State Requirements, Relief. Current Law: See above.	*H. §1415(b)(2) —* *New SSA §1919(e)(8)(C)(iii).* NF employees who believed they were penalized, discriminated, or retaliated against, or lost service contracts because they submitted a quality of care complaint against a NF, would be able to seek all appropriate relief through a civil action including reinstatement, reimbursement of lost wages and benefits, and exemplary damages where warranted, and such other relief as a court deems appropriate, as well as reasonable attorney and expert witness fees.	No provision.
Nursing Facilities—Complaint Processes and Whistle Blower Protection, State Requirements, Rights Not Waivable. Current Law: See above.	*H. §1415(b)(2) —* *New SSA §1919(e)(8)(C)(iv).* NF employees' rights under this provision would not be diminished by contract or other agreement and would not diminish any greater or additional protection provided by federal or state laws, contracts, or agreements.	No provision.
Nursing Facilities—Complaint Processes and Whistle Blower Protection, State Requirements, Requirement to Post Notice of Employee Rights. Current Law: See above.	*H. §1415(b)(2) —* *New SSA §1919(e)(8)(C)(v).* NFs would be required to conspicuously post in an appropriate location a sign as specified by the Secretary that identifies employees' rights to bring complaints against the facility, including a statement that employees may file a complaint with the Secretary against a NF.	No provision.

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Nursing Facilities—Complaint Processes and Whistle Blower Protection, Rule of Construction. Current Law: See above.	*H. §1415(b)(2) —* *New SSA §1919(e)(8)(D).* Nothing in this provision would prevent a NF resident, or someone acting on their behalf, from submitting a complaint in any format other than the standardized complaint form.	*S. §6105(a) —* *New SSA §1128I(f)(3).* Similar to H.R. 3962, except that the Senate bill changes SSA Sec. 1128 which would apply to both SNFs and NFs, whereas H.R. 3962 modifies first Sec. 1819(f) for SNFs and then SSA Sec. 1919(f) for NFs.
Nursing Facilities—Complaint Processes and Whistle Blower Protection, Good Faith Defined. Current Law: See above.	*H. §1415(b)(2) —* *New SSA §1919(e)(8)(E).* Individuals would be considered to be acting in "good faith" when submitting complaints if they believe: (1) their complaint is true, and (2) a violation has or may have occurred related to SSA's Medicaid provisions.	No provision.
Complaint Processes and Whistle Blower Protection, Effective Date. Current Law: See above.	*H. §1415(c)* SSA amendments made in Sec. 1415 would take effect one year after the enactment of H.R. 3962.	*S. §6105(b)* Same as H.R. 3962.
Ensuring staffing accountability Current Law: There are no provisions in current law for SNF and NFs to ensure staff accountability. *Submission of Staffing Information Based on Payroll Data in a Uniform Format.*	*H. §1416* H. §1416(a) — New SSA §1819(b)(8)(C)(I)-(iv). SSA Sec. 1819(b)(8) would be amended by adding a new paragraph at the end that would require the Secretary to consult with state LTC ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, before establishing requirements for SNFs to electronically submit to the Secretary direct care staffing information, including agency and contract staff. SNFs would be required to begin submitting the staffing information with the first quarter two years after the effective date of this provision. These direct care staffing data would be based on payroll and other verifiable data provided by SNFs in uniform format to the Secretary.	*S. §6106* S. §6106(a) — New SSA §1128I(g). Similar to H.R. 3962, except that the Senate bill changes SSA Sec. 1128 which would apply to both SNFs and NFs, whereas H.R. 3962 modifies first Sec. 1819(f) for SNFs and then SSA Sec. 1919(f) for NFs. In addition, the staffing information requirement would commence two years after enactment of the Senate bill rather than the first quarter after two years as in H.R. 3962.
	Other specifications would include: (i) the work categories performed by certified	Similar to H.R. 3962, except that the Senate bill changes SSA Sec. 1128 which would apply to both

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	employees, such as registered nurses, licensed practical nurses, licensed vocational nurses, certified nursing assistants, therapists, or other medical personnel; (ii) include resident census data and information on resident case mix; (iii) include a regular reporting schedule; and (iv) include employee tenure and turnover, as well as hours of care provided by each certified employee category, per resident per day.	SNFs and NFs, whereas H.R. 3962 modifies first Sec. 1819(f) for SNFs and then SSA Sec. 1919(f) for NFs.
	Nothing would prevent the Secretary from requiring submission of specific categories of information, such as nursing staff, before other categories of certified employees. Agency and contract staff would be reported separately from information on employees.	Similar to H.R. 3962, except that the Senate bill changes SSA Sec. 1128 which would apply to both SNFs and NFs, whereas H.R. 3962 modifies first Sec. 1819(f) for SNFs and then SSA Sec. 1919(f) for NFs.
Ensuring Staffing Accountability—Nursing Facilities—Submission of Staffing Information Based on Payroll Data in a Uniform Format. Current Law: See above.	*H. §1416(b) —* *New SSA §1919(b)(8)(C)(I)-(iv).* SSA Sec. 1919(b)(8) would be amended by adding a new section at the end that would require the Secretary to consult with state LTC ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, before establishing requirements for NFs to electronically submit to the Secretary direct care staffing information, including agency and contract staff. NFs would be required to begin submitting the staffing information with the first quarter two years after the effective date of this provision. These direct care staffing data would be based on payroll and other verifiable data provided by NFs in uniform format to the Secretary. Nothing would prevent the Secretary from requiring submission of specific categories of information, such as nursing staff, before other categories of certified employees. Agency and contract staff would be reported separately from information on employees.	*S. §6106(a) —* *New SSA §1128I(g).* Similar to H.R. 3962, except that the Senate bill changes SSA Sec. 1128 which would apply to both SNFs and NFs, whereas H.R. 3962 modifies first Sec. 1819(f) for SNFs and then SSA Sec. 1919(f) for NFs. In addition, the staffing information requirement would commence two years after enactment of the Senate bill rather than the first quarter after two years as in H.R. 3962.
	Other specifications would include:	

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	(i) the work categories performed by certified employees, such as registered nurses, licensed practical nurses, licensed vocational nurses, certified nursing assistants, therapists, or other medical personnel; (ii) include resident census data and information on resident case mix; (iii) include a regular reporting schedule; and (iv) include employee tenure and turnover, as well as hours of care provided by each certified employee category, per resident per day.	
	Nothing would prevent the Secretary from requiring submission of specific categories of information, such as nursing staff, before other categories of certified employees. Agency and contract staff would be reported separately from information on employees.	Similar to H.R. 3962, except that the Senate bill changes SSA Sec. 1128 which would apply to both SNFs and NFs, whereas H.R. 3962 modifies first Sec. 1819(f) for SNFs and then SSA Sec. 1919(f) for NFs.
Nationwide program for national background checks on direct patient access employees of LTC facilities and providers. Current Law: Sec. 307 of the MMA of 2003 (P.L. 108-173) established the framework for a program to evaluate national and State background checks on prospective employees who have direct access to patients of long-term care (LTC) facilities or providers. From January 2005 through September 2007 CMS administered a pilot program, in consultation with the Department of Justice (DoJ), in seven States (AK, ID, IL, MI, NV, NM, and WI).	*H. §1417.* The provision would require the Secretary to establish a "nationwide program" for national and State background checks on direct patient access employees of certain LTC facilities or providers. Except for certain modifications described below, the Secretary would be required to carry out the nationwide program under similar terms and conditions as the Background Check Pilot program under Sec. 307 of the MMA, as specified.	*S. §6201.* The provision would require the Secretary to establish a similar program. Key differences between the program's provisions are described below.
Background checks on direct patient access employees of LTC facilities and providers – Agreements.	*H. §1417(a)(1).* The nationwide program would require the Secretary to enter into agreements with newly participating States and certain previously participating States, as specified. Under such agreements a State may agree to cover and reimburse each LTC facility or provider for all costs attributable to conducting background checks and screenings that were not otherwise required prior to enactment. Federal funding with respect to such reimbursement would be limited to the amount made	*S. §6201(a)(1).* Identical provision, except it does not include language specifying that under such agreements a State may agree to cover and reimburse each LTC facility or provider for all costs attributable to conducting background checks and screenings not otherwise required to be conducted prior to enactment.

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	available to the State to carry out the nationwide program.	
Background checks on direct patient access employees of LTC facilities and providers – Required fingerprint check as part of criminal history background check.	*H. §1417(a)(3).* According to the procedures established under the pilot program, the provision would require certain LTC facilities or providers to obtain State and national criminal history background checks on their prospective employees through such means as the Secretary determines appropriate utilizing a search of State-based abuse and neglect registries and specified State and Federal databases and records. States would be required to describe and test methods that reduce duplicative fingerprinting, including the development of a "rap back" capability, such that if an employee is convicted of a crime following the initial background check and the employee's fingerprints match the prints on file, the State would immediately inform the employer of such conviction.	*S. §6201(a)(3).* Identical provision, except it would require background checks through such means as the Secretary determines appropriate, efficient, and effective. It would also require that criminal history background checks conducted under the program remain valid for a period of time specified by the Secretary.
Background checks on direct patient access employees of LTC facilities and providers – State requirements.	*H. §1417(a)(4).* The provision would require States that enter into an agreement with the Secretary to be responsible for monitoring compliance with the requirements of the nationwide program and have certain specified procedures in place. It also specifies that background checks and screenings would be valid for two years, as determined by the State and approved by the Secretary.	*S. §6201(a)(4).* Identical provision, except it contains no requirement for background checks and screenings to be valid for 2 years. Instead background checks would remain valid for a period of time specified by the Secretary (see S. §6201(a)(3) above).
Background checks on direct patient access employees of LTC facilities and providers – Payment.	*H. §1417(a)(5).* The provision would require States to guarantee a designated amount of non-Federal contributions to the program (directly or through donations from public or private entities). The Federal government would provide a match equal to three times the amount a State guarantees.	*S. §6201(a)(5).* Same provision, except that Federal funds would not exceed $3 million for newly participating States and $1.5 million for previously participating States.
Background checks on direct patient access employees of LTC facilities and providers –	*H. §1417(a)(6).* The provision would define the following terms:	*S. §6201(a)(6).* The provision includes identical definitions for these terms.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Definitions.	"conviction for a relevant crime", "disqualifying information," "finding of patient or resident abuse," "direct patient access employee," and "long-term care facility or provider." It would define the term "long-term care facility or provider" to include "an assisted living facility that provides a nursing home level of care conveyed by State licensure or State definition.	It would also define the terms "conviction for a relevant crime," "disqualifying information" and "finding of patient or resident abuse." It would define the term "long-term care facility or provider" to include "an assisted living facility that provides a level of care established by the Secretary."
Background checks on direct patient access employees of LTC facilities and providers – Evaluation and report.	*H. §1417(a)(7).* The provision would require the HHS Inspector General to conduct an evaluation of the nationwide program, as specified, and submit a report to Congress no later than 180 days after completion of the national program. Among other requirements, the evaluation would include a review of the various procedures implemented by participating States for LTC facilities or providers, including staffing agencies, to conduct background checks and identify the most appropriate, efficient, effective, and economical procedures for conducting such background checks.	*S. §6201(a)(7).* Identical provision, except it would require the evaluation to identify the most appropriate, efficient, and effective procedures for conducting such background checks, it omits the term "economical."
Background checks on direct patient access employees of LTC facilities and providers – Funding.	H. §1417(b). The provision would require the Secretary of the Treasury to transfer to HHS an amount specified by the HHS Secretary as necessary (not to exceed $160 million) to carry out the nationwide program for fiscal years 2010 through 2012. Such amounts would be required to remain available until expended. To provide for conducting the evaluation, the HHS Secretary would be authorized to reserve no more than $3 million of the amount transferred.	S. §6201(b). Same provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
GAO study and report on Five-Star Quality Rating System—Study. Current Law: There is no requirement in current law for a Five-Star Quality Rating System for SNFs or NFs. CMS initiated the Five-Star Quality Rating System to help LTC consumers, their families, and caregivers compare nursing homes. The Medicare NH Compare web site includes data from the quality rating system that gives nursing homes a rating of between one and five stars. Nursing homes with five stars are considered to provide superior quality and nursing homes with one star are considered to provide lower quality care. Nursing homes receive an overall five-star rating, and separate ratings for the following three sources of information: health inspections, staffing, and quality measures.	No provision.	*S. §6107* S. §6107(a) The Comptroller General and the Government Accountability Office (GAO) would be required to study CMS' nursing home Five-Star Quality Rating System and to include the following analyses: (1) how the Five-Star Quality Rating system is being implemented; (2) any problems associated with the implementation of the system; and (3) how the Five-Star Quality Rating system can be improved. *S. §6107(b)* Within two years of enactment of the Senate bill, GAO would be required to submit to Congress a report with the results of the required study along with recommendations for legislative and administrative action.

Part 2 – Targeting Enforcement.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Civil money penalties Current Law: Under Medicare law, the Secretary has the authority to impose civil monetary penalties, deny payments, appoint temporary management to bring facilities into compliance, and close facilities if nursing facilities fail to meet federal requirements or have deficiencies that jeopardize residents' health or safety.	*H. §1421* H. §1421(a)(1)—New SSA §1819(h)(2)(B)(ii). SSA Sec. 1819(h)(2)(B)(ii) would be amended by adding new provisions that would specify the amount of civil money penalties (CMPs) and guidelines for the Secretary to follow in imposing penalties on SNFs for deficiencies.	*S. §6111* S. §6111(a)(1)—New SSA §1819(h)(2)(B)(ii). Same as H.R. 3962.
Civil Money Penalties—Skilled Nursing Facilities—Per Instance and Per Day Amounts. Current Law: The Secretary may impose civil	*H. §1421(a)(1)—* *New SSA §1819(h)(2)(B)(ii)(I)-(III).* The Secretary would be authorized to impose per	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
monetary penalties of up to $10,000 for each day of noncompliance.	instance or per day CMPs for each instance or each day of noncompliance (as determined appropriate by the Secretary). Per instance CMPs would be the following: (1) in the case where a deficiency is the direct proximate cause of a resident's death, the penalty would not exceed $100,000; (2) in each case where a facility is cited for a resident's actual harm or immediate jeopardy, an amount equal to or greater than $3,050, but not more than $25,000; and (3) in each case of any other deficiency, penalty amounts per deficiency would range from not less than $250 to not more than $3,050. Per day CMPs would be the following: (1) an amount equal to or greater than $3,050 up to $25,000 where facilities were cited for deficiencies that caused actual harm or immediate jeopardy to residents; and (2) an amount between $250 and $3,050 for each case of any other deficiency.	
Civil Money Penalties—Skilled Nursing Facilities—Penalties Imposed by the State; Reduction of Civil Money Penalties in Certain Circumstances. Current Law: See above.	*H. §1421(a)(1)—* *New SSA §1819(h)(2)(B)(ii)(IV).* Subject to limitations where reductions are prohibited, if SNFs self-report and promptly correct deficiencies within 10 calendar days after imposition of a CMP, the Secretary may reduce the amount of the imposed CMP by up to 50%.	*S. §6111(a)(1)—* *New SSA §1819(h)(2)(B)(ii)(II).* Same as H.R. 3962
Civil Money Penalties—Skilled Nursing Facilities—Prohibition on Reduction for Certain Deficiencies. Current Law: See above.	*H. §1421(a)(1)—* *New SSA §1819(h)(2)(B)(ii)(V).* (aa) Repeat Deficiencies—The Secretary would be prohibited from reducing CMPs for SNFs where the Secretary had previously reduced a penalty for that facility in the last year, with respect to a repeat deficiency.	*S. §6111(a)(1)—* *New SSA §1819(h)(2)(B)(ii)(III).* Same as H.R. 3962.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	(bb) Certain Other Deficiencies—The Secretary would be prohibited from reducing CMPs for other deficiencies (1) where the deficiency was found to result in a pattern of harm or widespread harm that immediately jeopardizes residents' safety or health; or (2) where a deficiency resulted in the death of a patient.	
Civil Money Penalties—Skilled Nursing Facilities—Limitation on Aggregate Reductions. Current Law: See above.	*H. §1421(a)(1)—* *New SSA §1819(h)(2)(B)(ii)(VI).* Aggregate CMP reductions would not be permitted to exceed 35% on the basis of self-reporting, on the basis of a waiver or an appeal, or on the basis of both a waiver and an appeal.	No provision.
Civil Money Penalties—Skilled Nursing Facilities—Collection of Civil Money Penalties. Current Law: See above.	*H. §1421(a)(1)—* *New SSA §1819(h)(2)(B)(ii)(VII).* (aa) In collecting CMPs, the Secretary would be required within 30 days after imposing a CMP to provide the opportunity for an independent informal review by the state survey agency. The dispute resolution process would be required to generate a written record prior to collection of the CMP, but would not affect the responsibility of the state survey agency for making final CMP recommendation. (bb) When the penalties are imposed for each day of noncompliance, the Secretary would be prohibited from imposing a penalty for any day during the period beginning with the initial day and ending when the dispute resolution process is completed. (cc) In cases where the penalty dispute resolution process occurs prior to penalty collection; may provide an escrow account (under the Secretary's direction) for fees to be held beginning on the earlier of 90 days after fees are imposed, or the date the informal resolution process was completed; (dd) may provide that penalty fees are held in escrow	*S. §6111(a) —* *New SSA §1819(h)(2)(B)(ii)(IV).* Similar to H.R. 3962, except the Senate bill specifies that the Secretary would be required to issue regulations that would include items (aa)–(ff) in H.R. 3962 Sec. 1421(a)(1). In addition, the Senate bill does not include language that would require the state survey agency to maintain responsibility for making final CMP recommendations.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	accounts until appeals are resolved; (ee) in cases where appeals are resolved in favor of facilities, may provide, if escrow accounts are established, that penalty fees would be returned to facilities with interest; and (ff) in cases where all appeals are unsuccessful, may provide, that some portion of penalty amounts are used to support activities that will benefit residents, including assistance to support and protect residents, including residents who reside in facilities that voluntarily or involuntarily close or are decertified.	
	The activities funded with CMPs may include using the penalty funds to offset costs of relocating residents to home- and community-based settings, and other facilities, as well as projects to support resident and family councils and other consumer quality of care involvement (including joint training of staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).	Same as H.R. 3962.
Civil Money Penalties—Skilled Nursing Facilities—Procedure. Current Law: See above.	*H. §1421(a)(1)—* *New SSA §1819(h)(2)(B)(ii)(VIII).* SSA Sec. 1128A (except subsections (a) and (b)) and provisions that require a hearing prior to imposing CMPs, also would apply to the CMPs described in this provision.	No provision.
Civil Money Penalties—Nursing Facilities—Penalties Imposed by the State; In General. Current Law: Under Medicaid law, states have authority either by regulation or law to impose money penalties, deny payments, appoint temporary management to bring facilities into compliance, and close facilities if nursing facilities fail to meet state plan requirements or have deficiencies that	*H. §1421(b)(1) —* *New SSA §1919(h)(2)(G).* SSA Sec. 1919(h)(2) would be amended by adding a new provision at the end that would specify CMPs and guidelines for states to follow in imposing penalties on NFs for deficiencies.	*S. §6111(b)(1) —* *New SSA §1919(h)(3)(C)(ii)(I).* Same as H.R. 3962, except the requirements apply to the Secretary, not to states (see comparable sections below for Secretarial authority).

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
jeopardize residents' health or safety. State expenses for enforcement may be funded under the proper and efficient state plan administration provision of SSA Title XIX. States also have authority to establish reward programs for nursing facilities that deliver the highest quality care to medical assistance patients and fund these incentive rewards programs under Medicaid's proper and efficient administration provisions.		
Civil Money Penalties—Nursing Facilities—Penalties Imposed by the State; Applicable Per Day and Per Instance CMPs. Current Law: See above.	*H. §1421(b)(1)—* *New SSA §1919(h)(2)(G)(i)-(iii).* States would have authority to impose per instance or per day CMPs for each instance or each day of noncompliance (as determined appropriate by the Secretary). Per instance CMPs would be the following: (1) in the case where a deficiency is the direct proximate cause of a resident's death, the penalty would not exceed $100,000; (2) in each case where a facility is cited for a resident's actual harm or immediate jeopardy, an amount equal to or greater than $3,050, but not more than $25,000; and (3) in each case of any other deficiency, penalty amounts per deficiency would range from not less than $250 to not more than $3,050. Applicable per day CMPs would be the following: (1) an amount equal to or greater than $3,050 up to $25,000 where facilities were cited for deficiencies that caused actual harm or immediate jeopardy to residents; and (2) an amount between $250 and $3,050 for each case of any other deficiency.	No provision.
Civil Money Penalties—Nursing Facilities—Penalties Imposed by the State; Reduction of Civil	*H. §1421(b)(1)—* *New SSA §1919(h)(2)(G)(iv).*	*S. §6111(b)(1) —* *New SSA §1919(h)(3)(C)(ii)(II).*

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Money Penalties in Certain Circumstances. Current Law: See above.	Subject to limitations where reductions are prohibited, if NFs self-report and promptly correct deficiencies within 10 calendar days after imposition of a CMP, the state may reduce the amount of the imposed CMP by up to 50%.	Same as H.R. 3962, except the requirements apply to the Secretary, not to states (see comparable sections below for Secretarial authority).
Civil Money Penalties—Nursing Facilities—Penalties Imposed by the State; Prohibition on Reduction for Certain Deficiencies. Current Law: See above.	*H. §1421(b)(1)—* *New SSA §1919(h)(2)(G)(v)(I)-(III).* Repeat Deficiencies—States would be prohibited from reducing CMPs for SNFs where the state had previously reduced a penalty for that facility in the last year, with respect to a repeat deficiency. Certain Other Deficiencies—States would be prohibited from reducing CMPs for other deficiencies (1) where the deficiency was found to result in a pattern of harm or widespread harm that immediately jeopardizes residents' safety or health; or (2) where a deficiency resulted in the death of a patient. Limitation on Aggregate Reductions—Aggregate CMP reductions would not be permitted to exceed 35% on the basis of self-reporting, on the basis of a waiver or an appeal, or on the basis of both a waiver and an appeal.	*S. §6111(b) —* *New SSA §1919(h)(3)(C)(ii)(III).* Same as H.R. 3962, except the requirements apply to the Secretary, but not to states (see comparable sections below for Secretarial authority).
Civil Money Penalties—Nursing Facilities—Penalties Imposed by the State; Collection of Civil Money Penalties. Current Law: See above.	*H. §1421(b)(1) —* *New SSA §1919(h)(2)(G)(vi)(I)-(VI).* (I) In collecting CMPs, states would be required within 30 days after imposing a CMP to provide the opportunity for an independent informal review by the state survey agency. The dispute resolution process would be required to generate a written record prior to collection of the CMP, but would not affect the responsibility of the state survey agency for making final recommendations the CMP. (II) When the penalties are imposed for each day of noncompliance, states would be prohibited from imposing a penalty for any day during the period beginning with the initial day and ending when the	*S. §6111(b) —* *New SSA §1919(h)(3)(C)(ii)(IV)(aa)-(ff).* Same as H.R. 3962, except the Secretary would be required to issue regulations on the collection of CMPs and the requirements would apply to the Secretary, not to states (see comparable sections below for Secretarial authority). Same as H.R. 3962.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	dispute resolution process is completed.	
	(III) In cases where the penalty dispute resolution process prior to penalty collection; may provide an escrow account (under state direction) for fees to be held beginning on the earlier of 90 days after fees are imposed, or the date the informal resolution process was completed;	Same as H.R. 3962.
	(IV) may provide that penalty fees are held in escrow accounts until appeals are resolved;	Same as H.R. 3962.
	(V) in cases where appeals are resolved in favor of facilities, may provide, if escrow accounts are established, that penalty fees would be returned to facilities with interest; and	Same as H.R. 3962.
	(VI) in cases where all appeals are unsuccessful, may provide, that some portion of penalty amounts are used to support activities that will benefit residents, including assistance to support and protect residents, including residents who reside in facilities that voluntarily or involuntarily close or are decertified.	Same as H.R. 3962.
Civil Money Penalties—Nursing Facilities—Conforming Amendment. Current Law: See above.	*H. §1421(b)(1)(B) —* *New SSA §1919(h)(2)(A)(ii).* SSA Sec. 1919 would be amended to permit states to use penalty funds to offset costs of relocating residents to home- and community-based settings, and other facilities, as well as projects to support resident and family councils and other consumer quality of care involvement (including joint training of staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).	No provision.
Civil Money Penalties—Nursing Facilities—Penalties Imposed by the Secretary; In General. Current Law: See above.	*H. §1421(b)(2)(A)—* *New SSA §1919(h)(3)(C)(ii).* SSA Sec. 1919 would be amended by adding a new provision that would specify the amount of CMPs and	*S. §6111(b)(1) —* *New SSA §1919(h)(3)(C)(ii)(I).* Same as H.R. 3962.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	guidelines for the Secretary to follow in imposing penalties on NF deficiencies.	
Civil Money Penalties—Nursing Facilities—Penalties Imposed by the Secretary; Amount. Current Law: See above.	*H. §1421(b)(2)(A)—* *New SSA §1919(h)(3)(C)(ii)(I).* Subject to certain restrictions, the Secretary would be authorized to impose CMPs on NFs in amounts up to $10,000 for each day or each instance of noncompliance.	No provision.
Civil Money Penalties—Nursing Facilities—Penalties Imposed by the Secretary; Reduction of Civil Money Penalties in Certain Circumstances. Current Law: See above.	*H. §1421(b)(2)(A)—* *New SSA §1919(h)(3)(C)(ii)(II).* Subject to limitations where reductions are prohibited, if NFs self-report and promptly correct deficiencies within 10 calendar days after imposition of a CMP, the Secretary may reduce the amount of the imposed CMP by up to 50%.	*S. §6111(b)(11) —* *New SSA §1919(h)(3)(C)(ii)(II).* Same as H.R. 3962.
Civil Money Penalties—Nursing Facilities—Penalties Imposed by the Secretary; Prohibition on Reduction for Repeat Deficiencies. Current Law: See above.	*H. §1421(b)(2)(A)—* *New SSA §1919(h)(3)(C)(ii)(III).* The Secretary would be prohibited from reducing CMPs for NFs where the Secretary had previously reduced a penalty for that facility in the last year.	*S. §6111(b)(11) —* *New SSA §1919(h)(3)(C)(ii)(III).* (aa) Repeat Deficiencies—The Secretary would be prohibited from reducing CMPs for SNFs where the Secretary had previously reduced a penalty for that facility in the last year, with respect to a repeat deficiency. (bb) Certain Other Deficiencies—The Secretary would be prohibited from reducing CMPs for other deficiencies (1) where the deficiency was found to result in a pattern of harm or widespread harm that immediately jeopardizes residents' safety or health; or (2) where a deficiency resulted in the death of a patient.
Civil Money Penalties—Nursing Facilities—Penalties Imposed by the Secretary; Collection of Civil Money Penalties. Current Law: See above.	*H. §1421(b)(2)(A)—* *New SSA §1919(h)(3)(C)(ii)(IV)(aa)-(ff).* (aa) In collecting CMPs, the Secretary would be required within 30 days after imposing a CMP to provide the opportunity for an independent informal	*S. §6111(b)(11) —* *New SSA §1919(h)(3)(C)(ii)(IV).* The same as H.R. 3962, except the Secretary would be required to issue regulations covering

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	review by the state survey agency. The dispute resolution process would be required to generate a written record prior to collection of the CMP, but would not affect the responsibility of the state survey agency for making final recommendations the CMP. (bb) When the penalties are imposed for each day of noncompliance, the Secretary would be prohibited from imposing a penalty for any day during the period beginning with the initial day and ending when the dispute resolution process is completed. (cc) In cases where the penalty dispute resolution process occurs prior to penalty collection; may provide an escrow account (under the Secretary's direction) for fees to be held beginning on the earlier of 90 days after fees are imposed, or the date the informal resolution process was completed; (dd) may provide that penalty fees are held in escrow accounts until appeals are resolved; (ee) in cases where appeals are resolved in favor of facilities, may provide, if escrow accounts are established, that penalty fees would be returned to facilities with interest; and (ff) in cases where all appeals are unsuccessful, may provide, that some portion of penalty amounts are used to support activities that will benefit residents, including assistance to support and protect residents, including residents who reside in facilities that voluntarily or involuntarily close or are decertified. The activities funded with CMPs may include using the penalty funds to offset costs of relocating residents to home- and community-based settings, and other facilities, as well as projects to support resident and family councils and other consumer quality of care involvement (including joint training of staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved	the collection of CMPs.

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	by the Secretary).	
Civil Money Penalties—Nursing Facilities—Penalties Imposed by the Secretary; Procedure. Current Law: See above.	*H. §1421(b)(2)(A)— New SSA §1919(h)(3)(C)(ii)(V).* Provisions of SSA, Sec. 1128A (except subsections (a) and (b)) and provisions that require a hearing prior to imposing CMPs, also would apply to the CMPs described in H.R. 3962.	No provision.
Civil Money Penalties—Effective Date Current Law: See above.	*H. §1421(c).* The CMP provisions would take effect one year after enactment of H.R 3962.	*S. §6111(c).* Same as H.R. 3962.
National Independent Monitor Pilot Program Current Law: There are no requirements in current law to establish a national independent monitor program.	*H. §1422* H. §1422(a)(1)-(4). (1) Within one year of the effective date of H.R. 3962, the Secretary in consultation with HHS OIG would establish a pilot program to develop, test, and implement use of an independent monitor to oversee interstate and large intrastate SNF and NF chains. (2) Selection—The Secretary would be required to select SNF and NF chains to participate in the national independent monitor pilot program (NIMPP) from among those chains that apply to participate. (3) Duration—The NIMPP would be conducted over two years and would commence within one year of the effective date of H.R. 3962. (4) Implementation—The Secretary would be required to implement the NIMPP within one year of enactment of H.R. 3962.	*S. §6112* S. §6112(a)(1)-(4). Similar to H.R. 3962, except the Senate bill identifies the National Independent Monitor program as a demonstration rather than a pilot. Section heading is slightly different.
National Independent Monitor Pilot Program—Requirements. Current Law: See above.	*H. §1422(b).* The Secretary would be required to evaluate SNF and NF chains to participate in the NIMPP based on criteria identified by the Secretary, including where chains with one or more facilities have serious safety and quality of care problems; selection criteria for the NIMPP also may include chains with one or more facilities in CMS' Special Focus Facility program (or a successor program)	*S. §6112(b).* Same as H.R. 3962.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	or one or more facilities with a record of repeated serious safety and quality of care deficiencies.	
National Independent Monitor Pilot Program—Responsibilities of the Independent Monitor. Current Law: See above.	*H. §1422(c)(1)-(5).* An independent monitor that enters into a contract to participate in the NIMPP would be required to (1) conduct periodic reviews and root-cause deficiency analyses of chains to assess their compliance with state and federal laws and regulations; (2) undertake sustained oversight of chains (whether public or private) to involve chain owners and principal partners in facilitating compliance with state and federal laws and regulations applicable to facilities; (3) analyze management structure, expenditure distribution, and nurse staff levels of facilities of the chain compared to resident census, staff turnover rates, and tenure; (4) report findings and recommendations with respect to reviews, analyses, and oversight to the chain and facilities in the chain, to the Secretary and to relevant states; and (5) publish the results of these reviews, analyses, and oversight.	*S. §6112(c)(1)-(5).* Same as H.R. 3962.
National Independent Monitor Pilot Program—Implementation of Recommendations. Current Law: See above.	*H. §1422(d)(1)-(2).* (1) Receipt of Finding by Chain—Within 10 days of a chain receiving a finding (of deficiency) from the independent monitor, the chain would be required to submit a report to the independent monitor: (A) that outlines corrective actions the chain will take to address the independent monitor's recommendations; or (C) indicates that the chain will not implement the recommendations and why it will not do so. (2) Receipt of Report By Independent Monitor—Within 10 days after receiving the chain's response-report, the independent monitor would be required to submit a report containing the monitor's final	*S. §6112(c)(1)-(2).* Same as H.R. 3962.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	recommendations to: the chain, the chain's facilities, the Secretary, and the state or states where the facilities in question operate.	
National Independent Monitor Pilot Program—Cost of Appointment. Current Law: See above.	*H. §1422(e).* Nursing facility chains would be responsible for a portion of the costs associated with the appointment of the pilot program independent monitors. Chains would pay their portion of the costs to the Secretary. The Secretary would determine the amount and procedures for colleting the independent pilot program costs.	*S. §6112(e).* Same as H.R. 3962.
National Independent Monitor Pilot Program—Waiver of Authority. Current Law: See above.	*H. §1422(f).* The Secretary would have authority to waive provisions of SSA Titles XVIII and XIX if necessary to implement the NIMPP.	*S. §6112(f).* Same as H.R. 3962.
National Independent Monitor Pilot Program—Authorization of Appropriations. Current Law: See above.	*H. §1422(g).* There would be authorized such sums as necessary to be appropriated to carry out the NIMPP.	*S. §6112(g).* Same as H.R. 3962.
National Independent Monitor Pilot Program—Definitions. Current Law: See above.	*H. §1422(h).* Nursing facility means SNF and NF.	*S. §6112(h).* Same as H.R. 3962, except the term additional disclosable party has the meaning applied in SSA Sec. 1124(c)(5)(a), not as defined in H.R. 3962.
National Independent Monitor Pilot Program—Evaluation and Report Current Law: See above.	*H. §1422(i).* The HHS OIG would be required to evaluate the NIMPP within six months of completion of the program. The evaluation would determine whether the NIMPP should be established permanently; and if so, recommend appropriate procedures and mechanisms to establish the program. Within six months after the completion of the NIMPP, the HHS OIG would submit a report to Congress and the Secretary containing the results of the NIMPP and recommendations for appropriate legislative and administrative action.	*S. §6112(i).* Same as H.R. 3962.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Notification of facility closure Current Law: Medicare and Medicaid law identifies patients' rights and SNF and NF requirements in ensuring residents are aware of their rights. Residents have specific discharge and transfer rights, which include advance notification in cases where facilities close.	*H. §1423* H. §1423(a) — New SSA §1819(c)(7)(A). SSA Sec. 1819(c) would be amended to add a new paragraph at the end that would require SNF administrators to submit to the Secretary, LTC Ombudsman programs in the state where the facility was located, facility residents, and facility residents' legal representatives or other responsible parties written notification of their intent to close a SNF. SNF administrators would be required to provide the written notification within 60 days notice of their pending closure; or if closed by the Secretary, within the time frame specified by the Secretary. SNF administrators would be required not to admit new patients on or after written notice of planned closure; include in the closure notices, the plans to transfer and adequately relocate facility residents by a specified date prior to closure that has been approved by the state, and which also would include assurances that residents will be transferred to the most appropriate facilities or settings in terms of quality, services, and location as determined by residents' needs, best interests, and preferences.	*S. §6113* S. §6113 — New SSA §1128I(h)(1). In general, this provision is similar to the same provision in H.R. 3962, except that the Senate bill would amend SSA Sec. 1128I, whereas H.R. 3962 would first amend SSA Sec. 1819 for SNFs (Medicare) and then SSA Sec. 1919 for NFs (Medicaid).
Notification Of Facility Closure—Skilled Nursing Facilities; Relocation and Continuation of Payments Until Residents Relocated. Current Law: See above.	*H. §1423(a) —* *New SSA §1819(c)(7)(B).* States would be required to ensure that before a facility closes, all residents would be relocated to alternative settings, such as home- and community-based settings, or other facilities. The Secretary may determine the appropriate payment and whether and for how long to continue payments to closing facilities during the period after the notification of impending closure is submitted and the date when residents are transferred to other facilities or alternative settings.	*S. §6113 —* *New SSA §1128I(h)(2).* Same as H.R. 3962, except the Senate bill would apply to both SNFs and NFs. Same as H.R. 3962, except the Senate bill would apply to both SNFs and NFs.
Notification Of Facility Closure—Skilled Nursing	No provision	*S. §6113 —*

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Facilities; Sanctions. Current Law: See above.		*New SSA §1128I(h)(3).* SNF and NF administrators who fail to comply with the Facility Closure Notification requirements would be (A) subject to CMPs up to $100,000; (B) may be subject to exclusions from participation in federal health care programs; and (3) would be subject to any other penalties that may be prescribed by law.
Notification Of Facility Closure—Nursing Facilities. Current Law: See above.	*H. §1423(b) —* *New SSA §1919(c)(9)(A).* SSA Sec. 1919(c) would be amended to add a new paragraph at the end that would require NF administrators to submit to the Secretary, LTC Ombudsman programs in the state where the facility was located, facility residents, and facility residents' legal representatives or other responsible parties written notification of their intent to close a NF. NF administrators would be required to provide the written notification within 60 days notice of their pending closure; or if closed by the Secretary, within the time frame specified by the Secretary. NF administrators would be prohibited from admitting new residents after issuing written notice of planned closure. They also would be required to include in the closure notices, their plans to transfer facility residents by a specified date prior to closure that has been approved by the state, and which also would include assurances that residents will be transferred to the most appropriate facilities or settings in terms of quality, services, and location as determined by residents' needs, best interests, and preferences.	No provision. In general, this provision is similar to the same provision in H.R. 3962, except that the Senate bill would amend SSA Sec. 1128I, while H.R. 3962 would first amend SSA Sec. 1819 for SNFs (Medicare) and then SSA Sec. 1919 for NF (Medicaid).
Notification Of Facility Closure—Nursing Facilities; Relocation and Continuation of Payments Until Residents Relocated. Current Law: See above.	*H. §1423(b) —* *New SSA §1919(c)(9)(B).* States would be required to ensure that before NFs	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	close, all residents would be relocated to alternative settings, such as home- and community-based settings, or other facilities.	
	The Secretary may determine the appropriate payment and whether and for how long to continue payments to closing facilities during the period after the notification of impending closure is submitted and the date when residents are transferred to other facilities or alternative settings.	
Notification Of Facility Closure—Effective Date. Current Law: See above.	*H. §1423(c).* The notification of facility closure requirements would become effective one year after enactment of H.R. 3962.	*S. §6113(c).* Same as H.R. 3962.
National demonstration projects on culture change and use of information technology in nursing homes. Current Law: There are no provisions in current law authorizing demonstrations projects on culture change and use of information technology.	No provision.	*S. §6114* S. §6114(a). The Secretary would be required to conduct the following two demonstration projects for NFs and SNFs: (1) for the development of best practices for facilities involved in the culture change movement; and (2) for the development of best practices in facilities for the use of information technology to improve resident care.
National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes—Grant Award. Current Law: See above.	No provision.	*S. §6114(b)(1).* For each demonstration project the Secretary would be required to award one or more competitive grants to facility-based settings. The Secretary may allocate funds to grant recipients in one lump sum payment.
National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes—Consideration of Special Needs of Residents. Current Law: See above.	No provision.	*S. §6114(b)(2).* Grants awarded would be required to take into consideration the special needs of facility residents who have cognitive impairments.
National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes—Duration and Implementation.	No provision.	*S. §6114(c)(1) and (2).* The grants would be for up to three years. The grants would begin within one year of enactment of the

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Current Law: None.		Senate bill.
National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes—Authorization of Appropriations. Current Law: See above.	No provision.	*S. §6114(e).* Such sums as may be necessary to award the grants are authorized for appropriation.
National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes—Report. Current Law: See above.	No provision.	*S. §6114(f).* The Secretary would be required to submit to Congress a report on the demonstration projects within nine months of their completion. The report would identify recommendations for legislative and administrative action.

Part 3 – Improving Staff Training.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Dementia and abuse prevention training Current Law; In addition to statutory requirements for Medicare and Medicaid nursing facilities (skilled nursing facilities, SNFs, under Medicare and nursing facilities, NFs, under Medicaid), the Secretary establishes additional requirements for nurse aide training and competency evaluation programs and requirements for states to follow in evaluating and re-evaluating these training programs.	*H. §1431* H. §1431(a) and (b). SSA Sec. 1819(f)(2)(A)(i)(I) and SSA Sec. 1919(f)(2)(A)(i)(I) would be amended to revise the requirements for certified nursing assistant training. Sec. 1431 would require that SNFs and NFs add dementia and abuse prevention training to staff training. H. §1431(c). The dementia and abuse prevention training would be required one year after enactment.	*S. §6121* S. §6121(a) and (b). Similar to H.R. 3962, except the Senate bill would add a clarification to the definition of nurse aides that would stipulate that aides provided through an agency or under a contract would also be covered by the SSA Sec. 1819 and 1919 training requirements for nurses' aides. S. §6121(c).
Study and report on training required for certified nurse aides and supervisory staff Current Law: Medicare and Medicaid law have provisions that govern training for nurse aides for both SNF and NFs. These laws require the Secretary to establish requirements for nurse aide training and competency evaluation programs as well as parameters for states to use in monitoring these programs.	*H. §1432* H. §1432(a). (1) Within two years after enactment of H.R. 3962, the Secretary would be required to conduct a study on the content of certified nurse aide and supervisory staff training in SNFs and NFs. The report would be required to include the following: (A) whether the 75 hours of initial nurse aide training	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	required should be increased and if so, what the required number of initial training hours should be recommended (including dementia related training); and (B) whether the 12 hours per year of ongoing nurse aide training should be increased and what content changes are recommended. (2) In assessing the number of hours of initial nurse aide training required, the Secretary would consult with states that already have increased the number of hours of initial training above 75 hours. *H. §1432(b).* Within two years from the date of enactment, the Secretary would be required to submit a report to Congress on the results of the study, together with recommendations for legislative and administrative action.	
Qualification of director of food services of a skilled nursing facility or nursing facility. Current Law: Medicare and Medicaid contain certain requirements related to the provision of services and activities in a SNF and NF. Specifically, they require a SNF or NF, to the extent needed to fulfill residents plans of care, to provide for dietary services that assure that meals meet the daily nutritional and special dietary needs of each resident.	*H. §1433.* With respect to meeting specified staffing requirements for facilities that are certified to participate in Medicare and/or Medicaid, the provision would specify that the full-time director of food services of the facility, if not a qualified dietician, could also be a Certified Dietary Manager meeting the requirements of the Certifying Board for Dietary Managers, or a Dietetic Technician, Registered meeting the requirements of the Commission on Dietetic Registration, or an individual who has equivalent military, academic, or other qualifications, as specified by the Secretary. This provision would be effective 180 days after enactment.	No provision.

Elder Justice – Senate Bill

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Elder Justice Act	No provision.	*S. §6701- S. §6703*
Short Title of Subtitle Current Law: No provision	No provision.	*S. §6701.* The provision would cite Subtitle H as the "Elder Justice Act of 2009".
Definitions Current Law: No provision	No provision.	*S. §6702.* The provision would define any term used in Subtitle H to have the same meaning as such term defined in Sec. 2011 of the SSA, as added by Sec. 6703(a) below.
Elder Justice Current Law: No provision	No provision.	*S. §6703(a).* The provision would amend Title XX of the SSA to insert new Elder Justice provisions to a newly entitled Block Grants to States for Social Services and Elder Justice. It would insert a new Subtitle A—Block Grants to States for Social Services before Sec. 2001 of the SSA and add new sections with various Elder Justice provisions under a new Subtitle B—Elder Justice. The Elder Justice provisions under Subtitle B would be composed of two parts: Part I—National Coordination of Elder Justice Activities and Research and Part II—Programs to Promote Elder Justice. These provisions are described below.
Definitions Current Law: The Older Americans Act (OAA) defines the following terms: abuse, caregiver, elder justice, exploitation, fiduciary, long-term care, long-term care facility, neglect, and self-neglect. The Violent Crime Control and Enforcement Act defines the term: sexually violent offense.	No provision.	*S. § 2011* of the SSA, as added by *S. §6703(a).* The provision would define the following 22 terms: abuse, adult protective services, caregiver, direct care, elder, elder justice, eligible entity, exploitation, fiduciary, grant, guardianship, Indian tribe, law enforcement, long-term care, long-term care facility, neglect, nursing facility, self-neglect, serious bodily injury, social, State legal assistance developer, and State Long-Term Care Ombudsman.
General Provisions	No provision.	*S. §2012* of the SSA, as added by *S. §6703(a).*

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Current Law: Sec. 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) governs the protection of individual health privacy.		The provision would require the Secretary of HHS to ensure the protection of individual health privacy consistent with the regulations promulgated under Sec. 264(c) of HIPAA and applicable State and local privacy regulations. It would prohibit the proposed subtitle from being construed to interfere with or abridge an elder's right to practice his or her religion through reliance on prayer alone for healing when this choice is: (1) expressed, either orally or in writing, (2) set forth in a living will, health care proxy, or other advance directive documents, or (3) may be deduced from an elder's life history.
Elder Justice Coordinating Council Current Law: No provision.	No provision.	*S. §2021* of the SSA, as added by *S§6703(a).* The provision would establish an Elder Justice Coordinating Council in the Office of the Secretary. The Council would include the Secretary who would chair the Council and the U.S. Attorney General as well as the head of each federal department or agency, identified by the Chair, as having administrative or program responsibility related to elder abuse, neglect, and exploitation. The Council would be required to make recommendations to the Secretary regarding coordination of activities of HHS, DoJ, and other relevant federal, state, local, and private agencies and entities, relating to prevention of elder abuse, neglect, and exploitation and other crimes against elders. There would be authorized to be appropriated such sums as may be necessary to carry out this provision.
Advisory Board on Elder Abuse, Neglect, and Exploitation Current Law: No provision.	No provision.	*S. §2022* of the SSA, as added by *S§ 6703(a).* The provision would establish an Advisory Board on Elder Abuse, Neglect, and Exploitation to create a short- and long-term multidisciplinary plan for development of the field of elder justice and make recommendations to the Elder Justice Coordinating Council. There would be authorized to be appropriated such sums as may be necessary to carry out this provision.
Research Protections	No provision.	*S. §2023* of the SSA, as added by *S. §6703(a).*

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Current Law: No provision.		The provision would require the Secretary to promulgate guidelines to assist researchers working in the areas of elder abuse, neglect, and exploitation with issues relating to human subjects protections. For the purposes of the application of certain specified federal regulations to research conducted under Subpart A it would define "legally authorized representative" to mean, unless otherwise provided by law, the individual, or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.
Authorization of Appropriations Current Law: No provision.	No provision.	*S. §2024* of the SSA, as added by *S. §6703(a).* The provision would authorize to be appropriated $6.5 million for FY2011, and $7.0 million for each of FY2012 through FY2014 to carry out the functions under Part 1, Subpart A.
Establishment and Support of Elder Abuse, Neglect, and Exploitation Forensic Centers Current Law: No provision.	No provision.	*S. §2031* of the SSA, as added by *S. §6703(a).* The provision would require the Secretary, in consultation with the U.S. Attorney General, to award grants to eligible entities to establish and operate both stationary and mobile forensic centers and to develop forensic expertise pertaining to elder abuse, neglect, and exploitation. It would authorize to be appropriated $4 million for FY2011, $6 million for FY2012, and $8 million for each of FYs 2013 and 2014 to carry out these activities.
Enhancement of Long-Term Care Current Law: Sec. 202 of the OAA authorizes various functions of the Administration on Aging and the Assistant Secretary on Aging. Medicare and Medicaid law requires nursing facilities to meet certain Federal statutory requirements for the training and competency levels of certified nurse aides (CNAs) working in facilities that participate in these programs.	H. §2589(a) The provision would amend Sec. 202(b)(1) of the OAA to require the Assistant Secretary to make recommendations to other federal entities regarding appropriate and effective means of identifying and implementing investments in the direct care workforce and assisting states in developing state workforce development plans with respect to such workforce. It would also require the Assistant Secretary to establish a Personal Care Attendant Workforce Advisory Panel (no later than 90 days after enactment) and pilot program to	*S. §2041* of the SSA, as added by *S. §6703(a).* The provision would require the Secretary, in coordination with the Secretary of Labor, to carry out activities that provide employment incentives for direct care workers in long-term care (LTC). The Secretary would be required to award grants to eligible entities to conduct programs that offer direct care employees continuing training and varying levels of certification, among other things. The Secretary would also be authorized to make grants to LTC facilities for specified activities that would assist such entities in offsetting

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	examine and formulate recommendations on working conditions and training for workers providing LTC services and supports and other LTC workforce issues, as specified. The Panel would be required to include representatives of relevant home and community-based service providers, health care agencies and facilities, the disability community, the nursing community, direct care workers, older individuals, state and federal health care entities, and experts in workforce development and learning. The Advisory Panel would also be required to submit a report to the Assistant Secretary and Congress on workforce issues related to providing LTC services and supports and establish a demonstration program to pilot and evaluate the effectiveness of core competencies for eligible personal care or home care aides as well as recommended training curricula and resources. After completion of the demonstration program, the Assistant Secretary would be required to submit a report to Congress containing evaluation results along with recommendations for legislation or administrative action.	costs related to certified EHR technology. The Secretary would be required to adopt electronic standards for the exchange of clinical data by LTC facilities to the Secretary. Within 10 years after the date of enactment, the Secretary would be required to have procedures in place to accept the optional electronic submission of clinical data by LTC facilities. The Secretary would be required to promulgate regulations to carry out the adoption of standards for transactions involving clinical data by LTC facilities. It would authorize to be appropriated $20 million for FY2011, $17.5 million for FY2012, and $15 million for each of FY2013 and FY2014 to carry out the activities under this section.
Adult Protective Service Functions and Grant Program Current Law: Provisions related to some functions of adult protective services (APS) are found in Title XX of SSA, the Social Services Block Grant program (SSBG), administered by the Administration on Children and Families (ACF), and in the OAA, administered by the Administration on Aging (AoA), both in HHS. Title XX of the SSA permanently authorizes SSBG as a "capped" entitlement to States to carry out a wide range of social services on behalf of various groups. The statute sets out a number of goals for the use of these funds, including the goal of "preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests	No provision.	*S. §2042* of the SSA, as added by *S. §6703(a).* The provision would require the Secretary to ensure that the Department: (1) provides authorized funding to state and local APS offices that investigate reports of elder abuse, neglect, and exploitation of elders; (2) collects and disseminates data in coordination with DoJ; (3) develops and disseminates information on best practices regarding, and provides training on, carrying out APS; (4) conducts research related to the provision of APS; and (5) provides technical assistance to states and other entities that provide or fund APS. To carry out these functions, the section would authorize to be appropriated $3 million for FY2011, and $4 million for each of FY2012 through FY2014. The provision would also require the Secretary to establish two grant programs. The first would award

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
....” Funds are generally administered by State social services or human services agencies (for this purpose, sometimes referred to as adult protective services offices), and/or State agencies on aging. No match is required for Title XX funds, and Federal law does not specify a sub-State allocation formula. In other words, States have complete discretion for the distribution of funds within their borders. Title III of the OAA authorizes State agencies on aging to conduct various activities related to prevention of elder abuse, neglect and exploitation. No Federal funds are separately appropriated for this purpose under Title III, and States decide how much of their Title III allotments are to be used for prevention activities. In many States, State agencies on aging administer funds for adult protective services funded under Title XX of the SSA (described above). Title VII of the OAA authorizes a program of grants to States to carry out activities related to prevention of elder abuse, neglect, and exploitation. Funds are administered by State agencies on aging. Title VII, Subtitle B, Native American Organization and Elder Justice Provisions of the OAA, also authorizes a State grant program to promote comprehensive elder justice systems. The Assistant Secretary is authorized to award competitive grants to States for elder justice systems which are to provide for convenient public access to the range of available elder justice information, programs and services; coordinate the efforts of public health, social service and law enforcement authorities to identify and diminish duplication and gaps in the system; and provide a uniform method for standardization, collection, management,		annual grants to enhance APS programs provided by states and local governments. The second would award grants to states for APS demonstration programs. Annual grants awarded to states to enhance APS programs would be distributed to states based on a formula. For each of FY2011 through FY2014, it would authorize to be appropriated $100 million for annual grants to enhance APS programs and $25 million for the APS demonstration grants.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
analysis and reporting data on elder justice issues. No provision in current law specifically authorizes a dedicated amount of funds for State adult protective service demonstration programs. However, the OAA authorizes a related demonstration program, but with no specific authorization of appropriation. Sec. 413 of the OAA, Older Individuals' Protection from Violence Projects, requires the Assistant Secretary to award funds to States, area agencies on aging, nonprofit organizations, or tribal organizations to carry out a wide range of projects related to protection of older persons from violence. Funds are to be used to: support local communities to coordinate activities regarding intervention in and prevention of abuse, neglect, and exploitation; develop outreach to assist victims; expand access to family violence and sexual assault programs as well as mental health services, safety planning, and other services; and promote research on legal organization and training impediments to providing services through shelters and other programs.		
Long-Term Care Ombudsman Program Grants and Training Current Law: Title VII of the OAA authorizes allotments for vulnerable elder rights protection activities, including the State Long-Term Care Ombudsman Programs administered by AoA. The purpose of the programs are to investigate and resolve complaints made by, or on behalf of, older persons who are residents of LTC facilities. Title II of the OAA requires the Assistant Secretary for Aging to establish the National Long-Term Care Ombudsman Resource Center under the Director of the Long-Term	No provision.	*S. §2043* of the SSA, as added by *S. §6703(a).* The provision would require the Secretary to award grants to eligible entities with relevant expertise and experience in abuse and neglect in LTC facilities or state LTC ombudsman programs to: (1) improve the capacity of state LTC ombudsman programs to respond to and resolve abuse and neglect complaints; (2) conduct pilot programs with state or local LTC ombudsman offices; and (3) provide support for such state LTC ombudsman programs and such pilot programs. It would authorize to be appropriated $5 million for FY2011, $7.5 million for FY2012, and $10 million for each of FYs 2013 and FY2014.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Care Ombudsman program. The Center is required to, through grants and contracts, conduct research, provide training, technical assistance and information to support the activities of State and local long-term care ombudsmen. The Center also assists State long-term care ombudsmen in the implementation of the State long-term care ombudsman program.		The provision would also require the Secretary to establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and state LTC ombudsman programs. It would authorize to be appropriated $10 million for each of FY2011 through FY2014 for this purpose.
Provision of Information Regarding, and Evaluation of, Elder Justice Programs Current Law: No provision.	No provision.	*S. §2044* of the SSA, as added by *S. §6703(a).* The provision would require an applicant to meet certain requirements to be eligible to receive a grant under Part II. It would also require the Secretary to reserve a portion of the funds appropriated in each program under Part II (no less than 2%) to be used to provide assistance to eligible entities to conduct validated evaluations of the effectiveness of the activities funded under each program under Part II. This provision would not apply to the certified EHR technology grant program, instead the Secretary would be required to conduct an evaluation of the activities funded under this grant program and appropriate grant audits.
Report Current Law: No provision.	No provision.	*S. §2045* of the SSA, as added by *S. §6703(a).* The provision would require the Secretary to submit a report, not later than October 1, 2014, to the Elder Justice Coordinating Council and the appropriate committees of Congress compiling, summarizing, and analyzing state reports submitted under the APS grant programs and recommendations for legislative or administrative action, as the Secretary determines appropriate.
Rule of Construction Current Law: Sec. 402 of the SSA regarding eligible States and State plan requirements for TANF does not require State agency assistance with the employment of welfare recipients or recipients of Temporary	No provision.	*S. §2046* of the SSA, as added by *S. §6703(a).* The provision states that nothing in Subtitle B would be construed as (1) limiting any cause of action or other relief related to obligations under this subtitle that are available under the state law; or (2) creating a private cause of action for a violation of this subtitle. The

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Assistance to Needy Families (TANF) in long-term care facilities or other occupations related to elder care.		section would also, effective January 1, 2011, amend Sec. 402(a)(1)(B) of the SSA to require a state's TANF state plan to indicate whether the state intends to assist individuals to train for, seek, and maintain employment providing direct care in a LTC facility or in other occupations related to elder care. States that add this option would be required to provide an overview of such assistance.
Protecting Residents of Long-Term Care Facilities Current Law: The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987, P.L. 100-203) established Federal minimum statutory requirements that nursing homes must meet in order to receive payments for providing health care services to Medicare and Medicaid beneficiaries. These provisions apply to skilled nursing facilities (SNFs) participating in Medicare and nursing facilities (NFs) participating in Medicaid. Often these provisions are identical. OBRA 1987 also established requirements pertaining to the survey and certification process for determining whether providers meet the requirements for participation, and it included penalties the HHS Secretary and States may impose against noncompliant providers. The Secretary has promulgated regulations and issued accompanying guidance on the implementation of the statute. For the purposes of determining compliance with these requirements, the Secretary contracts with State survey, licensing, and certification agencies, often referred to as "State survey agencies," who then assume oversight of those providers participating in Medicare only and those dually participating in Medicare and Medicaid. The State assumes responsibility for oversight of those providers participating only	No provision.	*S. §6703(b)(1)&(2).* The provision would establish a National Training Institute for federal and state surveyors to carry out specified activities that provide and improve the training of surveyors investigating allegations of abuse, neglect, and misappropriation of property in programs and LTC facilities that receive payments under Medicare or Medicaid. It would authorize to be appropriated $12 million for each of FY2011 through FY2014 to carry out these activities. The HHS Secretary would also be required to award grants to state survey agencies that perform surveys of Medicare or Medicaid participating facilities to design and implement complaint investigation systems. It would authorize $5 million for each of FY2011 through FY2014 to carry out these activities.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
in the Medicaid program.		
Reporting to Law Enforcement of Crimes Occurring in Federally Funded Long-Term Care Facilities Current Law: Title XI, Part A of the SSA provides for general provisions related to various administrative functions established under the Act. Sec. 1128A specifies conditions for imposing civil monetary penalties, the process for determining the amount or scope of a penalty, assessment or exclusion, and the process for appeal.	No provision.	*S. §6703(b)(3).* The provision would amend Title XI, Part A of the SSA to add a new Sec. 1150B establishing certain requirements related to the reporting of crimes occurring in federally funded LTC facilities that receive at least $10,000 during the preceding year, as specified.
National Nurse Aide Registry Current Law: Medicare and Medicaid law requires States to establish and maintain a nurse aide registry of all individuals who have satisfactorily completed a state approved nurse aide training and competency evaluation program, or a nurse aide competency evaluation program. No present law exists concerning a nurse aide registry study.	No provision.	*S. §6703(c).* The provision would require the Secretary, in consultation with appropriate government agencies and private sector organizations, to conduct a study on establishing a national nurse aide registry. It would authorize to be appropriated such sums as may be necessary to carry out these activities, with funding for the study not to exceed $500,000.

Subtitle C – Quality Measurements.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Establishment of national priorities for quality improvement. Current Law: There are no provisions in current law requiring the Secretary to develop a national quality strategy, strategic plan, or improvement priorities. However, SSA Sec. 1890(a) requires the Secretary to identify and have in effect a contract with a consensus-	*H. §1441.* This section would amend SSA Title XI by adding a new Part E, "Quality Improvement Establishment of National priorities for Performance Improvement" and new Sec. 1191. Sec. 1191(a) would require the Secretary to establish and update national priorities for performance improvement.	*S. §3011.* This section would amend PHSA Title III by adding a new Part S "Health Care Quality Programs," a new Subpart I- National Strategy for Quality Improvement in Health Care", and a new Sec. 399HH. Sec. 399HH(a) would require the Secretary to establish a national strategy to improve the delivery of health care services

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
based entity, such as the National Quality Forum (NQF). Sec. 1890(b) requires the entity with a contract under (a) to perform the following duties: (1) synthesize evidence and convene stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings; (2) provide for the endorsement of standardized health care performance measures; (3) establish and implement a process to ensure that endorsed measures are updated or retired based on new evidence; (4) promote the development of electronic health records that facilitate the collection of performance measurement data; and (5) report annually to Congress.	Sec. 1191(b) would require the Secretary, in establishing the national priorities, to solicit and consider recommendations from multiple outside stakeholders. In addition, Sec. 1191(c) would require the Secretary to ensure priority is given to a number of factors in setting the national priorities.	and to identify national priorities for quality improvement as a part of this strategy. The Secretary would be required to submit to the relevant committees of Congress the national strategy not later than January 1, 2011. Sec. 399HH(a) would require the Secretary, in identifying the priorities, to take into consideration the recommendations submitted by the entity with a contract under SSA Sec. 1890(a) and with state agencies. In addition, Sec. 399HH(a) would require the Secretary to ensure that priorities identified would meet a number of specified requirements.
	No provision.	Sec. 399HH(b) would require the national strategy to include a comprehensive strategic plan to achieve the national priorities. The strategic plan would have to include provisions addressing a number of factors, including, for example, coordination among agencies within the Department.
	Sec. 1191(a) would require the Secretary to update the national priorities not less than triennially.	Sec. 399HH(c) would require the Secretary to update the national strategy not less than annually.
	No provision.	Sec. 399HH(d) would require the Secretary to submit the national strategy, and subsequent updates, to the relevant Committees of Congress. In addition, Sec. 399HH(e) would require the Secretary, not later than January 1, 2011, to create an Internet website to make public information about the national priorities and other information.
	Sec. 1191(e) would require the Secretary to provide for the transfer, from the Part A and Part B Medicare Trust Funds, $2 million for each of the fiscal years 2010 through 2014. In addition, this section would authorize to be appropriated, out of any funds in the Treasury not otherwise available, $2,000,000 for each of the fiscal years 2010 through 2014.	No provision.

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Development of new quality measures. Current Law: AHRQ has significant existing statutory authorities under PHSA Title IX with respect to the development of quality measures. This includes promoting health care quality improvement by conducting and supporting research that develops and presents scientific evidence regarding all aspects of health care, including methods for measuring quality and strategies for improving quality. In addition, AHRQ's role includes the ongoing development, testing, and dissemination of quality measures, including measures of health and functional outcomes, and the compilation and dissemination of health care quality measures developed in the private and public sector.	*H. §1442.* This section would amend SSA Part E, Title XI, as added by Sec. 1441, by adding a new Sec. 1192. Sec. 1192(a) would require the Secretary to enter into agreements, by contract, grant or otherwise, with qualified entities to develop quality measures for the delivery of health care services. The Secretary would be required, in carrying out this section, to consider recommendations of the consensus-based entity with a contract with the Secretary under SSA Sec. 1890(a) and to seek public input. Sec. 1192(c)(3) would require the Secretary to make measures developed under this section available to the public.	*S. §3013(a).* Sec. 3013 would amend PHSA Title IX by adding a new Part D, Subpart I, and a new Sec. 931. Sec. 931(c)(1) would require the Secretary to award grants, contracts, or intergovernmental agreements to eligible entities for the purposes of developing, improving, updating, or expanding quality measures.
	H. §1442. New SSA §1192(c)(1) would require the Secretary, in entering into agreements with qualified entities, to give priority to the development of quality measures that meet a number of specified criteria.	S. §3013(a). New SSA §931(c)(2) would require the Secretary, in awarding grants, contracts, or agreements, to give priority to the development of quality measures that meet a number of specified criteria.
	H. §1442. New SSA §1192(c)(2) would require entities that enter into an agreement under this section to develop quality measures that have the ability to be collected through health information technologies and that are available free of charge to users.	S. §3013(a). New SSA §931(c)(4) would require entities that receive a grant or contract under this section to develop measures that support measures required to be reported under the SSA; that support measures developed under SSA Sec. 1139A; that can be collected using health information technologies; that are free of charge to users; and that are publicly available.
	H. §1442. New SSA §1192(d) would require the Secretary, before entering in to an agreement with said entity, to ensure that the entity is a public, private, or academic institution with technical expertise in the area of health quality measurement.	S. §3013(a). New SSA §931(c)(3) would require an entity, to be eligible for a grant or contract under this section, to have demonstrated expertise in the development of quality measures; have adopted processes to include the views of providers whose performance is assessed by measures and other parties who will use the measures in the development of measures; collaborate with the entity with a contract under SSA Sec. 1890(a) so measures developed will meet the requirements to be considered for endorsement; have transparent policies regarding governance and conflicts of interest; and

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		submit an application to the Secretary, as specified.
	H. §1442. Sec. 1192(b) would require the Secretary to determine areas in which quality measures for assessing health care services are needed, consistent with the national priorities established by Sec. 1441.	S. §3013(a). Sec. 931(b)(1) would require the Secretary to identify, not less often than triennially, gaps where no quality measures exist and existing quality measures that need improvement, updating, or expansion, consistent with the national strategy developed under Sec. 399HH. The Secretary would be required to consider the gaps identified by the entity with a contract under Sec. 1890(a), the quality measures identified pursuant to SSA Sec. 1139B, and quality measures identified through the Medicaid Quality Measurement Program. In addition, Sec. 931(b)(2) would require the Secretary to make these gaps, as well as the process used to identify them, publicly available.
	H. §1442. Sec. 1192(c)(4) and Sec. 1192(c)(5) would authorize the Secretary to use amounts made available under this section to fund the updating by consensus-based entities of measures that have been previously endorsed, and the testing of proposed measures.	S. §3013(a). Sec. 931(d) would authorize the Secretary to use amounts made available under this section to update and test measures endorsed by the entity with a contract under SSA Sec. 1890(a) or adopted by the Secretary.
	No provision.	S. §3013(a). Sec. 931(e) would require the Secretary to ensure that grants or contracts awarded under this section are coordinated with grants and contracts awarded under SSA Secs. 1139A(5) and 1139B(4)(A).
	No provision.	S. §3013(a). Sec. 931(f), as added by Sec. 10303(a), would require the Secretary to develop, and periodically update, provider-level outcome measures for hospitals and physicians, and other providers as determined appropriate by the Secretary. The measures would be required to cover the following categories: acute and chronic disease and primary and preventive care. In developing the outcome measures, the Secretary would be required to seek to address risk adjustment, accountability, and sample size issues; and include the full scope of services that comprise a cycle of care. The section would require 10 measures for acute and chronic diseases to be

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		developed not later than 24 months after the date of enactment of the Act, and 10 measures for primary and preventive care to be developed not later than 36 months after the date of enactment of this Act.
	No provision.	S. §3013(b). This section would amend SSA 1890A, as added by Sec. 3014(b), by adding a new subsection (e) which would require the Administrator of the Center for Medicare & Medicaid Services to, through contracts, develop quality measures for use under the SSA.
	H. §1442. Sec. 1192(f) would require the Secretary to provide for the transfer, from the Part A and B Medicare Trust Funds, of $25,000,000 for the purposes of carrying out this section for each of the fiscal years 2010 through 2014. In addition, this section would authorize the appropriation, out of any funds not otherwise appropriated, $25,000,000 for each of the fiscal years 2010 through 2014.	S. §3013(c). This section would authorize to be appropriated $75,000,000 for each of fiscal years 2010 through 2014. Of the amounts appropriated in a fiscal year, not less than 50 percent shall be used for contracts to develop quality measures for use under the SSA.
	H. §1442. This section would amend new SSA Part E, as added by Sec. 1441, by adding a new SSA Sec. 1193. Sec. 1193(a) would require the Comptroller General of the United States to periodically evaluate the implementation of the data collection processes for quality measures used by the Secretary. Sec. 1193(b) would require the Comptroller General to consider a number of specified factors in carrying out this evaluation, and Sec. 1193(c) would require the Comptroller General to report to Congress and to the Secretary on the findings and conclusions of the results of each such evaluation.	No provision.
Multi-stakeholder pre-rulemaking input into selection of quality measures. Current Law: None.	*H. §1443.* This section would amend SSA Sec. 1808, by adding new subsection (d), to establish a process whereby multi-stakeholder groups would formally provide input into the selection of Medicare quality measures. Specifically,	*S. §3014(b).* This section would amend the SSA by inserting, after section 1890, the following new SSA Sec. 1890A, Quality Measurement. Sec. 1890A(a) would require the Secretary to establish a pre-rulemaking process, to

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	Sec. 1808(d)(1) would require the Secretary to make public a list of quality measures being considered for selection in rulemaking, and Sec. 1808(d)(2) would require the consensus-based entity that has entered into a contract with the Secretary under SSA Sec. 1890(a) to convene multi-stakeholder groups to provide recommendations on the selection of individual or composite quality measures for use in public reporting of performance information or in public health care programs. Sec. 1808(d)(3) would require the consensus-based entity, not later than February 1 of each year, to transmit to the Secretary the recommendations of the multi-stakeholder groups. Sec. 1808(d)(4) would require the consensus-based entity, in convening multi-stakeholder groups, to provide for an open and transparent process for the activities conducted pursuant to such convening. Sec. 1808(d)(5) would further require the proposed rule to contain a summary of the recommendations made by the multi-stakeholder groups, as well as other comments received regarding the proposed measures, and the extent to which the proposed rule follows such recommendations and the rationale for not following such recommendations.	include a series of six steps to select quality measures. Sec. 1890A(a)(1) would require the consensus-based entity with a contract under SSA Sec. 1890(a) to convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures. Sec. 1890A(a)(2) would require the Secretary to make measures under consideration available to the public not later than December 1 of each year beginning with 2011. Sec. 1890A(a)(3) and (4) would require the consensus-based entity to transmit to the Secretary, not later than February 1 of each year, beginning with 2012, and would require the Secretary to consider, the input of multi-stakeholder groups. Sec. 1890A(a)(5) would require the Secretary to publish the rationale for the use of any quality measure that has not been endorsed by the consensus-based entity with a contract under SSA Sec. 1890 in the Federal Register. Finally, Sec. 1890A(a)(6) would require the Secretary, not later than March 1, 2012, to conduct an assessment of the quality impact of the use of endorsed measures, described in section 1890(b)(7)(B) as added by Sec. 3014(a), and make this assessment available to the public.
	No provision.	S. §3014(b). Sec. 1890A(b) would require the Secretary to establish a process for disseminating quality measures used by the Secretary. This process would be required to include the incorporation of such measures in workforce programs and any other means determined appropriate by the Secretary; and the dissemination of quality measures through the national strategy as developed under PHSA Sec. 399HH, as added by Sec. 3011 of this Act.
	No provision.	S. §3014(b). Sec. 1890A(c) would require the Secretary to periodically review quality measures and determine whether to maintain the use of such measure or to

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		phase it out. In conducting such a review, the Secretary would be required to take steps to avoid duplication of measures used and take into consideration current innovative methodologies for quality improvement practices and endorsed measures.
	H. §1443. For purposes of carrying out this section, Sec. 1808(d)(7) would require the Secretary to provide for the transfer, from the Medicare Part A and Part B trust funds, of $1 million for each of the fiscal years 2010 through 2014. In addition, the section would authorize the appropriation of $1 million for each of the fiscal years 2010 through 2014 from any funds in the Treasury not otherwise appropriated.	S. §3014(c). This section would require the Secretary to provide for the transfer, from the Part A and Part B Medicare Trust Funds, $20 million to the CMS Program Management Account for each of fiscal years 2010 through 2014.
Application of quality measures. Current Law. SSA Sec. 1886(b)(3)(B)(vii) requires hospitals to submit specified quality data to the Secretary in order to receive a full annual payment update. SSA Sec. 1886(b)(3)(B)(viii)(V) provides that beginning with payments in fiscal year 2008, the Secretary shall add additional quality measures that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities. SSA Sec. 1833(t)(17)(A)(i) requires hospitals to submit data on outpatient quality measures to the Secretary in order to receive a full outpatient department (OPD) fee schedule increase. In addition, SSA Sec. 1833(t)(17)(C)(i) requires the Secretary to develop measures that reflect consensus among affected parties, and to the extent feasible and practicable, to include measures set forth by one or more national consensus building entities. SSA Sec. 1848(k) requires the Secretary to implement a system for the reporting by eligible professionals of data	*H. §1444(a)-(d).* This section would place requirements on the Secretary when selecting quality measures for use in existing quality programs for inpatient, outpatient, physician and renal dialysis services. These requirements relate to the endorsement of quality measures. Specifically, Sec. 1444(a) would amend section 1886(b)(3)(B) of the Social Security Act to require the Secretary to select measures for purposes of reporting data for inpatient hospital services furnished during fiscal year 2012 and each subsequent year, that have been endorsed by the consensus-based entity with a contract with the Secretary under section 1890 of the Social Security Act. If feasible and practical measures were not available, the Secretary would be authorized to select a non-endorsed measure, providing the Secretary gives due consideration to endorsed or adopted measures. The Secretary would be required to submit non-endorsed measures to the entity for consideration for endorsement, and if the entity were to not endorse the measure, and the Secretary were to continue to use the measure, the Secretary would be required to include the rationale for its continued use in rulemaking. Sec.	No provision.

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on specified quality measures. SSA Sec. 1848(k)(2)(C)(i) requires that for 2010 and subsequent years, the quality measures specified under this section will be such measures selected by the Secretary from measures that have been endorsed by the consensus-based entity with a contract under Sec. 1890(a). Section 1848(k)(2)(C)(ii) provides an exception in the case of a specified area or medical topic for which feasible and practical measures have not been endorsed, stipulating that such measures may be used as long as due consideration has been given to measures that have been endorsed or adopted by a consensus organization. SSA Sec. 1881(h)(1) requires renal dialysis facilities to meet (or exceed) a total performance score, based on quality measures as specified, in order to receive full payment for services furnished on or after January 1, 2012. In addition, SSA Sec. 1881(h)(2)(B) requires the Secretary to specify measures that have been endorsed by the consensus-based entity with a contract under SSA Sec. 1890(a), and authorizes the Secretary, where endorsed measures are not available, to use such measures provided that due consideration has been given to measures that have been endorsed or adopted by a consensus organization. SSA Sec. 1890(b)(2) requires the entity with a contract under SSA Sec. 1890(a) to provide for the endorsement of standardized quality measures. This process must consider whether a measure is evidence-based, reliable, and valid, among other things, and whether it is consistent across types of providers.	1444(b) would also amend section 1833(t)(17) of the Social Security Act to require that the provisions added to section 1886 (above) would also apply to quality measures for covered outpatient department services. Sec. 1444(c) would amend section 1848(k)(2)(C)(ii) and Sec. 1444(d) would amend section 1881(h)(2)(B)(ii) of the Social Security Act, to require the Secretary to submit non-endorsed measures for physicians' services and renal dialysis services, respectively, to the consensus-based entity for consideration for endorsement. The Secretary would further be required to, if the measure does not gain endorsement and if the Secretary continues to use the measure, to provide a rationale for continued use in rulemaking. H. §1444(e). The section would, by amending SSA Sec. 1890(b)(2), require NQF to explain the reasons underlying non-endorsement of a given measure, and to provide suggestions about changes to such measure that might make such a measure potentially endorsable. H. §1444(f). The amendments made by this section would be required to apply to quality measures applied for payment years beginning with 2012 or fiscal year 2012, as the case may be.	
Consensus-based entity funding. Current Law: SSA Sec. 1890(d) requires the Secretary to provide for the transfer, from the Part A and Part B Medicare Trust Funds, of $10 million for each of fiscal years 2009 through 2012 for purposes of carrying out	*H. §1445.* This section would amend SSA Sec. 1890(d) to require the Secretary to provide for the transfer of $10 million for fiscal year 2009, and for $12 million for each of fiscal years 2010 through 2012.	No provision.

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SSA Sec. 1890.		
Quality indicators for care of people with Alzheimer's Disease. Current Law: No provision.	*H. §1446.* Sec. 1446(a) would require the Secretary to develop quality indicators for the provision of medical services to people with Alzheimer's disease and other dementias and develop a plan for implementing the indicators to measure the quality of care provided to individuals with these conditions. Sec. 1446(b) would require the Secretary, within 24 months of enactment, to report to Congress on the status of the implementation of the requirements of this section.	No provision.
Interagency working group on health care quality. Current Law: No provision.	No provision.	*S. §3012.* Sec. 3012(a) would require the President to convene a working group to be known as the Interagency Working Group on Health Care Quality (the "Working Group"). Sec. 3012(b) would require the Working Group to have the goals of achieving collaboration, cooperation, and consultation between Federal agencies; avoiding inefficient duplication of quality improvement efforts and resources; and assessing the alignment of public and private sector quality improvement efforts. Sec. 3012(c) would require the Working Group to be composed of senior representatives from a number of specified agencies; and to be chaired by the Secretary. Sec. 3012(d) would require the Working Group to submit to the relevant Committees of Congress, no later than December 31, 2010, a report describing the Group's progress and recommendations.
Quality measurement. Current Law: SSA Sec. 1890(a) requires the Secretary to identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum (NQF). Sec. 1890(b) requires the entity with a contract under (a) to perform the following duties: (1) synthesize evidence and convene stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and	No provision.	*S. §3014.* S. §3014(a)(1). This section would amend SSA Sec. 1890(b), by adding new paragraphs (7) and (8), to outline new duties for a consensus-based entity. Sec. 1890(b)(7)(A) would require the entity to convene multi-stakeholder groups to provide input on the selection of quality measures and national priorities. Pursuant to Sec. 1890(b)(7)(B), quality measures would be those used pursuant to

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priorities for health care performance measurement in all applicable settings; (2) provide for the endorsement of standardized health care performance measures; (3) establish and implement a process to ensure that endorsed measures are updated or retired based on new evidence; (4) promote the development of electronic health records that facilitate the collection of performance measurement data; and (5) report annually to Congress.		specified SSA sections; those used in reporting performance information to the public; and those used in health care programs other than for use under this bill. Those data sets that are used for the purposes of classification systems used in establishing payment rates under this title would not be considered quality measures for purposes of this section. Sec. 1890(b)(7)(C) would require the entity, in convening multi-stakeholder groups under this section, to provide for an open and transparent process and would require this process to ensure that the process of selecting representatives provide for public nominations and comments. Sec. 1890(b)(8) would require the entity to transmit to the Secretary the input of multi-stakeholder groups no later than February 1st of each year, beginning in 2012. S. §3014(a)(2). This section would amend SSA Sec. 1890(b)(5)(A) to require the entity to submit a report to Congress and the Secretary describing gaps in endorsed measures and areas where evidence is insufficient to support endorsement of quality measures in priority areas identified under the national strategy. *S. §3014(c).* This section would require the Secretary to provide for the transfer, from the Part A and Part B Medicare Trust Funds, $20 million to the CMS Program Management Account for each of fiscal years 2010 through 2014 for carrying out all sections of this provision.
Data collection. Current Law: No provision.	No provision.	*S. §3015.* This section would amend PHSA Title III by adding at the end the following new PHSA Sec. 399II, Collection and Analysis of Data for Quality and Resource Use Measures. Sec. 399II(a), as amended by Sec. 10305, would require the Secretary to establish and implement an overall strategic framework to carry out the public

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		reporting of performance information, as described in new PHSA Sec. 399JJ, as added by Sec. 3015. In addition, the Secretary would be required to collect and aggregate consistent data on quality and resource use measures, and may award grants or contracts for this purpose. Finally, the Secretary would be required to ensure that the data collection, aggregation and analysis systems involve an increasingly broad range of patient populations, providers, and geographic areas over time. Sec. 399II(b) would allow the Secretary to award grants or contracts to eligible entities, as specified, to support new, or improve existing, efforts to collect and aggregate quality and resource use measures. The Secretary, under Sec. 399II(c), would only be permitted to award grants or contracts to entities that enable summary data that can be integrated and compared across multiple sources. Sec. 399II(e) would authorize the appropriation of such sums as may be necessary for each of fiscal years 2010 through 2014.
Public reporting. Current Law: SSA Sec. 1886(b)(3)(B)(viii)(VII) requires the Secretary to make public quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services. In addition, SSA Sec. 1848(m)(5)(G) requires the Secretary to post on the Internet website of the Centers for Medicare & Medicaid Services a list of eligible professionals who satisfactorily submitted data on quality measures as part of the Physician Quality Reporting Initiative (PQRI).	No provision.	*S. §3015.* Sec. 3015 would amend PHSA Title III by adding at the end a new PHSA Sec. 399JJ. Sec. 399JJ(a) would require the Secretary to make available to the public, through standardized websites, performance information summarizing data on quality measures. Sec. 399JJ(b) would require this performance information to include information regarding clinical conditions to the extent such information is available, and the information would, where appropriate, be provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions. Sec. 399JJ(c) would require the Secretary to consult with the entity with a contract under SSA Sec. 1890(a) and other entities as appropriate to determine the type of information that is useful to stakeholders. In addition, Sec. 399JJ(c) would require the entity with a contract under Sec. 1890(a) to convene multi-stakeholder groups to review the design and format of each website and to transmit the views of

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		these groups to the Secretary. Sec. 399JJ(d) would require the Secretary, where appropriate, to coordinate the manner in which data are presented through these Internet websites and for public reporting of other quality measures by the Secretary. Sec. 399JJ(e) would authorize the appropriation of such sums as may be necessary for each of fiscal years 2010 through 2014.
Developing methodology to assess health plan value Current Law: No provision.	No provision.	*S. §10329.* The Secretary would develop a methodology to measure health plan value and submit a report to Congress no later than 18 months after enactment. Where applicable, the methodology would take into consideration (1) the overall cost to enrollees under the plan; (2) the quality of the care provided for under the plan; (3) the efficiency of the plan in providing care; (4) the relative risk of the plan's enrollees as compared to other plans; (5) the actuarial value or other comparative measure of the benefits covered under the plan; and (6) other factors determined relevant by the Secretary. In developing the methodology, the Secretary would consult with relevant stakeholders including health insurance issuers, health care consumers, employers, health care providers, and other entities determined appropriate by the Secretary.
Public reporting of performance information. Current Law: SSA Sec. 1848(m)(5)(G) requires the Secretary to post on the Internet website of the Centers for Medicare & Medicaid Services a list of eligible professionals who satisfactorily submitted data on quality measures as part of the Physician Quality Reporting Initiative (PQRI). Sec. 131(d) of the Medicare Improvements for Patients and Providers Act of 2008 requires the Secretary to develop a plan to transition to a value-based purchasing program for payment under the Medicare program for covered professional services. Not later than May 1, 2010, the Secretary is required to submit a report to	No provision.	*S. §10331* Sec. 10331(a) would require the Secretary, not later than January 1, 2011, to develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program. In addition, the Secretary would be required, not later than January 1, 2013, to implement a plan for making publicly available information on physician performance through Physician Compare. Sec. 10331(b) would require the Secretary to, in developing and implementing this plan, include: (1) processes to assure that data made public is statistically valid and reliable; (2) processes by which providers

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Congress containing the plan and recommendations for legislative and administrative action.		whose performance is being publicly reported have an opportunity to review individual results prior to publication; (3) processes to assure that the implementation of the plan provide a robust and accurate portrayal of a physician's performance; (4) data that reflects the care provided to all patients seen by physicians to the extent such information would provide a more accurate portrayal of physician performance; (5) processes to ensure appropriate attribution of care; (6) processes to ensure timely statistical performance feedback is provided to physicians; and (7) implementation of computer and data systems by CMS that support valid, reliable and accurate public reporting activities authorized under this section. Sec. 10331(c) would require the Secretary to ensure that information is not disclosed in a manner that violates privacy law. Sec. 10331(d) would require the Secretary to take into consideration input provided by multi-stakeholder groups, consistent with SSA sections 1890(b)(7) and 1890A, as added by Sec. 3014 of this Act, in selecting quality measures for use in the activities under this section. Sec. 10331(e) would require the Secretary, in developing the plan under Sec. 10331(a), to consider the plan to transition to a value-based purchasing program for physicians and other practitioners developed under Sec. 131 of MIPPA. Sec. 10331(f) would require the Secretary to submit to Congress a report on the Physician Compare Internet website, including information on the plans to collect and publish data on physician quality and efficiency. Sec. 10331(g) would permit the Secretary to expand the information made available on the Physician Compare website at any time before the date on which the report is submitted under Sec. 10331(f).

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		Sec. 10331(h) would allow the Secretary to establish a demonstration program, not later than January 1, 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians. Medicare beneficiaries would not be permitted to be charged higher premiums or cost sharing, or be subject to a reduction in benefits, as a result of this demonstration program.
Availability of Medicare data for performance measurement Current Law: No provision.	No provision.	*S. §10332.* Beginning January 1, 2012, the Secretary would make certain Medicare data available to qualified entities for the evaluation of the performance of Medicare providers. The data would consist of standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D for one or more specified geographic areas and time periods requested by a qualified entity. The Secretary would protect the identity of Medicare beneficiaries in making the data available. A qualified entity would mean a public or private entity that the Secretary determines is qualified to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use. These entities would be required to meet any and all requirements as the Secretary may specify, such as to ensure the security of data. These qualified entities would pay a fee equal to the cost of making the data available; the fees would be deposited into the Federal Supplementary Medical Insurance (Medicare Part B) Trust Fund A qualified entity requesting data would submit a description of the methodologies that would be used to evaluate the performance of providers of services and suppliers using the data. The entity would use standard measures in the evaluations, if available, or alternative measures if the Secretary, in consultation with appropriate stakeholders, were to determine that

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		alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by standard measures. The entities would include data made available under this provision with claims data from sources other than Medicare claims data in the evaluation of performance of providers of services and suppliers and would only include information on the evaluation of performance of providers and suppliers in reports as described below. The entities would make the data available to providers of services and suppliers upon their request, prior to the release of the data, and submit to the Secretary the format of the reports. Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this provision would be required to include an understandable description of the measures, which would include quality measures and the rationale for use of other measures, risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans, researchers, and other stakeholders could assess such reports. The reports would be made available confidentially to any provider of services or supplier identified in the report, prior to the public release of the report, and offer the provider(s) an opportunity to appeal and correct errors. The reports would only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary; and would be made available to the public. Qualified entities must agree to release the information on the evaluation of performance of providers of services and suppliers based on this data and could only

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		use the data for the reports described above. Data released to a qualified entity under this provision would not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.

Subtitle D – Physician Payments Sunshine Provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Reports on financial relationships between manufacturers and distributors of covered drugs, devices, biologicals, or medical supplies under Medicare, Medicaid, or CHIP and physicians and other health care entities and between physicians and other health care entities. Current Law: In recent years, questions have been raised over the propriety of certain financial relationships between health care professionals, e.g., physicians, and the pharmaceutical and other medical industries. As part of these relationships, companies may give gifts or make payments to health care professionals as part of their marketing efforts, or for other purposes. In an effort to promote transparency and prevent inappropriate relationships, several states and the District of Columbia have enacted legislation requiring pharmaceutical companies to disclose gifts and payments made to health care professionals. While companies are free to voluntarily disclose this information, there is currently no federal requirement to do so. Under section 1877 of the SSA, the federal prohibition on physician self-referrals, if a physician (or an immediate family member of a physician) has a "financial	*H. §1451.* This provision would add a new section 1128H to the SSA to require that beginning no later than March 31, 2011, covered drug, device, biologicals, or medical supply manufacturers and distributors that make certain payments or transfers of value to a covered recipient must annually report, in electronic form, specified information on such transactions to the Secretary of HHS. Information submitted must include the aggregate amount of all payments or other transfers of value provided by the manufacturer or distributor to covered recipients (and to entities or individuals at the request of or designated on behalf of a covered recipient), including all payments and transfers of value regardless of whether such payments or transfers of value were individually disclosed. A covered recipient includes a physician, a pharmacist, a health insurance issuer or group health plan, a pharmacy benefit manager, a hospital, a medical school, and others. Under this section, a payment or transfer of value means a transfer of anything of value, or of any of the following:(i) gift, food, or entertainment; (ii) travel or	*S. §6002.* This section would add a new section (section 1128G to the SSA) to require that, beginning no later than March 31, 2013, covered manufacturers that make a payment or another transfer of value to a covered recipient to report annually, in electronic form, specified information on such transactions to the Secretary of HHS. Unlike the House bill, distributors would not be subject to these reporting requirements. A covered recipient is defined as either a physician or a teaching hospital. A payment or transfer of value means a transfer of anything of value. Such term does not include a transfer of anything of value that is made indirectly to a covered recipient through a third party in connection with an activity or service, where the applicable manufacturer is unaware of the identity of the covered recipient. Certain information would be excluded from these reporting requirements, including payments or transfers of $10 or less, unless the aggregate annual payments or transfers to a recipient exceeds $100 (which, after 2012,

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relationship" with an entity, the physician may not make a referral to the entity for the furnishing of certain health services for which payment may be made under Medicare or Medicaid, and the entity may not present (or cause to be presented) a claim to the federal health care program or bill to any individual or entity for these services furnished pursuant to a prohibited referral. "Financial relationship" consists of either an ownership or investment interest or a compensation arrangement. An ownership or investment interest may be equity, debt, or other means; however, Section 1877(c) specifies that this section does not include certain investment securities which may be purchased on terms generally available to the public and meet additional requirements, or that are shares of certain regulated investment companies. A compensation arrangement means an arrangement involving remuneration between a physician or an immediate family member of such physician and an entity. Section 1877(f) requires an entity that provides covered services for which payment may be made under Medicare to report to the Secretary information on the entity's ownership, investment, and compensation arrangements, including the covered items and services provided by the entity, and the names and unique physician identification numbers of all physicians who have an ownership or investment interest in, or a compensation arrangement with the entity, or whose immediate relatives have such an ownership or investment interest or compensation relationship with the entity.	trip;(iii) honoraria; (iv) research funding or grant; (v) education or conference funding; (vi) consulting fees; and (vii) ownership or investment interest and royalties or license fees. The term also includes certain compensation, fees, or interest held by a physician in a manufacturer, subject to exceptions. Certain information would be excluded from the reporting requirements, including payments or transfers of $5 dollars or less, a loan of a covered device for a short-term trial period for evaluation purposes, items or services provided under a contractual warranty where the terms are specified in a purchase or lease agreement, items given to a patient who is not acting in a professional capacity, and in-kind items for the provision of charity care. Section 1128H would allow manufacturers and distributors to delay submission of their reports to the Secretary of payments and transfers of value made to covered recipients pursuant to certain services furnished as part of a product development agreement, or in connection with a clinical investigation of a new drug, device, biological, or medical supply. This delay must end after the earlier of (1) the date of approval or clearance of the drug, device, biological, or medical supply by the FDA (or the date the clinical investigation is listed on the NIH website) or (2) two calendar years after the payment or transfer of value was made. The information subject to delayed reporting would be considered confidential and would not be subject to disclosure under the Freedom of Information Act or other similar federal, state, or local law until the date on which the information is made available to the public.	would be indexed for inflation), patient educational materials, in-kind items for the provision of charity care, and loans of a covered device for a short-term time period. While drug samples are considered a payment or transfer of value that must be reported under the House bill, the Senate bill would exclude from the reporting requirements samples that are not intended to be sold and are for patient use. Section 1128G would also allow manufacturers and distributors to delay submission of their reports to the Secretary of payments and transfers of value made to covered recipients pursuant to certain services furnished as part of a product development agreement, or in connection with a clinical investigation of a new drug, device, biological, or medical supply. However, this delay must end after the earlier of (1) the date of approval or clearance of the drug, device, biological, or medical supply by the FDA or (2) four calendar years after the payment or transfer of value was made. Like the House bill, the information subject to delayed reporting would be considered confidential and would not be subject to disclosure under the Freedom of Information Act or other similar federal, state, or local law until the date on which the information is made available to the public. Section 1128G would require manufacturers and group purchasing organizations to report annually to the Secretary certain information regarding an ownership or investment interest held by a physician (or an immediate family member) in the manufacturer or group purchasing organization during the preceding year. Unlike the House bill, this section of the Senate Bill would not require hospitals to report ownership information. Certain penalties would apply to manufacturers and group purchasing organizations for failure to submit these reports to the Secretary. Manufacturers and organizations that fail to submit the required information

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		in a timely manner in accordance with regulations would be subject to a civil monetary penalty of at least $1,000 but not more than $10,000 for each payment or transfer of value not reported, up to a maximum of $150,000 for each annual submission of information. A reporting entity that knowingly fails to submit information would be subject to a civil monetary penalty of at least $10,000 but not more than $100,000 for each payment or transfer of value not reported as required, up to a maximum of $1,000,000 with respect to an annual submission. Similar to the House bill, the Senate bill would also require the Secretary to establish procedures to ensure that information required to be submitted under this section is available through an Internet website that is searchable, is in a format that is clear and understandable, and meets several other requirements. Among these requirements, the Senate bill differs from the House bill in that the website must not contain the National Provider Identifier of the covered recipient. In addition, the Senate bill provides that the manufacturer, group purchasing organization, or covered recipient must have an opportunity to review and submit corrections to the information submitted for a period no less than 45 days prior to such information being made available to the public. Section 1128G would also require the Secretary to submit reports to Congress and to states. Section 1128G would also preempt duplicative state laws, subject to specified exemptions.
Disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services. Current Law: Section 1877 of the SSA states that if a physician (or an immediate family member of a	No provision.	*S. §6003.* This section would amend the in-office ancillary services exception and would add a requirement that with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
physician) has a financial relationship with an entity, the physician may not make a referral to the entity for the furnishing of designated health services (DHS) for which payment may be made under Medicare or Medicaid, and the entity may not present (or cause to be presented) a claim to the federal health care program or bill to any individual or entity for DHS furnished pursuant to a prohibited referral. One of the many exceptions to this prohibition is for in-office ancillary services. Section 1877(b)(2) of the SSA permits the furnishing of certain DHS that are ancillary to the referring physician's medical services and where certain supervision, location, and billing requirements are met.		other DHS as determined by the Secretary, the referring physician must inform the individual in writing at the time of the referral that the individual may obtain the services from a person other than the referring physician; a physician who is a member of the same group practice as the referring physician; or an individual who is directly supervised by the physician or by another physician in the group practice. The individual must be provided with a written list of suppliers who furnish these services in the area in which the individual resides.

Other Transparency Provisions

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Pharmacy Benefit Managers transparency requirements. Current Law: Pharmacy benefit managers (PBMs) are companies that administer drug benefit programs for employers and health insurance carriers. Drug manufacturers may provide a variety of types of price concessions to PBMs for a particular drug in exchange for the placement of the drug on the PBM's formulary (its list of approved drugs).	*H. §233(c).* A pharmacy benefit manager (PBM) under contract with a qualified health benefits plan (QHBP, as defined under Division A of this Act) to manage prescription drug coverage would be required to provide information to the Commissioner and to the QHBP offering the plan the following information in a form and manner to be determined by the Commissioner: (1) the number and total cost of prescriptions under contract that are filled via mail order and at retail pharmacies; (2) an estimate of aggregate average payments under the contract, per prescription, made to mail order and retail pharmacies, and the average amount per prescription that the PBM was paid by the plan for prescriptions filled at mail order and retail pharmacies; (3) an estimate of the aggregate average payment per prescription under the contract received from pharmaceutical manufacturers, including all rebates, discounts, price concessions, or	*S. §6005.* The Senate provision would require the reporting of certain information by PBMs that contract with Part D drug plans as well as with QHBPs. The information would be reported to the Secretary of HHS rather than to the Commissioner, and to Part D plans and the exchanges. Similar information would be reported, however the House provision would also require information regarding switching of prescribed drugs due to PBM policies. The bills contain similar confidentiality and penalty provisions, but are tailored to the PBM contracts subject to the requirements in the different provisions. Specifically, the Senate proposal would require PBMs that manage prescription drug coverage under a contract with a Part D drug plan or a qualified health benefits plan offered through an exchange, established by

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	administrative and other payments from pharmaceutical manufacturers, and a description of the types of payments and the amount of these payments that were shared with the plan, and a description of the percentage of prescriptions for which the PBM received such payments; (4) information on the overall percentage of generic drugs dispensed under the contract at retail and mail order pharmacies, and the percentage of cases in which a generic drug is dispensed when available; (5) information on the percentage and number of cases under the contract in which individuals were switched because of PBM policies or at the direct or indirect control of the PBM from a prescribed drug that had a lower cost for the QHBP offering entity to a drug that had a higher cost for the QHBP offering entity, the rationale for these switches, and a description of the PBM policies governing such switches. Information disclosed by a PBM would be considered confidential, and such information would be prohibited from disclosure by the Commissioner or QHBP except for specified purposes, including to permit state or federal law enforcement authorities to use the information provided for program compliance purposes and for the purpose of combating waste fraud and abuse; and to permit GAO, MedPAC, CBO, or the Secretary of HHS, to review the information. The Commissioner would be required to prepare a public report on an annual basis providing industrywide aggregate or average information to be used in assessing the overall impact of PBMs on prescription drug prices and spending. The report would not disclose the identity of a specific PBM, prices charged by a PBM, or by a specific retailer, manufacturer, or wholesaler, or any other confidential or trade secret information. The provisions of (b)(3)(C) of section 1927 would apply to a PBM that fails to provide the required information or that knowingly provides false information in the same manner as such provisions apply to a manufacturer with an agreement under such section that fails to provide information	a state under Section 1311 of this bill, to share certain financial information with the Secretary of HHS, the plans the PBMs contract with through Medicare Part D, or the exchanges in a manner, form, and timeframe specified by the Secretary. PBMs would be required to disclose information on: (1) the percent of all prescriptions that are provided through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed for each type of pharmacy (for example, independent, chain, supermarket or mass merchandiser pharmacy) that is paid by the PBM under contract; (2) the aggregate amount and types of rebates, discounts or price concessions that the PBM negotiates on behalf of the plan and the aggregate amount of these that are passed through to the plan sponsor, and the total number of prescriptions dispensed; and (3) the aggregate amount of the difference between the amount the plan pays the PBM and the amount that the PBM pays the retail and mail order pharmacy, and the total number of prescriptions dispensed. Information disclosed by a health benefits plan or PBM would be considered confidential and could not be disclosed by the plan receiving the information or by the Secretary. The Secretary may disclose the information in a form that does not identify a specific PBM or plan, or prices charged for drugs except for purposes necessary to carry out this section or the Medicare Part D program, review of the information by GAO or CBO, and for States to carry out section 1311 of the Senate Bill. Health benefits plans and PBMs that fail to provide information on a timely basis or knowingly provide false information would be subject to penalties in the same manner as subsection (b)(3)(C) of section 1927 of the SSA applies to a manufacturer with an agreement under that section.

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	under subsection (b)(3)(A) of such section or knowingly provides false information under such section respectively.	
Prescription drug sample transparency. Current Law: Section 503 of the Prescription Drug Marketing Act of 1987 (PDMA, P.L. 100-293), regulates the distribution of drug samples by a drug manufacturer or distributor. Under the Act, drug manufacturers or distributors may distribute drug samples by mail or common carrier (1) to practitioners licensed to prescribe such drugs or, at the request of a licensed practitioner, to pharmacies of hospitals or other health care entities, only in response to a written request for drug samples; and (2) under a system which requires the recipient of the drug sample to execute a written receipt for the drug sample upon delivery and the return of the receipt to the manufacturer or distributor of record. A written request for a sample must contain: (1) the name, address, professional designation, and signature of the practitioner making the request; (2) the identity of the drug sample requested and the quantity requested; (3) the name of the manufacturer of the drug sample requested; and (4) the date of the request. A drug manufacturer or distributor that distributes drug samples by means other than mail or a common carrier must meet these requirements and carry out specified additional activities. Drug manufacturers and distributors must also comply with certain recordkeeping requirements, including maintaining a record of distributions of drug samples which identifies the drugs distributed and the recipients of the distributions for a period of three years.	No provision.	*S. § 6004.* This provision would add a new section 1128H of the SSA to require drug manufacturers and authorized distributors of an applicable drug to submit annually to the Secretary of Health and Human Services the identity and quantity of drug samples requested and distributed under section 503 of the Prescription Drug Marketing Act of 1987. This submission must be aggregated by the name, address, professional designation, and signature of the practitioner making the request for the sample (or an individual acting on the practitioner's behalf), as well as any other category of information that the Secretary determines is appropriate. An applicable drug is defined to include drugs that are available by prescription and for which payment is available under Medicare or a Medicaid state plan (or a waiver of such plan).

Subtitle E – Public Reporting on Health Care-Associated Infections.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Public reporting of health care-associated infections. Current federal law does not, in general, require the reporting of health care-associated infections (HAIs), although such reporting is required in a number of states. Provisions in current federal law attempt to incentivize the reduction of some specific types of health-care acquired catheter-associated infections (which are only one type of HAI) in two ways: through withholding of Medicare reimbursement under certain circumstances, and through incentives for voluntary physician and hospital reporting.	*H. §1461.* This section would add a new SSA§1138A requiring the Secretary to provide that in order to participate in Medicare and Medicaid, hospitals (including critical access hospitals) and ambulatory surgical centers (ASC) would be required to report certain HAIs (as defined) that develop in the facility. The Secretary would be required to establish reporting protocols (in consultation with the CDC) and procedures regarding the validity of reported data to ensure appropriate comparisons between facilities, and to post information online in a manner that permits comparisons by facility and by patient demographic characteristics. The Secretary also would be required to promulgate applicable regulations within one year of enactment, and provide annual reports to Congress on specified activities. The section also would provide that it should not be construed as preempting or otherwise affecting applicable state reporting laws. Hospital and ASC reporting requirements would become effective on a date specified by the Secretary, but no later than two years after enactment. Finally, within 18 months of enactment, GAO would be required to report on the program, and the Secretary would be required to report to Congress regarding the appropriateness of expanding the program to include reporting of additional types of information, such as health care worker immunization rates.	No provision.

Title V – Medicare Graduate Medical Education.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Distribution of unused residency positions. Current Law: With certain exceptions, BBA 1997 limited the number of allopathic and osteopathic residents for which Medicare would reimburse a teaching hospital at the level reported in its cost report ending on or before December 31, 1996. The limit does not include dental or podiatry residents. MMA authorized the redistribution of up to 75% of each teaching hospital's unused resident positions to hospitals seeking to increase their medical residency training programs. Any adjustments made to teaching hospitals' resident limits would be permanent.	*H. §1501.* The Secretary would reduce the otherwise applicable resident limit for a hospital that has residency positions that were unused. Unused positions would be established when a hospital's reference residence level is less than its otherwise applicable resident limit. The reduction would be effective for portions of cost reporting periods occurring on or after July 1, 2011. 90% of unused slots would be redistributed to qualifying hospitals. The increase in resident training positions would be distributed to qualifying hospitals not later than July 1, 2011.	*S. §5503.* Provision titled "Distribution of Additional (not unused) residency positions. Same general provisions except that 65% of the difference (not 90%) would be redistributed.
Establish teaching hospitals' resident reference level (baseline) positions. Current Law: Under MMA's redistribution provisions, with certain exceptions, a hospital's resident level was established by that included in the most recent cost reporting period ending on or before September 30, 2002, for which a report has been settled (or if not settled, then submitted, subject to audit). A hospital was permitted to submit a timely request to increase this level due to a an expansion of an existing residency program that was not reflected on this recent cost report. After audit and subject to the Secretary's discretion, the level was established as that included in the cost reporting period that includes July 1, 2003. Also, expansions for programs approved before January 1, 2002 that were not operational were permitted.	*H. §1501.* A hospital's reference residence level would be established as the highest resident level of any of the 3 most recent cost reporting periods (ending before the date of enactment). Hospital cost reports that had been settled or those that had been submitted, subject to audit, would be used to establish the residence level. Also, a hospital's reference resident level could be increased to reflect an expansion of an existing residency training program that is not reflected on the most recent settled or submitted cost report. The increase would occur after audit and would include the previous redistribution of unused resident positions that occurred under MMA. The Secretary would be authorized to determine an alternative resident reference level for hospitals that submit a timely request before the start of the 2009 to 2010 academic year.	*S. §5503.* A hospital's reference residence level would be established as the highest resident level of any of the 3 most recent cost reporting periods (ending before the date of enactment) for the hospital for which a cost report has been settled (or, if not, submitted (subject to audit) as determined by the Secretary.
Exempt certain hospitals' resident slots from	*H. §1501.*	*S. §5503.*

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
redistribution. Current Law: Under MMA's redistribution provisions, rural teaching hospitals with less than 250 beds were exempt from redistribution.	The resident reference level for the replacement hospital for the former Martin Luther King Jr. Hospital would not be affected. A hospital's resident reference level would be increased to the extent that its level was increased because of the prior redistribution of resident slots. The redistribution provisions would apply to hospitals that are members of the same affiliation group. A hospital's available resident slots would be adjusted to the extent that hospitals can demonstrate that they are filling any additional resident slots allocated to other hospitals through an affiliation agreement. Alternatively, available slots would be adjusted for those residency positions that have been aggregated under Section 402 of the SSA Amendments of 1967.	Redistribution would not apply to rural teaching hospitals with less than 250 beds or the replacement hospital for the former Martin Luther King Junior Hospital. Hospitals in New York that were part of a qualifying entity with an approved voluntary residency reduction plan or hospitals that were part of qualifying entity under the authority Section 402 of the SSA Amendments of 1967 would be exempt if they demonstrate a specific plan in place for filling the unused positions by not later than 2 years from enactment.
Establish teaching hospitals application requirement. Current Law: Under MMA's redistribution, the Secretary was authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application by such number for portions of cost reporting periods that occur on or after July 1, 2005.	*H. §1501.* The Secretary would be required to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application by such number for portions of cost reporting periods that occur on or after July 1, 2011. The aggregate number of increases in resident limits may not exceed the estimated aggregate reduction in resident limits.	*S. §5503.* Same provision.
Cap on number of redistributed residents. Current Law: Under MMA's redistribution, teaching hospitals were allowed to request up to an additional 25 full time equivalent (FTE) positions for direct graduate medical education (DGME) and indirect medical education (IME) payments.	*H. §1501.* In no case would more than 20 FTE additional residents be made available to a qualifying hospital.	*S. §5503.* In no case would a hospital receive more than 75 FTE additional residents.
Consider likelihood of filling positions and other characteristics. Current Law: Under MMA's redistribution provisions, hospitals were required to demonstrate the likelihood that the redistributed positions would be filled within 3 cost reporting periods beginning July 1, 2005.	*H. §1501.* When determining which qualifying hospitals would receive an increase in their otherwise applicable resident limit, the Secretary would take into account the demonstrated likelihood that a hospital would fill the positions within the first 3 cost reporting periods beginning on or after July 1, 2011.	*S. §5503.* The same provision with respect to a demonstrated likelihood within the first 3 cost reporting periods. In addition, the Secretary would take into account whether a hospital has an accredited rural training track.

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Maintain and expand number of resident slots for primary care programs. Current Law: No provision.	*H. §1501.* A hospital that qualifies for an increase in its otherwise applicable resident limit would be required to ensure that the number of primary care residents is maintained at its base level of primary care residents increased by the number of additional primary care residents provided to the hospital. The hospital would have to assign all additional resident positions for primary care residents. The hospital's residency programs would have to be fully accredited or, if not yet in operation as of the base year, the hospital would have to be actively applying for such accreditation for the program. A hospital's base level of primary care residents is the level of such residents in a base period determined without regard to whether such positions were in excess of the otherwise applicable resident limits. Hospitals receiving positions would be required to maintain records and periodically report on the number of primary care residents in its training programs. As a condition of continuing payment, the hospitals would be required to maintain the level of positions at not less than the sum of the level of primary care resident positions before receiving additional positions plus the number of additional positions.	*S. §5503.* A hospital that receives an increase to its otherwise applicable resident limit would ensure during a 5 year period that (1) its number of FTE primary care residents is not less than the average number of FTE primary care residents during the 3 most recent cost reporting periods; and (2) not less than 75% of the positions attributable to the increase are in primary care or general surgery residency. The Secretary would determine whether a hospital has met these requirements during the 5 year period. A hospital that has not met the 2 requirements would have its otherwise applicable resident level reduced by the amount it was increased under this section. The Secretary would provide for the distribution of the positions attributed to these reductions in accordance with the consideration and priorities established in the section.
Give priorities to certain hospitals. Current Law: As well as demonstrating a likelihood that redistributed positions be filled within 3 years, MMA required that the unused slots be redistributed according to specific priorities: rural hospitals, urban hospitals located in areas with a population of one million or less, specialty training programs that are the only specialty program in a state, and all other hospitals. The redistribution was effective for portions of cost reporting periods starting July 1, 2005. The redistributed resident slots have different IME and DGME payment formulas from those used to reimburse hospitals' previous residents.	*H. §1501.* The Secretary would distribute the resident slots based on the following criteria: (1) the hospital had a reduction in the resident training positions under this section; (2) the hospital has a 3-year primary care residency training program, such as family practice and general internal medicine; (3) the hospital has formal arrangements that place greater emphasis upon training in federally qualified health centers, rural health clinics, off-campus provider-based outpatient departments, and other non-provider settings, and those hospitals that receive Medicare DSH payments and emphasize training in an outpatient department (4) the hospital has residents above its otherwise applicable limit as of July 1, 2009; (5) the hospital places a greater emphasis on training in a health	*S. §5503.* The Secretary would distribute the increase to hospitals based on the following factors: (1) the hospital is located in a State with a resident-to-population ratio in the lowest quartile; (2) whether the hospital is in a state, territory, or in the District of Columbia that is the top 10 in terms of the ratio of the total population living in a health professional shortage area (HPSA) to its total population; and (3) whether the hospital is in a rural area. 70% of the positions would be distributed to States in the lowest quartile of resident to population ratios; 30% would be distributed to qualifying entities with high HPSA penetration and rural hospitals. Resident positions that are not distributed by July 1, 2011 would be distributed to those hospitals with rural training tracks

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	professional shortage area or health professions needs area; or (6) the hospital is in a State with a low resident-to-population ratio (including a greater preference for those states with lower resident to population ratios).	and a demonstrated likelihood of filling positions as well as the other enumerated priorities.
Establish IME and DGME payment amounts for redistributed resident slots. Current Law: The redistributed resident slots under MMA had different IME and DGME payment formulas from those used to reimburse hospitals' previous residents.	*H. §1501.* The per resident amounts (PRAs) for the resident positions distributed under this provision would equal the hospitals' PRAs for primary and nonprimary care positions for the purposes of calculating direct graduate medical payments. The indirect medical education adjustment for the resident positions distributed under this provision would be computed in the same fashion as the hospital's existing resident positions.	*S. §5503.* Same provision.
Increasing training in nonprovider settings. Current Law: Medicare reimburses the direct costs of graduate medical education (DGME) for approved residency training programs without regard for the setting where the residents' activities relating to patient care are performed as long as the hospital incurs all, or substantially all, of the costs for the training program in that setting. Through regulation, CMS has defined all, or substantially all costs, as 90% of resident stipends and fringe benefits and costs associated with a supervising physician. However, as presently administered, a hospital cannot include the time spent by residents working at a non-hospital site if it incurs all, or substantially all, of the costs for only a portion of the residents in that program at the non-hospital site.	*H. §1502.* Effective for cost reporting periods beginning on or after July 1, 2009, all time spent by a resident would count towards the determination of a FTE resident with respect to Medicare's direct graduate education payment, without regard to the setting where the activities are performed, if the hospital incurs the costs of the stipends and the fringe benefits of the resident during the time the resident spends in that setting. Any hospital claiming payment for the time spent in a non-provider setting would be required to maintain and make available necessary records regarding the amount of time and this amount in comparison to the amounts of time in a specified base year. Effective for discharges on or after July 1, 2009, all the time spent by a resident in patient care activities in a non-provider setting would be counted towards the determination of a FTE resident with respect to Medicare's indirect medical education payment if the hospital incurs the costs of the stipends and fringe benefits of the resident during the time spent in that setting. The Office of the Inspector General (OIG) would be	*S. §5504.* Same general provision, but would be effective for cost reporting periods beginning on or after July 1, 2010. Also it states that if more than one hospital incurs the costs, either directly or indirectly through a third party, the hospitals would count a proportional share of the time as determined by a written agreement between the hospitals. No requirement for an OIG study or a demonstration project for approved teaching health centers. The section would not require the reopening of any settled cost reports where there is not a jurisdictionally proper appeal on the issues of IME or DGME payments pending as of the date of enactment.

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	required to analyze the resident data to assess the extent to which there is an increase in time spent by medical residents training in non-provider settings. The Secretary would conduct a demonstration project where an approved teaching health center would be eligible for payments for its own direct cost of GME activities for primary care residents as well as for the direct costs of such GME activities of its contracting hospital for such residents. Under the project, such a center would contract with an accredited teaching hospital to carry out the inpatient responsibilities of the primary care residency program. The center would be responsible for payment of the hospital's costs of the salary and fringe benefits for residents. The number of the residents at the center would not count against the contracting hospital's resident limit. The contracting hospital would not reduce the number of residents in its primary care residency training program. An approved teaching health center would be a non-provider setting, such as a FQHC or rural health center that develops and operates an accredited primary care residency program for which funding would be available if it were operated by a hospital.	
Rules for counting resident time for didactic and scholarly activities. Current Law: Medicare pays teaching hospitals the costs of approved medical residency training programs through two mechanisms: an indirect medical education (IME) adjustment within the inpatient prospective payment system (IPPS) and direct graduate medical education (DGME) payments made outside of IPPS. Certain non-patient care activities that are part of an approved training program are not allowable for DGME or IME payment purposes. With respect to training that occurs in hospital settings, Medicare does not include the time that residents spend in non-patient care activities, including didactic activities, when calculating	*H. §1503.* When calculating DGME payments, Medicare would count the time that residents in approved training programs spend in certain non-patient care activities in a nonhospital setting that is primarily engaged in furnishing patient care. The term "non-provider setting that is primarily engaged in furnishing patient care" would be a non-provider setting in which the primary activity is the care and treatment of patients as defined by the Secretary. Reimbursable non-patient care activities would include didactic conferences and seminars but would not include research that is not associated with the treatment or diagnosis of a particular patient. In addition, Medicare would count all the vacation, sick	*S. §5505 as modified by S. §10501(j)* Same provision, but the effective date would apply to cost reporting periods beginning on or after July 1, 2009, for DGME (not July 1, 2008).

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IME payments. With respect to training that occurs in nonhospital settings, Medicare would not count the time that residents spend in non-patient care activities, including didactic activities, when calculating DGME or IME payments.	leave and other approved leave spent by resident in an approved training program as long as the leave time does not extend the program's duration. When calculating IME payments, Medicare would adopt the same rules about counting residents' leave time. Medicare would also include all the time spent by residents in approved training programs on certain non-patient care activities (including didactic conferences and seminars, but not in certain research activities that are not associated with the treatment or diagnosis of an particular patient) if the hospital is an IPPS hospital, a hospital paid under the IPPS for Puerto Rico, is a hospital paid under a state specific hospital reimbursement system, or is a provider-based hospital outpatient department. Except as otherwise provided, these provisions would be effective for cost reporting periods beginning on or after January 1, 1983. The provisions affecting DGME would apply to cost reporting periods on or after July 1, 2008. The provisions affecting IME would apply to cost reporting periods on or after October 1, 2001. This section would not affect the interpretation of the law in effect prior to that date. The provisions would not be implemented in a manner that would require reopening of any settled hospital cost reports where there is not a jurisdictionally proper appeal pending on IME and DGME payments as of the date of enactment.	
Preserving the resident cap positions from closed hospitals. Current Law: CMS has established certain regulations governing Medicare's provider enrollment requirements that determine under what circumstances providers can bill the Medicare program including those involved in change of ownership (CHOW) transactions. Very generally, in order to acquire a teaching hospital's resident cap under a CHOW transaction, the acquiring	*H. §1504.* The Secretary would promulgate regulations to establish a process where the residency allotments in a hospital with an approved medical residency program that closes on or after a date that is 2 years before the date of enactment could be used to increase the otherwise applicable residency limit for other hospitals in the State. The increase in residency programs would be distributed to hospitals in the State in a manner specified by the	*S. §5506.* Same general provision with certain exceptions. There is no requirement that the Secretary would have to consider the recommendations submitted by the state's designated senior health official. Instead the bill would establish a priority for hospitals in certain areas (with preference given within each category to hospitals that are members for the same affiliated group): (1) first to hospitals that are located in the same core-based

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entity must retain the original provider number. However, the acquiring entity would also assume all liabilities associated with that provider number. Starting August 29, 2005 (the day after Hurricane Katrina), hospitals were permitted to form emergency affiliation agreements if located in federally declared disaster areas starting the first day of a Section 1135 emergency period. Under 42 Code of Federal Regulations (CFR) 413.79, a home hospital located in such an area that experiences at least a 20% decline in inpatient occupancy can temporarily transfer its resident cap to a host hospital.	Secretary. This process would be take into consideration the recommendations submitted by senior health official (designated by the state's governor) provided that the recommendations are not submitted later than 180 days after the date of the hospital closure. For hospitals that were closed after a date that is 2 years before the date of enactment, the time limit would be 180 days from the date of enactment. The aggregate number of increased residency limits would equal the number of residency positions in approved medical programs that closed on or after the date of enactment. These provisions would not affect any temporary adjustment to a hospital's FTE resident cap established under 42 CFR 413.79 as in effect on the date of enactment or any redistribution that occurred because of the provision in Section 1501 of this legislation.	statistical area (CBSA) or a contiguous CBSA to the hospital that closed; (2) second, to hospitals in the same State; (3) to hospitals located in the same region; (4) only if the Secretary is not able to distribute to other hospitals in the region, in accordance with the priorities established in Section 5503 used to redistribute residency slots. Hospitals would receive increases to their residency limits only if they can demonstrate a likelihood of filling the positions within 3 years. As with H.R. 3962, the aggregate increase to residency slots would equal the number in approved medical programs that closed on or after the date of enactment. Chapter 35 of Title 44 of the US Code would not apply to the implementation of this provision. The section would not require the reopening of any settled cost reports where there is not a jurisdictionally proper appeal on the issues of IME or DGME payments pending as of the date of enactment.
Improving accountability for approved medical residency training. Current Law: Medicare will reimburse teaching hospitals for the direct and indirect costs associated with an approved teaching program accredited by an independent entity, such as the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. Medicare has never linked its payments to promoting or fostering any goals in medical education.	*H. §1505.* Certain goals of medical residency training programs would be established. Specifically, resident training would be designed so that physicians would be able to: (1) work effectively in various health care delivery settings; (2) coordinate patient care within and across settings; (3) understand the relevant cost and value of various diagnostic and treatment options; (4) work effectively in inter-professional and multi-disciplinary teams in provider and non-provider settings; (5) identify systematic errors in health care delivery and implement solutions for such errors; and (6) be meaningful electronic health record users. GAO would be required to evaluate the extent to which medical residency training programs are meeting the above workforce goals in a range of residency programs, including primary care and specialties; and have the appropriate faculty expertise to teach the topics required to achieve such goals. The study would be	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	submitted to Congress no later than 18 months after the date of the enactment. The study would include recommendations with respect to the development of curriculum requirements and an assessment of the accreditation processes of the Accreditation Council for Graduate Medical Education and the American Osteopathic Association.	

Title VI – Program Integrity.

Subtitle A – Increased Funding to Fight Waste, Fraud, and Abuse.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Increased funding and flexibility to fight fraud and abuse. Current Law: Activities to fight health care fraud, waste, and abuse are funded by the Health Care Fraud and Abuse Control (HCFAC) account. The HCFAC account funds two programs: 1) the HCFAC program, which finances the investigative and enforcement activities undertaken by HHS, the OIG, the DOJ, and the FBI, and 2) the Medicare Integrity Program (MIP), which finances the program integrity activities undertaken by CMS contractors. HCFAC was established by HIPAA, which sought to increase and stabilize Federal funding for health care anti-fraud activities. HIPAA appropriated funds to the HCFAC account for years 1997 through 2003. In December 2006, Congress passed the Tax Relief and Health Care Act or TRHCA which extended the mandatory annual appropriation for the HCFAC program by a CPI adjustment until 2010. TRHCA did	*H. §1601.* This provision would appropriate an additional $100 million annually to the HCFAC account beginning with FY2011. Funding would be appropriated to the HCFAC account in the same proportion as is currently appropriated in statute and would be available until expended. The provision would also provide some additional discretion to the Secretary on the use of MIP funds. Under current law, the Secretary is required to enter into contracts with eligible entities to carry out MIP activities. Under the provision, the Secretary would be authorized to promote the integrity of the Medicare program by entering into contract with eligible entities or "otherwise" to carry out MIP activities.	S. §6402(i) and §6402(j)(1)(C). This provision would appropriate an additional $10 million annually to the HCFAC account for fiscal years 2011 through 2020. Funding would be appropriated to the HCFAC and MIP programs in the same proportion as is currently allocated in statute and would be available until expended. In addition to applying a CPI-adjustment to the MIP program beginning in 2011, the provision would also permanently apply the CPI adjustment mandated under TRHCA to the HCFAC program. Identical to the House provision, the Secretary would be authorized to promote the integrity of the Medicare program by entering into contract with eligible entities or "otherwise" to carry out MIP activities.

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not extend the annual appropriation for MIP. Total mandatory and discretionary funding for the HCFAC account in FY2009 amounted to approximately $1.4 billion.		

Subtitle B – Enhanced Penalties for Fraud and Abuse.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Enhanced penalties for false statements on provider or supplier enrollment applications. Current Law: The Centers for Medicare and Medicaid Services (CMS) has implemented regulations requiring Medicare providers and suppliers to submit an application to enroll in the Medicare program to receive billing privileges. Providers and suppliers must resubmit and recertify the accuracy of their enrollment information every 5 years. Medicaid statute delegates the administration of the Medicaid program to the states. State Medicaid agencies determine whether a provider or supplier is eligible to participate in the program by providing for written agreements with providers and suppliers. Section 1128A(a) of the SSA imposes CMPs and assessments on a person or other entity who engages in various types of improper conduct with respect to federal health care programs, including penalties against a person who knowingly presents or causes to be presented false or fraudulent claims. This section generally provides for CMPs of up to $10,000 for each item or service claimed, $15,000 or $50,000 under other circumstances, and an assessment of up to three times the amount claimed.	*H. §1611.* This provision would subject any provider or supplier that knowingly makes or causes to be made any false statement, omission, or misrepresentation on an application, agreement, bid, or contract to participate or enroll in a federal health care program to a CMP of $50,000 for each misrepresentation. The provision would apply to Medicaid managed care organizations, Medicare Advantage (MA) plans, Prescription Drug Plan (PDP) plans, and providers and suppliers that participate in such managed care organizations and plans. In addition, such a person may be subject to an assessment of not more than 3 times the amount claimed as the result of the false statement, omission, or misrepresentation. These amendments would apply to acts committed on or after January 1, 2010.	*S. §6402(d)(2)(A).* Identical provision except part of a broader provision which imposes CMPs on: 1) excluded providers or suppliers that knowingly order or prescribe a medical item or service, and 2) persons who know of an overpayment and do not report and return the overpayment.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Enhanced penalties for submission of false statements material to a false claim. Current Law: Section 1128A(a) of the SSA imposes CMPs and assessments on a person or other entity who engages in various types of improper conduct with respect to federal health care programs, including penalties against a person who knowingly presents or causes to be presented false or fraudulent claims. This section generally provides for CMPs of up to $10,000 for each item or service claimed, $15,000 or $50,000 under other circumstances, and an assessment of up to three times the amount claimed.	*H. §1612.* The provision would impose CMPs on persons who knowingly make, use, or cause to be made or used any false statement or record material to a false or fraudulent claim submitted for payment to a federal health care program. These persons would be subject to a CMP of $50,000 for each false record or statement. This amendment would apply to violations committed on or after January 1, 2010.	*S. §6408(a).* Identical provision.
Enhanced penalties for delaying inspections. Current Law: Section 1128A(a) of the SSA imposes CMPs and assessments on a person or other entity who engages in various types of improper conduct with respect to federal health care programs, including penalties against a person who knowingly presents or causes to be presented false or fraudulent claims. This section generally provides for CMPs of up to $10,000 for each item or service claimed, $15,000 or $50,000 under other circumstances, and an assessment of up to three times the amount claimed. The Secretary has the right to inspect and evaluate the quality, appropriateness, and timeliness of services provided by MA plans. The Secretary also has the right to audit any records of a MA plan that relate to the ability of the plan to bear risk, the services performed, or the amounts paid by the plan.	*H. §1613(a) and (b).* The provision would provide that persons who fail to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the OIG, for the purpose of audits, investigations, evaluations, or other statutory functions of the OIG, be subject to CMPs of $15,000 for each day of failure. This amendment would apply to violations committed on or after January 1, 2010. The provision would also provide the Secretary with the authority to inspect and evaluate the operations of a MA plan in a timely manner.	*S. §6408(a) and (b)(1).* Identical provision except imposes a CMP for knowingly making, using, or causing to be made or used, a false record or statement material to a false claim as well as imposing CMPs for delaying inspections. Additionally, the provision requiring timely inspections for MA plans would become effective on the date this legislation is enacted.
Enhanced hospice program safeguards. Current Law: Medicare statute mandates the establishment of minimum health and safety standards that must be met by providers participating in the Medicare and Medicaid programs (i.e. hospitals, hospices, nursing homes, and home health agencies). In order to receive payment, providers must meet these	*H. §1614.* **Overview.** This provision would require the Secretary to take immediate action against a hospice that has demonstrated substandard quality of care and that has failed to meet health and safety requirements determined by the Secretary. For deficiencies that immediately jeopardize the health and safety of	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
health and safety standards, often referred to as Conditions of Participation (CoPs). Generally, state agencies, under contract with CMS, survey providers to determine compliance with CoPs. Alternatively, a provider can be deemed to meet these requirements if it has been accredited by an approved national accreditation body. If a provider has been found to be non-compliant with its CoPs, CMS has the authority to impose certain sanctions, including revoking the provider's participation agreement. States also have the authority to impose sanctions on Medicare and Medicaid participating facilities found to be non-compliant with their CoPs. In April 2007, the OIG recommended Congress enact legislation granting CMS the authority to impose additional remedies on poor performing hospices.	individuals being treated in a hospice, the Secretary would be required to take immediate action by either appointing temporary managers to oversee the operations of the hospice (while improvements are being made) or terminating the hospice's participation in federal health care programs. The Secretary would be authorized to impose additional remedies if necessary. If the Secretary determines that identified deficiencies do not immediately jeopardize the patients' health and safety, the Secretary, in lieu of terminating the providers' participation in the program, may impose other intermediate sanctions. If after a period of intermediate sanctions, the deficiencies have not been corrected, the Secretary would be required to terminate the providers' participation in federal health programs. The Secretary would also be authorized to impose CMPs on hospice providers for any days the hospice was not compliant with federal health and safety standards. **Intermediate Sanctions.** By July 1, 2012 the Secretary would be required to develop and implement a range of intermediate sanctions to apply to hospice programs and the appropriate procedures for appealing these sanctions. The sanctions may include CMPs of up to $10,000 for each day of non-compliance or in the case of a per instance penalty not more than $25,000, a denial of all or part of future payments to which the hospice is entitled (which would terminate upon the Secretary's finding that the hospice program no longer demonstrated substandard quality and met other requirements as determined by the Secretary), requiring the appointment of temporary managers to oversee the operation of the hospice program, corrective action plans, and staff training. The sanctions could be imposed in addition to those imposed under State or Federal law and would not be construed as limiting other available remedies.	

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	Procedures for Applying Sanctions. By July 1, 2011, the Secretary would be required to create the specific procedures and conditions under which the relevant sanctions would apply, including the amount of any fines and severity of the sanctions. The conditions would be required to minimize the time between the identification of deficiencies and imposition of sanctions, and would provide for more severe fines for repeated deficiencies. The due process protections provided in the CMP law (SSA, Section1128A), such as written notice and the right to a hearing, would apply in the same manner to the imposition of a CMP for hospices. These provisions would also apply to hospice programs participating in Medicaid and CHIP.	
Enhanced penalties for individuals excluded from program participation. Current Law: Section 1128A(a) of the SSA imposes CMPs and assessments on a person or other entity who engages in various types of improper conduct with respect to federal health care programs including penalties against a person who knowingly presents or causes to be presented false or fraudulent claims. Among these false claims, any person who knowingly submits claims for items or services furnished during a period in which the person was excluded from participation in Medicare or Medicaid, may be subject to CMPs under certain circumstances.	*H. §1615.* The provision would require that a person who orders or prescribes an item or service, including, without limitation, home health care, diagnostic and clinical lab tests, prescription drugs, durable medical equipment, ambulance services, or physical or occupational therapy or any other item or service during a period when the person has been excluded from participation in a federal health care program, and the person knows or should know that a claim for such item or service will be presented to such a program, be subject to a CMP of $50,000 for each order or prescription. This amendment would apply to violations committed on or after January 1, 2010.	*S. §6402(d)(2).* Substantially similar provision except that there is no prescribed CMP amount for violations of the requirement.
Enhanced penalties for provision of false information by MA and Part D plans. Current Law: The Secretary has the authority to impose CMPs on MA organizations and Part D plans for different types of violations. Among the types of violations are failing to provide medically necessary care; imposing excess beneficiary premiums; discouraging or denying enrollment; misrepresenting or falsifying information; failing to comply with balance billing	*H. §1616.* This provision would grant the Secretary the authority to impose an additional penalty on MA organizations and Part D plans that misrepresent or falsify information to include an assessment of not more than three times the amount claimed by a plan or plan sponsor based on the misrepresentation or falsified information. The provision would apply to violations committed on or after January 1, 2010.	*S. §6408(b)(3).* Substantially similar provision except that the provision enhances the penalty amount by the amount claimed by a plan based on the misrepresentation of falsified information as opposed to three times the amount claimed.

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requirements; and contracting with providers excluded from the Medicare program. CMPs range from $25,000 to $100,000 for each violation.		
Enhanced penalties for MA and Part D marketing violations. Current Law: The Secretary has the authority to impose CMPs on MA organizations and Part D plans for different types of violations. Among the types of violations are failing to provide medically necessary care; imposing excess beneficiary premiums; discouraging or denying enrollment; misrepresenting or falsifying information; failing to comply with balance billing requirements; and contracting with providers excluded from the Medicare program. CMPs range from $25,000 to $100,000 for each violation.	*H. §1617.* This provision would increase the number of violations that could be subject to the imposition of sanctions and CMPs by the Secretary. Beginning January 1, 2010, plans that: 1) enroll individuals in an MA or Part D plan without the prior consent of the individual or designee (except Part D dual eligibles), 2) transfer an individual from one plan to another without prior consent or solely for the purpose of earning a commission, 3) fail to comply with marketing requirements, including CMS regulations and guidance, or 4) employ or contract with an individual or entity that engages in such conduct would be subject to sanctions imposed by the Secretary. Sanctions would apply to any employee or agent of an MA organization or Part D sponsor, or any provider or supplier who contracts with an MA organization or Part D sponsor.	*S. §6408(b)(2).* Identical provision.
Enhanced penalties for obstruction of program audits. Current Law: The OIG has permissive authority (i.e. discretion) to exclude an entity or individual from a federal health program for a conviction related to the interference with or obstruction of certain criminal offenses related to health care fraud.	*H. §1618.* This provision would expand OIG's permissive exclusion authority to include a conviction related to the obstruction of an audit as well as an investigation. The permissive exclusion would apply to obstruction of audits and investigations of the use of funds received, directly or indirectly, from any Federal health care program. The provision would apply to violations committed on or after January 1, 2010.	*S. §6408(c).* Identical provision.
Exclusion of certain individuals and entities from participation in Medicare and State health care programs. Current Law: Section 1128 of the SSA provides that the Secretary (and through delegation, OIG) has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. Exclusion is mandatory for	*H. §1619.* The bill would address the effect of a health care provider exclusion on payment made under federal health care programs. Under this section, payment cannot be made from any federal health care program with respect to an item or service furnished by (1) an excluded individual or entity, or (2) at the medical direction, or on the prescription of an authorized	No provision.

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those convicted of certain criminal offenses, and generally the exclusion cannot be for a period of less than five years. OIG also has permissive authority to exclude an individual or entity from a federal health program, which includes the discretion to determine whether and for how long to impose an exclusion. A permissive exclusion may be imposed under numerous circumstances, including conviction of certain misdemeanors relating to fraud, theft, embezzlement, breach of fiduciary duty or other financial misconduct. Under 42 C.F.R. § 1001.1901, unless and until an excluded individual or entity is reinstated into a federal health care program, no payment will be made by a program for any item or service furnished by the individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion.	individual (e.g., a physician) when the person submitting a claim for the item or service knew or had reason to know of an individual's exclusion. Subject to certain restrictions, such an item or service would be determined regardless of how the service was paid for by a Federal health care program or to whom the payment has been made. However, the section would allow payment to be made for certain emergency items or services furnished by an excluded individual or entity or under the medical direction of the same. If a person eligible for benefits under Medicare or Medicaid submits a claim for payment for items or services furnished by an excluded individual or entity, and the eligible person did not know or have reason to know that the individual or entity was excluded, then payment must be made for the items or services. If a claim for payment for items or services furnished by an excluded individual or entity is submitted by an individual or entity other than a person eligible for benefits under Medicare or Medicaid or that excluded individual or entity itself, and the Secretary determines that the individual or entity that submitted the claim took reasonable steps to learn of the exclusion and reasonably relied upon inaccurate or misleading information from the relevant federal health care program or its contractor, the Secretary may waive repayment of the amount paid in violation of the exclusion to the individual or entity that submitted the claim. However, in such instance, if the federal health care program contractor provided misleading or inaccurate information, the Secretary would be required to take appropriate action to recover the payment from the contractor.	
OIG authority to exclude from Federal health care programs officers and owners of entities convicted of fraud.	*H. §1620.* This provision would clarify that this authority would apply only to those officers, managing employees, or	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Current Law: The Secretary (and through delegation, the OIG) has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. The Secretary's exclusion authority is mandatory under circumstances, and permissive in others. For example, under the Secretary's permissive exclusion authority, the Secretary may exclude individuals with a direct or indirect ownership or control interest in an entity that has been sanctioned, provided the individual either knows or should know of the basis for the sanction, or is an officer and managing employee of a sanctioned entity. A sanctioned entity is one that has been convicted of certain specified offenses or one that has been excluded from participation under Medicare or a state health care program.	persons that had a direct or indirect ownership or control interest in the entity at the time of the action constituting the basis for the conviction or exclusion.	
Self-referral disclosure protocol. Current Law: Section 1877 of the SSA, commonly referred to as the Stark law, provides that if a physician or a physician's immediate family member has a "financial relationship" with an entity, the physician may not make a referral to the entity for the furnishing of certain health services for which payment may be made under Medicare, and the entity may not present (or cause to be presented) a claim to the federal health care program, or bill to any other entity for these services furnished pursuant to a prohibited referral. Violators of the physician self-referral law may be subject to sanctions including a denial of payment for relevant services, civil monetary penalties, and exclusion from participation in the Medicare and Medicaid programs. In 1998, the Office of the Inspector General issued a Self-Disclosure Protocol (SDP) that includes a process under which a health care provider can voluntarily self-disclose evidence of potential fraud, in an effort, according to OIG, to avoid the costs or disruptions that may be associated with an investigation or litigation. OIG has also indicated that health care providers who utilize the	*H. §1621.* The Secretary in cooperation with the OIG, would be required to establish a protocol for allowing health care providers and suppliers to disclose actual and potential violations of the Stark law no later than 6 months from date of enactment. A self-referral disclosure protocol ("SRDP") must include information regarding the person, official, or office to whom such disclosures may be made, as well as the implication of the protocol on corporate integrity agreements and corporate compliance agreements. The Secretary would be required to post information on the CMS website regarding how to disclose these violations. The SDRP would be separate from the OIG advisory opinion process. In addition, the Secretary would also have the authority to reduce the amount that would be paid for a violation of the Stark law. This section provides factors that the Secretary may consider in reducing this amount. No later than 18 months after the development of the SRDP protocols, the OIG would submit a report to Congress on the implementation of this section. The report would include the number of health care	*S. §6409.* Similar provision, except it does not contain the provision relating to the reporting and returning of overpayments in relation to the SRDP.

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self-disclosure protocol may be subject to penalties "on the lower end of the continuum." On March 24, 2009, OIG issued an "Open Letter to Health Care Providers" that makes refinements to the SDP. In the Open Letter, OIG announced that it would no longer accept disclosure of a matter that involves only liability under the physician self-referral law in "the absence of a colorable anti-kickback statute violation." Some commentators have alleged that the change created confusion for health care providers seeking to disclose potential Stark law violations.	providers of services and suppliers making disclosures pursuant to an SRDP; (2) the amounts collected pursuant to the SRDP; (3) the types of violations reported under the SRDP; and (4) such other information as may be necessary to evaluate the impact of this section. This section would not affect the application of section 1128G(c) of the Social Security Act (as added by section 1641 of the bill), which relates to the reporting and returning of overpayments made under Medicare, Medicaid, or SCHIP. However, in the case of a health care provider or supplier who discloses an overpayment to the Secretary pursuant to a SRDP, the 60-day period for reporting and returning the overpayment as provided under section 1128G would be extended with respect to the return of an overpayment. This period would be extended to the extent necessary for the Secretary to determine what is due and owed, pursuant to the SRDP.	
Administrative remedy for knowing participation by beneficiary in health care fraud scheme. Current Law: None.	No provision.	*S.§6402(a).* The provision would require that the Secretary impose an administrative penalty – commensurate with the offense – on any Medicare, Medicaid, or CHIP beneficiary who has knowingly participated in a Federal health care fraud scheme.
Health care fraud enforcement Current Law: The Sentencing Reform Act of 1984 created a sentencing system under which the United States Sentencing Commission establishes federal sentencing guidelines. Until 2005, the guidelines were binding on a court. The judge had discretion to sentence a criminal defendant, but only within the narrow sentencing range that the guidelines provided. The Supreme Court in *United States v. Booker* declared that the guidelines must be considered advisory rather than	No provision.	*S.§10606* The U.S. Sentencing Commission would be required to review the federal sentencing guidelines and policy statements applicable to persons convicted of federal health care offenses. The Commission would also amend the guidelines and statements applicable to federal health care offenses involving government health care programs to provide that the aggregate dollar amount of fraudulent bills submitted to a program constitutes evidence of the amount of intended loss by the

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mandatory. Instead of being bound by the guidelines, sentencing courts must now treat the federal guidelines as just one of a number of sentencing factors. Under section 242(a) of HIPAA (18 U.S.C. § 1347), a person who knowingly or willfully executes, or attempts to execute, a scheme or artifice: (1) to defraud a health care benefit program; or (2) to obtain, by false or fraudulent means, money or property owned by, or under the custody or control of, any health care benefit program, can be subject to criminal fines and imprisonment. Section 241 of HIPAA (18 U.S.C. § 24) defines "federal health care offense" as a violation of, or a criminal conspiracy to violate a number of criminal statutes. By defining an offense as a "federal health care offense," violations of these listed statutes may lead to additional criminal liability, and other enforcement mechanisms may apply. For example, section 247 of HIPAA allows the Attorney General to seek injunctive relief and freeze assets for persons committing or about to commit a "federal health care offense." 18 U.S.C. §1345. Under 18 U.S.C. § 1510(b), an officer of a financial institution who intends to obstruct a judicial proceeding and notifies another person about the existence or contents of a subpoena for records of that financial institution, or information that has been furnished to the grand jury in response to that subpoena, must be fined under this title or imprisoned not more than 5 years, or both. The Civil Rights of Institutionalized Persons Act (CRIPA, 42 U.S.C. §1997 et seq.) provides authority for the Department of Justice (DOJ) to initiate or intervene in lawsuits in federal courts in order to protect the rights of institutionalized persons. This includes individuals in state or locally run jails and prisons, juvenile correctional facilities, state or locally run mental health facilities, state or locally run developmental disability and mental		defendant. The Commission would also amend the federal sentencing guidelines to provide between a 2, 3, or 4-level increase in the offense level (depending on the amount of the loss) for defendants convicted of these offenses, or otherwise amend the guidelines and policy statements if it is appropriate. In carrying out these requirements, the Commission would be required to meet certain additional standards. These standards include ensuring that the guidelines and statements provide for increased penalties for persons convicted of health care fraud offenses under appropriate circumstances, and that there is reasonable consistency with other relevant directives and guidelines under the Federal Sentencing Guidelines. With respect to section 242 of HIPAA, a person would not need to have actual knowledge of the section or specific intent to commit a violation of this section. Certain additional offenses would be deemed federal health care fraud offenses. These offenses include the federal anti-kickback statute under section 1128B of the Social Security Act (42 U.S.C. § 1320a-7b), section 1349 of the U.S. Criminal Code (attempting or conspiring to commit a criminal offense), section 301 of the Federal Food Drug and Cosmetic Act, or section 501 of ERISA. The legislation would also amend certain subpoena authority relating to health care. First, the requirement that a subpoena be furnished to a grand jury would be removed under 18 U.S.C. § 1510. Thus, an officer of a financial institution that intends to obstruct a judicial proceeding and notifies another person about the existence or contents of a subpoena for records of that financial institution, or information that has been furnished in response to that subpoena, could be fined or imprisoned not more than 5 years, or both. In addition, the Attorney General (or, at the direction of the Attorney General, any officer or employee of the Department of Justice) could require access by subpoena to any institution that is the subject of an

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retardation facilities, and state or locally run nursing homes.		investigation under CRIPA and to any document, record, material , file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report relating to any institution that is the subject of an investigation under the Act to determine whether there are conditions which deprive persons residing in or confined to the institution of constitutional rights, privileges, or immunities or federal laws. Requirements for the issuance and enforcement of subpoenas would apply. The various information obtained under a subpoena under this section of the bill could not be used for any purpose other than to protect the constitutional and legal rights, privileges, or immunities of persons who reside or will reside in an institution, and the DOJ could not transmit this information for any other purpose. If the information is transmitted by the DOJ and used in a publicly available manner, it would have to be altered to prevent the disclosure of personally identifiable information.

Subtitle C – Enhanced Program and Provider Protections.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Enhanced CMS program protection authority. Current Law: CMS has implemented regulations requiring providers and suppliers to complete an application to enroll in the Medicare program and receive billing privileges. As part of the enrollment process, providers and suppliers are required to submit information necessary to verify identity and state licensure. CMS reserves the right to perform on-site inspections of a provider or supplier to verify compliance with standards. If enrollment requirements are not met, CMS may revoke Medicare billing privileges.	*H. §1631.* **Overview.** Beginning January 1, 2011, this provision would provide the Secretary with the authority to impose the following types of measures on providers and suppliers enrolling and re-enrolling in Medicare, Medicaid, and CHIP: 1) screening, 2) enhanced oversight, and 3) moratoriums on enrollment. The Secretary would have the authority to impose these measures in instances where there is a significant risk of fraud with respect to a single category of providers or suppliers or a category of providers or suppliers operating within a	*S. §6401.* Similar provision, with the following exceptions:

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Providers and suppliers must resubmit and recertify the accuracy of their enrollment information every 5 years. CMS may deny a provider's or supplier's enrollment in Medicare or revoke a provider's billing privileges for the following reasons: non-compliance with enrollment requirements, exclusion from participation in Federal health care programs, conviction of a felony, or the submission of false or misleading information on the enrollment application. CMS manual instructions require that Medicare contractors query the following databases prior to approving an application for enrollment in Medicare: Qualifier.net, the Medicare Exclusions Database (List of Excluded Individuals/Entities or LEIE), and the Government Services Administration (GSA) debarment list. All Medicare contractors are required to query these databases when enrolling providers in the program. Medicaid beneficiaries may obtain services from any Medicaid participating provider recognized by the state. In addition, for Medicaid beneficiaries enrolled in a primary care case management system, a Medicaid managed care organization, or similar entity, must not restrict the choice of a qualified provider of family planning services and supplies (with some other exceptions). States are not required to provide Medicaid coverage for such services when offered by persons or entities convicted of felonies.	specific geographic area. **Screening.** With respect to screening, the Secretary would be required to establish procedures for how screening would be conducted. The types of screening may include licensing board checks, screening against the List of Excluded Individuals (LIEI), background checks, and unannounced pre-enrollment or other site visits. **Enhanced Oversight.** The Secretary would also be required to establish procedures for enhanced oversight. During periods of enhanced oversight (between 30 days	**Screening.** Within 180 days after the date this legislation is enacted, the Secretary would be required to establish procedures for how screening would be conducted. The Secretary would be required to develop these procedures in consultation with the OIG. Screening would be required to include a licensure check (which may include checks across states). Screening may include a criminal background check, fingerprinting, unscheduled and unannounced site visits (including pre-enrollment), database checks, and screening deemed appropriate by the Secretary. Unlike the House version, to cover the costs of the screening, the provision mandates that providers and suppliers be subject to fees. Fees would start at $200 in 2010 for individual providers (i.e. physicians), and $500 for institutional providers. Beginning in 2011, fees would increase annually by the percentage change in the CPI. The Secretary could, on a case-by-case basis, exempt such fees if they would impose a hardship. The Secretary would be required to use the funds collected for program integrity efforts. The provision would establish different effective dates for new and current providers as well as providers and suppliers revalidating their enrollment. New providers would be subject to the revised screening requirements within one year from the date this legislation is enacted. Current providers would be subject to the revised screening requirements within 2 years and providers re-validating their enrollment within 6 months. Providers and suppliers that have not been screened within three years from the date this legislation is enacted could not be enrolled or re-enrolled in any of the three programs. **Enhanced Oversight.** Similar except the provision specifies that the provision would apply to new providers. Also, the provision does not include the

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	and one year) the Secretary would be authorized to take certain actions against providers, including required or unannounced site visits or inspections, prepayment review, enhanced review of claims, and other actions as specified by the Secretary. The Secretary would be allowed to extend these periods to more than one year if necessary. The provision includes a specific requirement applicable to DME suppliers. Beginning January 1, 2011, the Secretary would be required to withhold payment to new DME suppliers for 90 days if that DME supplier resides in a geographic area or is within a category of providers determined to be at high risk of fraud by the Secretary. **Enrollment Moratorium.** In instances of serious ongoing fraud, the Secretary would have the authority to impose a moratorium on enrolling providers within a category of providers and suppliers, including a category within a specific geographic area. Moratoriums could not be imposed if the Secretary makes a determination that the moratorium would adversely impact access to care. **Medicaid and CHIP.** The Secretary would be authorized to require states to implement these program safeguards as a requirement in their Medicaid or CHIP state plans. State CHIP plans would also be required to include their procedures for enforcing these requirements. Any actions taken or determinations made by the Secretary in imposing these requirements would not be subject to judicial review. Additionally, states would be allowed to conduct enhanced oversight activities beyond those required by the Secretary.	special 90-day period of enhanced oversight applicable to DME suppliers. *Disclosure Requirements.* The provision would impose new disclosure requirements on providers and suppliers enrolling or re-enrolling in Medicare, Medicaid, or CHIP. Applicants would be required to disclose current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in Medicare, Medicaid, or CHIP, or has had their billing privileges revoked. The Secretary would be authorized to adjust payments or deny enrollment in these programs if these affiliations pose an undue risk to the program. **Enrollment Moratorium.** Substantially similar, except does not include the prohibition on the Secretary imposing moratoriums if they might adversely impact access to care. **Medicaid and CHIP.** Medicaid state plans would be required to specify that the state would comply with these provider and supplier screening, oversight, and reporting requirements. They would also be required to specify that the state: (1) complies with the Secretary-established process for screening providers and suppliers; (2) complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers; (3) requires Medicaid providers and suppliers to comply with these disclosure requirements; (4) complies with any Secretary-imposed temporary moratorium on the enrollment of new providers or suppliers and, at the state's option, the

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		state imposes, on participation agreements, periods of enrollment moratoria or numerical caps or other limitations for providers or suppliers identified by the Secretary as being at high-risk for fraud (states would be exempted from compliance with these requirements when it determines that compliance would impact beneficiaries' access to Medicaid); (5) requires providers and suppliers to establish a compliance program that contains certain core elements of Medicare compliance requirements; (6) complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of CMS, in accordance with regulations of the secretary; and**,** (7) requires all ordering or referring physicians or other professionals to be enrolled in Medicaid as a participating provider and that the national provider identifier of any ordering or referring physicians or other professional be specified on any claim for payment that is based on an order or referral of the physician or other professional., and (8) the state plan would specify that this subsection would not preclude or limit the ability of the state to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond these required the Secretary. The CMS Administrator would also be required to establish a process for making available to each Medicaid and CHIP state agency the name, national provider identifier, and other identifying information, or any provider of medical or other items or services or supplier that is terminated from participation under Medicare, Medicaid or CHIP within 30 days, and, with respect to all such providers or suppliers terminated from Medicare on the date of enactment of this Act, within 90 days (these requirements would be effective on the date of enactment).

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Enhanced Medicare, Medicaid, and CHIP program disclosure requirements relating to previous affiliations. Current Law: In order to receive payment from Medicare, providers must enroll in the Medicare program. CMS regulations mandate that enrollment applications contain information necessary to uniquely identify the provider (i.e. proof of business name, social security number, or Tax ID number) and include documentation necessary to verify licensure or eligibility to furnish Medicare covered items or services. Persons who sign the enrollment applications are required to have an ownership or control interest in the provider or supplier. Upon initial enrollment in the program, the signature on the enrollment application must be that of an authorized official. Renewal or updated applications may be signed by a delegated official. CMS has the authority to perform on-site inspections of a provider to verify enrollment information and determine compliance with Medicare enrollment requirements. CMS has established an internet database called the Provider Enrollment, Chain and Ownership System (PECOS) for providers to submit enrollment information. Medicaid statute delegates the administration of the Medicaid program to the states. State Medicaid agencies determine whether a provider or supplier is eligible to participate in the Medicaid program by providing for written agreements with providers and suppliers. Written agreements require that providers and suppliers maintain specific records, disclose certain ownership information, and grant access to federal and state auditors to books and records.	*H. §1632.* **Disclosure.** This provision would require that providers and suppliers submitting applications to enroll or re-enroll in Medicare, Medicaid, or CHIP after July 1, 2011 disclose information related to any current or previous affiliation (within the last 10 years) with providers or suppliers that have uncollected debt, have been suspended or excluded from participating in such program, are subject to a payment suspension, or have had their billing privileges revoked. **Safeguards.** The Secretary would have the authority to apply program safeguards to these providers and suppliers, such as enhanced screening of claims, required or unannounced site visits and inspections, additional reporting requirements, and conditioning such enrollment on the provision of a surety bonds, if the Secretary determines that certain affiliations pose a risk of fraud, waste, and abuse. **Authority to Deny Enrollment.** The provision would also provide the Secretary with the authority to deny enrollment in Medicare, Medicaid, or CHIP in instances when at least one affiliation or affiliations poses a serious risk of fraud. **Appeal Rights.** No provision.	*S. §6401(a).* **Disclosure.** Similar provision except: 1) the effective date of the provision would be on or after the date that is one year from the date the legislation is enacted, 2) there is no limit on disclosures to previous affiliations within the last 10 years, and 3) the provision would apply to any current or previous affiliation with a provider or supplier that has uncollected debt, that has been subject to a payment suspension under any federal health care program, that has been excluded from participating in Medicare, Medicaid, or CHIP, or has had their billing privileges revoked. **Safeguards.** The provision also does not grant the Secretary the explicit authority to apply additional program safeguards to providers and suppliers that disclose certain affiliations. **Authority to Deny Enrollment.** The provision would grant the Secretary the authority to deny enrollment if an affiliation poses an undue risk of fraud, waste, and abuse. **Appeal Rights.** The provision provides that a denial would be subject to an appeal.
Required inclusion of payment modifier for certain evaluations and management services. Current Law: Evaluation and management services include certain primary care services, hospital inpatient medical services, consultations, other visits, preventive	*H. §1633.* This provision would require the Secretary to establish a payment modifier under the fee schedule for evaluation and management services that result in the ordering of additional services (i.e. lab tests), prescription drugs,	No provision.

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medicine visits, psychiatric services, emergency care facility services, and critical care services.	DME, or other services determined by the Secretary to be at high risk of fraud, waste, and abuse. The Secretary would be authorized to require providers and suppliers to report the payment modifier on claims.	
Evaluations and reports required under Medicare Integrity Program. Current Law: Medicare statute authorizes the establishment of the Medicare Integrity Program or MIP. MIP requires the Secretary to enter into contracts with private entities to conduct a variety of program integrity activities for the Medicare program including auditing providers, reviewing claims for medical necessity, and identifying and investigating alleged fraud. MIP was established along with the HCFAC program by HIPAA, which sought to increase and stabilize federal funding for health care anti-fraud activities.	*H. §1634.* For the contract year beginning in 2011, this provision would require MIP contractors to assure the Secretary that they will conduct periodic evaluations of the effectiveness of their activities. Annual reports would be required to be submitted to the Secretary.	*S. §6402(j).* Similar provision except more prescriptive. This provision would require MIP contractors to provide the Secretary and the OIG with performance statistics, including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment for such activities. The Secretary would also be required to conduct evaluations of eligible entities at least every 3 years. Finally, no later than 6 months after the end of each fiscal year beginning in 2011, the Secretary would be required to submit a report to Congress describing the use and effectiveness of MIP funds.
Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse. Current Law: Since 1998, the OIG has been issuing a series of compliance guidance documents for providers participating in federal health care programs to assist in preventing fraud, waste, and abuse. The purpose of the documents is to encourage health care providers to adopt compliance programs and internal control measures to monitor their adherence to applicable rules, regulations, and requirements. The adoption of these programs is not mandatory. There is no current law explicitly directing health care providers to adopt compliance programs.	*H. §1635.* This provision would prohibit the Secretary from enrolling or re-enrolling a provider or supplier in Medicare that has not established a compliance program, except physicians and skilled nursing facilities, to reduce fraud, waste, and abuse. The Secretary, in consultation with the OIG, would be required to establish the core elements for these provider compliance programs. Requirements may include written policies, procedures, and standards of conduct; a designated compliance officer and compliance committee; training and education on fraud, waste and abuse for employees and contractors; a confidential mechanism (i.e. hotline) for receiving compliance questions and reports; guidelines for enforcing standards; internal monitoring and auditing procedures applicable to providers and contractors; and procedures for 1) ensuring prompt responses to detected and potential offenses, 2) developing corrective action initiatives, and 3) returning all identified Medicare, Medicaid, and CHIP overpayments. The Secretary would be required to develop a timeline for the establishment	*S. §6401(a)(3).* Similar provision with the following exceptions: 1) the mandate to establish a compliance program would apply to providers and suppliers participating in Medicaid and CHIP in addition to Medicare, 2) the provision is narrower in scope in that it would only apply to providers and suppliers within a particular industry or category, 3) the Secretary would be required to develop a timeline for implementation for each provider based on the extent to which compliance programs have been adopted by the providers within that industry or category, and 4) the provision does not specify an exemption for physicians and skilled nursing facilities.

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	of these requirements and the date by which providers and suppliers would be required to have a compliance program in place. The provision would also authorize the Secretary to conduct a pilot program, prior to mandating these requirements, to test the establishment of compliance programs for certain categories of providers that the Secretary has determined to be at high risk for fraud, waste, and abuse.	
Maximum period for submission of Medicare claims reduced to not more than 12 months. Current Law: Medicare statute requires that payments only be made, except in certain circumstances, to Medicare eligible providers and only if a written request for payment is filed within three calendar years after the year in which the services were provided. The Secretary is authorized to reduce this period to no less than one year if it deems it necessary for the efficient administration of the program. As established by CMS regulations, in general, the time limit on submitting a claim for payment is the close of the calendar year after the year in which the services were furnished.	*H. §1636.* The provision would reduce the time period for filing a written request for payment from three calendar years to one calendar year for services provided under Medicare Parts A and B. The Secretary would have the authority to specify exceptions to this one year period. The provision would also add a new requirement for MA and PDP plans. Contracts with MA organizations and PDP sponsors would be required to mandate that any provider under contract with, in partnership with, or affiliated with the MA organization or PDP sponsor ensure that a written request for payment be submitted within one year from the date the services are provided. The provision would apply to services furnished on or after January 1, 2011.	*S. §6404.* Similar provision with two exceptions: 1) the provision would not apply to MA and PDP plans, and 2) the provision would apply to services furnished on or after January 1, 2010. For services furnished before January 1, 2010, the provision would require that claims be filed by December 31, 2010.
Physicians who order DME or HH services required to be Medicare enrolled physicians or eligible professionals. Current Law: CMS has implemented regulations requiring Medicare providers and suppliers to submit an application to enroll in the Medicare program in order to receive billing privileges. Providers and suppliers must resubmit and recertify the accuracy of their enrollment information every 5 years. Medicare statute defines eligible professional as a physician, certain types of practitioners (i.e. physician assistant, nurse practitioner, clinical social worker, and	*H. §1637.* For written orders and certifications made on or after July 1, 2010, physicians or eligible professionals who order DME or HH services would be required to enroll in the Medicare program. The Secretary would have the authority to extend these requirements to physicians and eligible professionals that order other categories of Medicare items and services, including covered Part D drugs, if the Secretary determines that it would help reduce fraud, waste, and abuse.	*S. §6405 as amended by §10604.* Identical provision.

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others), a physical or occupational therapist, qualified speech language pathologist, or a qualified audiologist.		
Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse. Current Law: In order to receive payment from Medicare, physicians are required to certify that certain types of services (e.g. home health) meet certain conditions. For example, prior to receiving payment for home health services, physicians are required to certify that the individual was confined to his or her home; that a plan for furnishing services to the individual has been established; and that such services were provided under the care of a physician. In the case of DME, the Secretary is authorized to require that payment be made for items and services only if a physician has communicated to the supplier a written order for the item. OIG has "permissive" authority to exclude an entity or an individual from a federal health program under numerous circumstances, including failing to supply documentation related to payment for items and services.	*H. §1638.* Beginning January 1, 2010 the Secretary would have the authority to disenroll, for no more than one year, a Medicare enrolled physician or supplier that fails to maintain and provide access to written orders or requests for payment for DME, certification for home health services, or referrals for other items and services to the Secretary. Medicare providers would be required to maintain and provide access to documentation relating to these written orders or requests for payment. The provision would also extend the OIG's permissive exclusion authority to include individuals or entities that order, refer, or certify the need for health care services that fail to provide adequate documentation to the Secretary to verify payment.	*S. §6406.* Identical provision.
Face-to-face encounter with patient required before eligibility certifications for home health or durable medical equipment services. Current Law: In order to receive payment from Medicare, physicians are required to certify that specified services (i.e. home health) meet certain conditions. For example, prior to receiving payment for home health services, physicians are required to certify that the individual was confined to his or her home; that a plan for furnishing services to the individual has been established; and that such services were provided under the care of a physician. In the case of DME, the Secretary is authorized to require that payment be made for items and services only if a physician has	*H. §1639.* This provision would require that after January 1, 2010, physicians or, in the case of DME, authorized eligible health care professionals, have a face-to-face encounter (including through telehealth and other than with respect to encounters that are incident to services involved) with the individual prior to issuing a certification or re-certification for home health services or DME as a condition for payment under Medicare Parts A and B. The provision would also apply to physicians making home health certifications in Medicaid and CHIP and written orders for DME. Physicians must document that they had the face-to-face	*S. §6407 as amended by §10605.* Similar provision, except the provision includes different timeframes for the face-to-face encounter. For those providers furnishing home health services that are paid under Part A, physicians would be required to document that they had a face-to-face encounter with the patient within a reasonable time frame; for providers furnishing home health services under Part B, physicians would be required to document that they had a face-to-face encounter within the 6-month period preceding the certification. In the case of DME, physicians would be required to document that a physician, physician assistant, nurse practitioner, or clinical nurse specialist had a face-to-face encounter during the 6-month period

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communicated to the supplier a written order for the item.	encounter with the individual during the 6-month period preceding the certification, or other reasonable timeframe as determined by the Secretary. The Secretary would be authorized to apply the face-to-face encounter requirement to other Medicare items and services based upon a finding that doing so would reduce the risk of waste, fraud, and abuse.	preceding the certification. The provision would not apply to CHIP. The provision would also specify that eligible professionals would include nurse practitioners or clinical nurse specialists who are collaborating with the physician, a certified nurse midwife, or physician assistant as defined in statute.
Extension of testimonial subpoena authority to program exclusion investigations. Current Law: As mentioned above, Section 1128 of the SSA provides that the Secretary (and through delegation, OIG) has the authority to exclude individuals and entities from participation in federal health care programs under a variety of circumstances. Exclusion is mandatory for those convicted of certain criminal offenses, and generally the exclusion cannot be for a period of less than five years. OIG also has permissive authority to exclude an individual or entity from a federal health program, which includes the discretion to determine whether and for how long to impose an exclusion. Persons who may be subject to an exclusion are entitled to reasonable notice and a hearing, as well as judicial review of the Secretary's final determination. Sections 205(d) and (e) of the SSA provide the Commissioner of Social Security with certain subpoena authorities.	*H. §1640.* The provisions of 205(d) and (e) of the SSA would apply with respect to the Department of Health and Human Services Secretary's program exclusion authority. Thus, the Secretary would be able to issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence that relates to matters under investigation or in question by the Secretary. The Secretary would also have the ability to delegate this authority to the Inspector General of HHS and the Administrator of CMS for the purposes of a program exclusion investigation. Certain requirements regarding the serving of subpoenas and compensation for subpoenaed witnesses may apply. This section would also provide for judicial enforcement of subpoenas. This provision would apply to investigations beginning on or after January 1, 2010.	*S. §6402(e).* Same provision as House, except no specified effective date.
Required repayments of Medicare and Medicaid overpayments. Current Law: Medicare statute specifies that identified overpayments to providers or suppliers that are not paid within 30 days of the date of the overpayment determination will accrue interest on the balance of the overpayment at the rate applicable to late payments established by the Treasury. Under current Medicaid law, when states discover that overpayments have been made to individuals or other	*H. §1641.* This provision would require that any person who knows of an overpayment to report and return the overpayment, along with notification for the reason for the overpayment, to the Secretary, the State, an intermediary, a carrier, or a contractor. Overpayments would be required to be reported and returned within 60 days of the date of the overpayment determination. Overpayments returned after the 60 days would create an obligation as defined in section 3729(b) (3) of title 31 of the USC. If it is determined that the reason for the	*S. §6402(a).* Substantially similar provision except establishes a different deadline for reporting overpayments for providers that submit cost reports for payment. The deadline for reporting and returning overpayments would be 60 days from the date on which the overpayment was identified or the date any corresponding cost report is due, if applicable.

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entities, they have 60 days to recover or attempt to recover the overpayment before an adjustment is made to their federal matching payment. Adjustments in federal payments are made at the end of the 60 days, whether or not recovery is made. When states are unable to recover overpayments because the debts were discharged in bankruptcy or were otherwise uncollectable, federal matching payments would not be adjusted.	overpayment was related to fraud, repayment would not limit the provider or supplier's liability for additional administrative obligations such as interest, fines, penalties, or civil and criminal sanctions.	
Expanded application of hardship waivers for OIG exclusion to beneficiaries of any Federal health care program. Under section 1128 of the SSA, the Secretary (and, through delegation, OIG) has the authority to exclude individuals and entities from participation in federal health care programs. Exclusions from federal health programs are mandatory under certain circumstances, and permissive in others. Subject to exceptions, in the case of a mandatory exclusion, the minimum period of exclusion cannot be less than five years. However, under section 1128(c)(3)(B) of the SSA, upon the request of a federal health care program administrator who determines that the exclusion would impose a hardship on individuals entitled to benefits under Medicare Part A or enrolled under Medicare Part B (or both), the Secretary may, after consultation with the Inspector General of HHS, waive the exclusion under certain circumstances with respect to that program, in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.	*H. §1642.* Under section 1128(c)(3)(B) of the SSA, the Secretary would, in accordance with the requirements of the section, be able to waive a mandatory exclusion period where a hardship is imposed on beneficiaries of federal health care programs, in addition to those entitled to benefits under Medicare Part A and Part B.	*S. §6402(k).* Identical provision.
Access to certain information on renal dialysis facilities. Current Law: No provision.	*H. §1643.* This provision would require End State Renal Disease Facilities to provide the Secretary with access to information relating to any ownership or compensation arrangement between the facility and the medical director of such facility or between the facility and any physician for the purposes of an audit or evaluation.	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Billing agents, clearinghouses, or other alternate payees required to register under Medicare. Current Law: CMS has implemented regulations requiring Medicare providers and suppliers to submit an application to enroll in the Medicare program in order to receive billing privileges. The enrollment application requires that providers and suppliers include the names, addresses, and tax ID numbers for billing agencies on their applications.	*H. §1644.* Beginning January 1, 2012, this provision would require billing agencies, clearinghouses, or other payees that submit Medicare or Medicaid claims on behalf of a health care provider to register with the Secretary in a form and manner as determined by the Secretary.	No provision.
Conforming CMPs to FCA amendments. The recently enacted Fraud Enforcement and Recovery Act of 2009 (FERA), P.L. 111-21, made several amendments to the False Claims Act (FCA) that, according to legislative history, were intended to clarify the meaning of several provisions of the FCA in light of judicial interpretations of the statute that ran contrary to congressional intent and limited the scope of the law. These amendments made by FERA expanded the types of conduct that may lead to FCA liability.	*H. §1645.* This section would make similar changes to section 1128A of the SSA. Among the changes, the bill would amend section 1128A(a)(1) to remove the requirement for presentment of a claim to government officers, employees, agents, or agencies in order to be liable for CMPs. The bill would create a new section 1128A(a)(12), which would impose CMPs on a person who conspires to commit a violation of section 1128A. In addition, a new section 1128A(a)(13) would provide that a person who knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to a federal health care program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to a federal health care program can be subject to CMPs. The bill would also expand the reach of section 1128A(a)(4), under which a person excluded from participating in a federal health care program (in addition to Medicare or a State health care program) who retains ownership in an entity participating in the program, or is an officer or managing employee of such an entity, would be subject to CMPs. Under section 1128A(c)(1), the Secretary could initiate a proceeding to determine whether to impose a civil monetary penalty, assessment, or exclusion for an occurrence up to ten years, instead of six years under current law, after the occurrence took place.	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Requiring provider and supplier payments under Medicare to be made through direct deposit or EFT at insured depository institutions. Current Law: There is no statutory requirement for EFT under Medicare, however CMS manual instructions require that all new providers and suppliers entering the Medicare program enroll in EFT.	*H. §1646.* Beginning July 2012, this provision would prohibit payment to any provider or supplier billing Medicare unless the payment is made through EFT or direct deposit.	No provision.
Inspector General for the Health Choices Administration. Current Law: No provision.	*H. §1647.* This section would create an Inspector General (IG) for the Health Choices Administration, who would be appointed by the President, by and with the advice and consent of the Senate. This section would add the Health Choices Administration to the list of establishments in the IG Act of 1978, as amended, and would also add the Commissioner of the Health Choices Administration to the list of establishment heads in that act. In addition to the authorities provided to IGs of establishments in the IG Act of 1978, as amended, the IG would have the authority to conduct, supervise, and coordinate audits, evaluations, and investigations of the programs and operations of the Health Choices Administration, including matters relating to fraud, abuse, and misconduct in connection with the admission and continued participation of any health benefits plan participating in the Health Insurance Exchange. The IG also would have the authority to conduct audits, evaluations, and investigations relating to any private Health Insurance Exchange-participating health benefits plan. In consultation with the HHS IG, the IG for the Health Choices Administration would have the authority to conduct audits, evaluations, and investigations relating to the public health insurance option. The IG would also have access to all relevant records, including records relating to claims paid by the health benefits plans that participate in the Health Insurance Exchange. The authorities that would be granted to the Health	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	Choices Administration and the IG would not limit the duties, authorities, and responsibilities of the HHS IG, as in existence as of the date of enactment of the act, to oversee HHS programs and operations. The HHS IG would retain primary jurisdiction over fraud and abuse in connection with payments made under the public health insurance option. This provision would be effective in the date of enactment of this legislation.	
Data matching. Current Law: Currently, claims and payment data for Medicare and Medicaid are housed in multiple databases. CMS is in the process of consolidating information stored in these databases into an Integrated Data Repository (IDR). According to the agency's website, the eventual goal of the IDR is to support an integrated data warehouse containing data related to Medicare & Medicaid claims, beneficiaries, providers, and health plans.	No provision.	*S. §6402(a).* The provision would require CMS to include in the IDR claims and payment data from the following programs: Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), Social Security, and the Indian Health Service (IHS). The priority would be the integration of Medicare and Medicaid claims and payment data. Data for the remaining programs would be integrated as appropriate. The Secretary would be required to enter into data sharing agreements with the federal agencies listed above for the purposes of identifying fraud, waste, and abuse. This provision would grant the OIG and the DOJ explicit access to Medicare, Medicaid, and CHIP payment and claims data for the purposes of conducting law enforcement and oversight activities. The provision would also grant the OIG the authority to obtain information (i.e. supporting documentation, medical records, etc.) from any individual that directly or indirectly provides medical services payable by a Federal health care program.
Matching agreements with the Commissioner of Social Security. Current Law: No provision.	No provision.	*S. §6402(b)(3).* The provision would require the Commissioner of Social Security, upon request, to enter into an agreement with the Secretary of HHS or the OIG to match data in the system of records. The agreement would be required to include safeguards to maintain confidentiality.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Inclusion of national provider identifier (NPI) on all applications and claims. Current Law: Health care providers often have many different provider numbers, one for billing each private insurance plan or public health care program. The administrative simplification provisions of HIPAA required the adoption and use of a standard unique identifier for health care providers or National Provider Identifier (NPI). All health care providers who are considered covered entities under HIPAA were required to obtain and submit claims using an NPI as of May 2007.	No provision.	*S. §6402(a).* The provision would require the Secretary to issue a regulation by January 1, 2011 mandating that all Medicare and Medicaid providers include their NPI on all claims and enrollment applications.
Withholding of federal matching payments for states that fail to report enrollee encounter data in the Medicaid Statistical Information System. Current Law. Under the Medicaid Statistical Information System (MSIS), states submit their person-specific Medicaid eligibility and claims data on a quarterly basis to the Secretary. This information is designed to provide CMS with a detailed national database of program information capable of supporting a broad range of analytic and user needs. Until the passage of the Balanced Budget Act of 1997 (BBA 97), participation in MSIS was voluntary. BBA 97 required States to participate in MSIS, effective January 1, 1999.	No provision.	*S. §6402(c).* Federal matching payments would not be made to states for services about which the enrollee encounter data (as defined by the Secretary) is not submitted to MSIS by the states in a timely manner (as determined by the Secretary).
Suspension of Medicare and Medicaid payments pending investigation of credible allegations of fraud. Current Law: CMS and its contractors have the authority to withhold payment in whole or in part if there is reliable evidence of an overpayment or fraud. CMS regulations stipulate the procedures CMS and its contractors must follow when deciding to suspend payment.	No provision.	*S. §6402(h).* The Secretary would have the authority to suspend payments to a provider or supplier pending a fraud investigation, except when there is not good cause. The Secretary would be required to consult with the OIG in determining whether there is a credible allegation of fraud. The provision would require the Secretary to promulgate regulations to implement this mandate.
Expansion of the Recovery Audit Contractor (RAC) Program.	No provision.	*S. §6411* The provision would require that the RAC program be

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Current law: Recovery Audit Contractors, or RACs, are private organizations that contract with CMS to identify and collect improper payments made in Medicare Parts A and B. Congress originally required the Secretary to conduct a three-year demonstration program using RACs in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). In December 2006, Congress passed the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432), which made the program permanent and mandated the expansion of RACs nationwide by January 1, 2010. Medicare pays RACs differently than it pays other administrative contractors. Historically, Medicare's administrative contractors have been paid a fixed annual budget for a defined scope of work. In contrast, Congress mandated that CMS pay RACs using contingency fees. A contingency fee is a negotiated payment, typically a percentage, for every overpayment recovered. There is no requirement in current law for states to establish recovery audit contractor (RAC) programs under the Medicaid program.		expanded to Medicare Parts C and D and Medicaid not later than December 31, 2010. **Medicare.** Among the requirements for Medicare Part C and D RACs, would be ensuring that each Medicare Advantage or PDP plan have in place an anti-fraud plan, reviewing the allowability of reinsurance payments made to Part D plans, and comparing Part D plan's enrollment estimates for high cost beneficiaries. **Medicaid.** Regarding Medicaid, states would be required to establish contracts, consistent with state law, and similar to the contracts the Secretary has established for the Medicare RAC program, with one or more RACs. These state RACs would identify underpayments, overpayments, and recoup overpayments made for services provided under state Medicaid plans as well as waivers. The state Medicaid RAC program would be subject to exceptions and requirements the Secretary may establish for the state RAC program. In addition, states would be required to make certain assurances for their Medicaid RAC programs, including that (I) under such contracts, payment would be made to such a contractor only from amounts recovered; (II) from such amounts recovered, payment—would be made on a contingent basis for collecting overpayments; and may be made in such amounts as the State may specify for identifying underpayments; (III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and (IV) such program is carried out in accordance with such requirements as the Secretary would be required to specify, including that amounts expended by the state to carry out the program would be considered amounts expended as necessary for the proper and efficient

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		administration of the state plan or a waiver of the plan; among others. The Secretary, acting through the Administrator of CMS, would be required to coordinate the expansion of the Recovery Audit Contractor program to Medicaid with states, particularly with respect to each state that enters into a contract with a recovery audit contractor for purposes of the State's Medicaid program prior to December 31, 2010. The Secretary would be required to promulgate regulations to carry out this subsection and the amendments made by this subsection, including with respect to federal financial participation, as specified by the Secretary. The Secretary, acting through the Administrator of CMS, would be required to submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program under Medicaid and Medicare and would be required to include recommendations for expanding or improving the program.
Modernizing computer and data systems of CMS to support improvements in care delivery. Current Law: Currently, claims and payment data for Medicare and Medicaid are housed in multiple databases. CMS is in the process of consolidating information stored in these databases into an Integrated Data Repository (IDR). According to the agency's website, the eventual goal of the IDR is to support an integrated data warehouse containing data related to Medicare & Medicaid claims, beneficiaries, providers, and health plans.	No provision.	*S. §10330.* The provision would require the Secretary to develop a plan along with a budget to modernize the computer and data systems of CMS. In developing the plan, the Secretary would be required to consider how such a system could make data available in a timely and reliable manner to providers and suppliers to support their efforts to better manage and coordinate care, and support consistent evaluations of payment and delivery system reforms. The Secretary would be required to post the plan on the CMS website within 9 months from the date this legislation is enacted.

Subtitle D – Access to Information Needed to Prevent Fraud, Waste, and Abuse.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Access to information necessary to identify fraud, waste, and abuse. Current Law: The Government Accountability Office (GAO)—with more than 3,100 staff positions and an annual budget exceeding $507 million in FY2008—is the largest of several support agencies that provide research, review, and analysis for Congress. GAO operates under the control and direction of the Comptroller General of the United States (CG). Sometimes called "Congress's watchdog" and its "investigative arm," GAO provides a variety of services to Congress including oversight, investigation, review, and evaluation of executive programs, operations, and activities. In order to fulfill its mission, the Government Accountability Office has been given broad powers to gain access to information and materials of government entities, based on its original authority as well as later supplements (31 U.S.C. 712 and 716). MA and PDP plans are required to furnish to the Secretary certain information as a condition for payment. This information may be used by officers, employees, and HHS contractors only for the purposes of, and to the extent necessary, determining these payments. Every contract with a MA or PDP plan is required to provide that the Secretary have access to and have the right to inspect and audit any books and records of the plan related to costs.	*H. §1651.* The provision would clarify the CG's access to obtain any information, inspect any record, or interview any officer or employee under Section 716 of Title 31 of U.S.C. with respect to information obtained by the Secretary related to Medicare Part C and Part D. The provision would expand access to Part D data that's furnished to the Secretary as a condition for payment to include the OIG, the CMS Administrator, and the DOJ for conducting program integrity and fraud control activities under Medicare and Medicaid.	*S. §6402(a) and (b).* S. §6402(b). Substantially similar, except the provision does not include a separate clause clarifying access to this information for the CG. Additionally, the provision grants access to the DOJ and GAO for the purposes of carrying out health oversight activities more generally. S. §6402(a) also includes an additional clause which adds a section to Title XI Section 1128, that mandates access to HHS claims and payment data related to Medicare, Medicaid, and CHIP for the OIG and the Attorney General for the purposes of conducting law enforcement and oversight activities. The OIG would also have the authority to obtain information from any individual (including a beneficiary or entity) that is a: 1) provider, supplier, grant recipient, contractor or subcontractor, or 2) that directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies, or receives an item or service payable by any Federal health care program. This would include access to any supporting documentation necessary to validate claims for payment under Medicare or Medicaid.
Elimination of duplication between Healthcare Integrity and Protection Databank (HIPDB) and the National Practitioner Databank (NPDB). Current Law: Medicare statute requires the Secretary to develop and maintain a national health care fraud and abuse data collection program for the reporting of	*H. §1652.* This provision would require the Secretary to establish a process to terminate the HIPDB immediately upon enactment of this legislation. The Secretary would be required to ensure that the information that was formerly collected in the HIPDB is transferred to the	*S. §6403.* The provision essentially accomplishes the same objective - terminating the HIPDB and transferring the data in the HIPDB to the NPDB - but is more prescriptive and makes a number of technical modifications to the statute. For example,

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
adverse actions taken against health care providers or suppliers. The OIG issues regulations implementing the Health Care Integrity and Protection Data Bank (HIPDB). The statute requires the following types of health care related adverse actions be reported to the HIPDB - civil judgments, federal or state criminal convictions, actions taken by federal or state licensing agencies, and provider exclusions from Medicare and Medicaid. Only final adverse actions are reportable to the HIPDB. Administrative fines, citations, corrective action plans, and other personnel actions are not reportable except under certain circumstances. Settlements, in which a finding of liability has not been established, are also not reportable. Both federal and state government agencies as well as health plans are required to report to the HIPDB. Health plans that fail to report are subject to a civil monetary penalty of $25,000. The Secretary is authorized to charge fees to access information in the database. However, fees cannot apply to requests from federal entities. HIPDB cannot duplicate the reporting requirements established for the NPDB. Title IV of the Health Care Quality Improvement Act of 1986, as amended, established the National Practitioner Data Bank (NPDB). The NPDB contains data related to the professional competence of healthcare practitioners. The types of information included in the NPDB are medical malpractice payments, adverse licensure actions, adverse clinical privileging actions, adverse professional society membership actions, and exclusions from Medicare and Medicaid. The statute defines the entities eligible to report and query the databank. Malpractice payers that fail to report are subject to a CMP. Section 1921 of the SSA expanded the scope of reporting requirements for the NPDB to encompass additional adverse licensure actions and actions taken by State licensing and certification agencies, peer review organizations, and private accreditation organizations.	NPDB. Requirements pertaining to the establishment of the HIPDB, such as rules for reporting information, the types of information that are reported, and rules for disclosure, would all apply to the NPDB upon termination of the HIPDB. The provision would eliminate the OIG's responsibility for reporting adverse actions to the database. After the Secretary certifies that the transition of information from the HIPDB to the NIPD is complete, any fees charged by the Secretary for access to the database would apply to federal agencies. The Department of Veterans Affairs (VA) would be exempted from these charges for one year. The transition would be funded from the fees collected to access the database and from additional amounts as necessary from the annual HCFAC appropriation available to the Secretary and the OIG. Funding would be available for one year after the enactment date of this legislation.	the provision expands the types of agencies and entities that would have access to information contained in the new NPDB to include federal and state health care programs, licensing authorities, Medicare Quality Improvement Organizations (QIOs), State Medicaid Fraud Control Units, hospitals and other health care entities, law enforcement officials, and the GAO (*the same agencies, authorities and officials that currently have access to adverse event information mandated for States to collect under section 1921*). When establishing the new NPDB, the provision would require that the Secretary provide for the maximum appropriate coordination between the current reporting requirements under the NPDB law and State reporting requirements under Section 1921. The provision would make modifications to State's current reporting requirements under Section 1921. Only state licensing, certification law, and fraud enforcement agencies would be required to report certain adverse actions to the State.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Section 1921 also required that actions taken against all health care practitioners be included in the databank. States are required to have a system for reporting adverse actions to the NPDB. Both databases are overseen by the Health Resources and Services Administration (HRSA) within HHS.		
Compliance with HIPAA privacy and security standards. Current Law: The HIPAA Privacy and Security Rules were promulgated by HHS pursuant to sections 262(a) and 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to establish national standards for the privacy and security of protected health information. The HIPAA Privacy and Security Rules apply primarily to covered entities—health plans, health care clearinghouses, and health care providers who transmit financial and administrative transactions electronically. Failure to comply with these regulations may result in civil or criminal penalties for covered entities. The HITECH Act, enacted as part of the American Recovery and Reinvestment Act, extends civil and criminal liability to business associates of covered entities for violations that occur on or after February 17, 2010. Business associates are defined as persons who perform, or assist in the performance of a function or activity involving the use or disclosure of individually identifiable health information on behalf of a covered entity. Examples of business associates include persons who perform legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.	*H. §1653.* The provision would mandate compliance with HIPAA privacy and security requirements and the Privacy Act of 1974 in carrying out the provisions of this subtitle.	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
The HIPAA Privacy Rule governs the disclosure of protected health information (PHI)—that is, individually identifiable health information "created or received by a [covered entity]" that "[r]elates to the ... health or condition of an individual" or to the provision of or payment for health care. A covered entity is permitted to use or disclose PHI without patient authorization for treatment, payment, or health care operations. For other purposes, a covered entity may only use or disclose PHI with patient authorization subject to certain exceptions. Exceptions permit the use or disclosure of PHI without patient authorization or prior agreement for public health, judicial, law enforcement, and other narrow purposes. The HIPAA Privacy Rule also requires covered entities and business associates to provide an accounting of certain disclosures; to make reasonable efforts to disclose only the minimum information necessary; to safeguard PHI from inappropriate use or disclosure; and to provide a notice of their privacy practices. Individuals also have a right to review and obtain copies of their PHI and to request corrections. The HIPAA Security Rule, applies only to PHI in electronic form (EPHI), and requires a covered entity or business associate to maintain administrative, technical, and physical safeguards to ensure the confidentiality, integrity, and availability of all EPHI the covered entity creates, receives, maintains, or transmits. The HITECH Act will also impose a breach notification requirement that is triggered when unsecured PHI or EPHI is compromised. This requirement is applicable to both covered entities and business associates and will become effective 30 days after HHS issues final regulations implementing this requirement. The Privacy Act of 1974 generally prohibits disclosures of records contained in a system of records maintained		

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
by a federal agency without the written request or consent of the individual to whom the record pertains. A system of records is a group of records under the control of an agency from which information is retrieved by the name of the individual or by some identifier assigned to the individual, such as a Social Security Number. The Privacy Act contains certain statutory exceptions, and a list of agency systems of records, including the routine uses of those records, is published in the Federal Register.		
Disclosure of Medicare Fraud and Abuse Hotline number on Explanation of Benefits. Current Law: The Secretary is required to provide Medicare beneficiaries with a clear and simple explanation of benefits on an annual basis. In addition to information on Medicare benefits and cost-sharing, the notice is required to include a statement indicating that beneficiaries should review their explanation of benefits for accuracy and report questionable charges by calling the OIG's fraud hotline.	*H. §1654.* Beginning July 1, 2011, this provision would transfer the toll-free fraud hotline from the OIG to the Secretary and require that the explanation of benefits include the new hotline number.	No provision.

Title IX – Miscellaneous Provisions.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Repeal of Trigger Provision. *Current Law.* The Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds are overseen by a board of trustees that reports annually to Congress on Medicare expenditures and revenues. As part of their analysis, as required by The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173, MMA), Subtitle A of title VIII, the	*H §1901.* This provision would repeal the 45% trigger provision in the MMA.	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
trustees must determine whether or not general revenue financing will exceed 45% of total Medicare outlays within the next seven years. MMA requires that if an excess general revenue funding determination is made for two successive years, the President must submit a legislative proposal to respond to the warning and Congress is required to consider the proposals on an expedited basis. On January 6, 2009, the House approved a rules package (H.Res. 5) that nullifies the trigger provision in the House for the 111th Congress.		
Repeal of Comparative Cost Adjustment (CCA) program. Current Law: The Medicare Prescription Drug,, Improvement, and Modernization Act of 2003 created a six-year program that will begin in 2010 to examine comparative cost adjustment (CCA) in designated CCA areas. Specifically, the program requires that payments to local MA plans in CCA areas be based, in part, on competitive bids (similar to payments for regional MA plans), and Part B premiums for individuals enrolled in traditional Medicare may be adjusted either up or down. This program is to be phased-in and there is also a 5% annual limit on the adjustment, so that the amount of the adjustment to the beneficiary's premium for a year can not exceed 5% of the amount of the monthly Part B premium in non-CCA areas.	*H. §1902.* This bill would repeal the Comparative Cost Adjustment program.	No provision.
Extend gainsharing demonstration. Current Law: Certain gainsharing demonstrations to evaluate arrangements between hospitals and physicians have been authorized. CMS is currently operating two projects, each consisting of one hospital in New York and West Virginia. Although authorized to begin on January 1, 2007, the project began on October 1, 2008 and was scheduled to end on December 31, 2009. The Secretary was required to submit mandated reports by certain due dates. The project was appropriated $6 million in FY2006 to be available for expenditure through FY2010.	*H. §1903.* The authority to conduct the gainsharing demonstration project in operation as of October 1, 2008 would be extended until September 30, 2011. The due date of the required interim report would be extended from December 1, 2008, to March 31, 2011 with the final report due on March 31, 2013. An additional $1.6 million would be appropriated in FY2010; all appropriations would be available through FY2014 or until expended.	*S. §3027.* Same provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Home visitation grants to states for quality home visitation programs for families with young children and families expecting children. Current Law: No provision.	*H. §1904* New SSA §440 Would amend Title IV-B of the SSA, which currently authorizes programs related to Child and Family Services, to create a Section 440 in a new "Subpart 3 – Support for Quality Home Visitation Programs."	*S. § 2951* New SSA § 511 Would amend Title V of the Social Security Act, which currently authorizes the Maternal and Child Health (MCH) block grant, to add a new Section 511 "Maternal, Infant, and Early Childhood Home Visiting Program."
	Purpose *New SSA §440(a)* The purpose of the new section would be to improve the well-being, health and development of children through provision of grants for the expansion of high quality programs providing voluntary home visitation for families with young children and those expecting children.	*New SSA § 511(a) and (c)(1)* The overall purpose of new section would be to strengthen maternal and child health services activities under Title V of the Social Security Act, improve coordination of services, and to identify and provide comprehensive services that improve outcomes for families in high-risk communities. Grants for early childhood home visitation programs would be made to promote improvements for families receiving home visitation services in the areas of maternal and child health, child development, parenting related to child development outcomes, school readiness, and socio-economic status and to reduce child abuse and neglect and injuries among those families.
	Funding and Reservations *New SSA §440(l) and (m)* Would appropriate $750 million for this program over five years as follows: $50 million for FY2010; $100 million for FY2011; $150 million for FY2012; $200 million for FY2013 and $250 million for FY2014. Would require HHS to annually reserve 5% for evaluation, training and technical assistance, and 3% of remaining funds for grants to support tribal home visitation programs.	*New SSA § 511(j)* Would appropriate $1.5 billion for this program over five years as follows: $100 million for FY2010; $250 million for FY2011; $350 million for FY2012; $400 million for FY2013 and $400 million for FY2014. Would require HHS to annually reserve 3% for evaluation, technical assistance and research; and 3% of appropriated amount to support tribal and Urban Indian Organization home visitation programs.
	Entities Eligible *New SSA §440(c) and (n)* The 50 states, District of Columbia, Puerto Rico,	*New SSA §511(k)(1)* Same as H.R. 3962 but also includes: Urban Tribal

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	American Samoa, Guam, Northern Mariana Islands, U.S. Virgin Islands, Indian tribes, and tribal organizations.	Organizations and, beginning with FY2012, certain non-profit organizations (but only in states where no early childhood home visitation grant has been awarded).
	Eligible Families *New SSA §440(f)(1)(A)* Would limit state's ability to claim federal support for home visitation services to those services provided on a voluntary basis to families with young children (under the age of school entry), and families expecting children.	*New SSA § 511(k)(2) and (e)(7)* Would define "eligible families" as 1) a woman who is pregnant, and the father of the expected child; 2) a parent or primary caregiver of a child under the age of entry to kindergarten, including grandparents, other relatives, and foster parents; or 3) a non-custodial parent of a child under kindergarten age if that parent has an ongoing relationship with, and at times provides physical care for, the child. Would require states to have procedures to ensure home visiting is provided on a voluntary basis.
	Statewide Assessment *New SSA § 440(b)(2)* Would require states, as a part of their application for a home visitation grant to submit to HHS the results of a statewide needs assessment that described: 1) Communities that are in high need of home visitation services; and 2) The number, quality, and capacity of home visitation programs, in the state, for families with young children and those expecting children; the number and type of families who are receiving services under the programs; sources and amount of funding provided to the programs; gaps in home visitation services in the state; and training and technical assistance activities designed to achieve or support the goals of the programs.	*New SSA § 511(b)* As a condition of receiving FY2011 funding under the MCH block grant, this section would require states (no later than six months after enactment) to conduct a statewide needs assessment. States would be required to submit the results of the assessment, along with a description of how they intend to respond to needs identified, to HHS. In the statewide needs assessment a state would be required to identify: 1) Communities with concentrations of: poor maternal, infant, or child health outcomes; child maltreatment; poverty; crime; domestic violence; high-school dropouts; substance abuse; or unemployment; 2) Substantively similar to H.R. 3962 except that the state would *not* need to identify sources and amount of funding provided to the current home visiting programs nor training and technical assistance activities designed to achieve or support the goals of the programs. 3) The state's capacity for providing substance abuse treatment and counseling services to individuals and

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		families in need of treatment or counseling services. The assessment would need to be separate from, but coordinated with, other assessments and inventories currently required under the MCH block grant, Head Start, and the Child Abuse Prevention and Treatment Act (CAPTA).
	Requirements Related to Evidence Base for Home Visitation Program Models Funded *New SSA § 440(f)* Generally, would only permit federal reimbursement for support of home visiting programs that adhere to clear evidence-based models of home visitation that have demonstrated positive effects on important program-determined child and parenting outcomes.	*New SSA § 511(d)(3)* Would permit these grant funds to be used only for home visitation programs that: 1) Conform to a clear and consistent home visitation model that has been in existence for at least 3 years, is grounded in empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards to ensure high quality service delivery and continuous program quality improvement, and that when evaluated using rigorous random control research designs has demonstrated significant and sustained positive outcomes on benchmark areas (described below) and those results have been published in a peer-reviewed journal; *or* 2) Use a model that meets all the above criteria *except* that the model was evaluated using a quasi-experimental research design and the results showed significant (but not necessarily sustained) positive outcomes and those results may have been (but were not necessarily) published in a peer-reviewed journal; *or* 3) Use a promising model or new approach to achieving positive outcomes for families served, has been developed or identified by a national organization or institution of higher education and which will be evaluated through well-designed and rigorous processes.
	States would be permitted to spend a declining share of the program funds for home visiting services that "do not adhere to a program model with the strongest	States would only be permitted to use up to 25% of their allotment of the federal funds for a promising model or new approach to achieving positive outcomes

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	evidence of effectiveness." For FY2010 that share would be 60% and it would decrease by 5 percentage points each year until it reached 40% for FY2014.	for families served (i.e. option 3 above).
	No provision.	HHS would be required to establish criteria for evidence of effectiveness and to ensure that the process for establishing the criteria is transparent and provides for public comment.
	Content of Home Visiting Services Funded *New SSA § 440(f)* Would require that programs eligible for federal reimbursement must provide parents with 1) knowledge of age-appropriate child development in cognitive, language, social, emotional, and motor domains and realistic expectations of age-appropriate child behaviors; 2) skills for interacting with their children to enhance age-appropriate development and to recognize and seek help related to developmental delays, health, and social, emotional, and behavioral issues; 3) knowledge of health and wellness issues for children and parents; 4) modeling, consulting, and coaching on parenting practices; and 5) activities designed to help them become full partners in the education of their children.	No provision.
	Other Requirements for Home Visiting Programs Funded *New SSA § 440(f)* Home visiting programs eligible for federal reimbursement must employ well-trained and competent staff; maintain high quality supervision; provide for ongoing training and professional development for staff; show strong organizational capacity to implement the program; monitor fidelity or implementation to ensure services are delivered according to the specific model; and establish appropriate linkages and referrals to other community resources and supports.	*New SSA § 511(d)(3)* Substantively same to H.R. 3962; would additionally specify that staff may be nurses, social workers, child development specialists, or others; that high quality supervision would be provided to establish home visitor competence; and that the ongoing training provided is to be specific to the model of home visitation being funded.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	Benchmarks No provision.	*New SSA § 511(d)(1)* This section would require states to establish three- and five-year benchmarks that can be used to demonstrate that the home visitation program results in improvements for eligible families served in each of the following areas: maternal and child health; prevention of child injuries and reductions in the number of emergency department visits; school readiness and achievement; reductions of crime or domestic violence; family economic self-sufficiency; and coordination and referrals for other community resources and supports. No later than 30 days after the end of the third year of its early childhood home visitation program, states would be a required to submit a report to HHS showing outcomes achieved compared to the benchmarks it established. Any state that cannot show improvement in at least four of the benchmark areas must develop and implement a corrective action plan based on technical assistance provided by HHS. The plan would be subject to HHS approval and its implementation monitored by that agency. HHS would be required to terminate funding to a grantee if state did not submit this three-year report (within a period of time determined by HHS) or if the corrective action failed to lead to improvements in any of the benchmark areas. Not later than December 31, 2015, this section would further require states to submit a final report demonstrating any improvements in benchmark areas to HHS.
	Application Requirements *New SSA § 440(b)* To receive funds states would need to submit an application to HHS for approval, that includes: 1) Results of their statewide needs assessment. 2) A description of the home visiting programs that will	*New SSA § 511(e)* To receive funds states would need to submit an application to HHS for approval, that includes: 1) Explanation of how populations selected to be served and home visitation models to be used are consistent with results of statewide needs assessment. 2) Substantively same as H.R. 3962. Also would require

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	be supported with the new federal dollars and the evidence supporting their effectiveness. 3) Describe outcomes intended to be achieved by home visitation. 4) Assurance that the state will identify and give priority to funding services in high-needs communities, especially those with high proportion of low-income families or high incidence of child maltreatment. 5) Assurance that state will promote coordination with other home visitation programs and other child and family services, health services, income supports, and other related assistance; and that the programs supported will provide referrals to other programs serving children and families if appropriate. 6) An assurance that the state will reserve 5% of its grant funds for training and technical assistance for funded home visitation programs. 7) Assurance that the state will make annual reports to HHS detailing its progress in improving well-being, health, and development of children through expansion of home visitation services and including specified services and program data [see new SSA § 440(i) for list]. 8) Assurance that the state will cooperate with any evaluation conducted by HHS under this program. 9) No provision. 10) Include any other information required by HHS.	states to explain basis of their selection of specific models and to assure that the state will provide evidence of fidelity to the program model implemented. 3) Specific three- and five-year benchmarks that state has established to demonstrate that the home visiting program improves lives of families served. 4) Substantively same as H.R. 3962 but provides longer list of "high risk" populations (e.g., includes low income eligible families and those with history of child abuse and neglect or interactions with the child welfare agency, eligible families with substance abuse issues; those that include children with developmental delays or disabilities, and others). 5) Description of other state programs that include home visitation services, including programs carried out under the MCH block grant, the Promoting Safe and Stable Families Program (under Title IV-B of SSA), Early Head Start, and Community-Based Grants to Prevent Child Abuse and Neglect (under Title II of CAPTA). 6) No provision. 7) Require annual report as does H.R. 3962 but would largely give HHS discretion on specific program and services data that must be reported (see also new SSA § 511(i)(2)(D)). 8) Same as H.R. 3962. 9) Assurance that state will establish procedures to ensure that participation of each eligible family is voluntary and that services are provided to those families in accordance with an individual assessment done for each family. 10) Same as H.R. 3962

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	Allotment of Funds, Matching, Maintenance of Effort and Other Fiscal Rules *New SSA § 440 (c),(d), and (e)* Each state and territory that meets the requirements for the grant would receive an allotment of the funds that is equal to its share of children living in families with incomes at or below 200% of poverty among all children in those eligible states and territories that are living in families with income at or below 200% of poverty. HHS would be permitted to reallot funds that a state certifies it will not spend.	*New SSA § 511(c), (f), (i)(2)(G), (j)(3)* Requires HHS to make grants for early childhood home visitation to eligible entities but does not stipulate how the funds are to be distributed. Permits HHS to determine the duration of the grants.
	To receive its full allotment a grantee would be required to provide no less than 15% in program matching funds for FY2010; no less than 20% in FY2011; and no less than 25% in FY2012 and any succeeding fiscal year.	Does not include matching fund requirements.
	Beginning with FY2011, to be eligible for this funding, a state may not have spent less in the immediately previous fiscal year than the total amount it spent (in state and local funds) in the fiscal year preceding that one for home visitation programs for families with young children and families expecting. (For example, to receive FY2011 funding, HHS must determine that during FY2010 the state spent no less on home visiting from state and local funds than it did in FY2009; to be eligible for FY2012 funding HHS must find that the state spent no less in FY2011 than it did in FY2010, etc.)	Would provide that funds must be used to supplement rather than supplant current state spending but does not provide a specific maintenance of effort level.
	States would be permitted to spend program funds on home visiting services meeting stipulated requirements as well as for training, technical assistance and evaluation related to the program. A state would not be permitted to include as a program expenditure any cost for which it has submitted a claim for federal payment under another federal law.	States would be permitted to use part of the funds made available during the first 6 months of the grant for planning or implementation activities needed to assist in the establishment of programs that meet the stipulated federal program requirements. States would be permitted to use no more than 10% of the grant funds for program administration. Grant funds provided to a state are to remain available for expenditure by the state through the end of the second succeeding fiscal year after the award.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	Provisions Related to Tribal Entities *New SSA § 440 (c),(h) and (n)* In general, Indian tribes or tribal organizations applying for these funds would be required to meet the same grant application requirements as described for states and to use the funds only in support of high quality home visitation program models as required of states. However, HHS could waive or modify any other of the program requirements, including those related to maintenance of effort and matching funds for an Indian tribe if failure to do so would impose an undue burden on the Indian tribe. From the amount of funds reserved for tribes, HHS would be required to allot to each eligible tribe an amount of funds equal to its share of children living in families with incomes at or below 200% of poverty among all children in eligible tribes living in families with income at or below 200% of poverty. Would define Indian tribe and tribal organization as they are defined for purposes of the Promoting Safe and Stable Families Program (PSSF, Title IV-B, Subpart II of the Social Security Act) . "Indian tribe" is defined as 1) any tribe, band, nation, or other organized group or community of Indians that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians and for which a reservation exists (including Indian reservations, public domain Indian Allotments, and former Indian reservations in Oklahoma); and 2) any organized group of Alaska Natives (i.e., Alaska Native organization) that is eligible to operate a federal program under the Indian Self Determination and Education Assistance Act or such group's designee. "Tribal organization" is defined as the recognized governing body of any Indian tribe.	*New SSA § 511(h)(2)(A) and (k)(3)* HHS would be required to specify requirements for Indian tribes (or a consortium of Indian tribes), tribal organizations, or urban Indian organizations to apply for and conduct an early childhood home visitation program. The requirements would need to be consistent ("to the greatest extent practicable") with the requirements made of states, and they must stipulate that tribal entities 1) conduct a needs assessment similar to the statewide needs assessment that must be conducted by all states; and 2) establish quantifiable three- and five-year benchmarks to demonstrate improvements in same outcome areas for which state must establish benchmarks. HHS would be required to make grants to eligible entities but no specific allotment procedures are given. Would define Indian tribe, tribal organization, and Urban Indian Organization as they are defined in the Indian Health Care Improvement Act (IHCIA). "Indian tribe" is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. "Tribal organization" is defined as the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and

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		which includes the maximum participation of Indians in all phases of its activities. "Urban Indian organization" is defined as a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and public and private entities for the purpose of carrying out activities related to the provision of health care and referral services to urban Indians (as authorized by Section 503(a) of IHCIA).
	Provisions Related to Grants to Nonprofit Organizations No provision.	*New SSA § 511 (h)(2)(B), (j)(3) and (k)(1)(B)* As of the beginning of FY2012, if a state has not applied and been approved for an early childhood home visitation grant, HHS may use amounts appropriated for this program to make a grant to a nonprofit organization to conduct an early childhood home visitation program in the state. To make these grants HHS may use funds not expended by states within the period of the grants availability. HHS must specify the requirements for such an organization to apply for and conduct the program. To the greatest extent practicable those requirements must be consistent with the requirements made of states, and HHS must stipulate that the nonprofit organization 1) carry out the program based on the needs assessment conducted by the state; and 2) establish quantifiable three- and five-year benchmarks to demonstrate improvements in the same outcome areas for which states must establish benchmarks. For purposes of these grants a nonprofit organization includes an organization with an established record of providing early childhood home visitation programs or initiatives in a state or several states.
	Application of Certain Other Provisions in Current Law *New SSA § 440(n)* Would provide that for purposes of the home visitation	*New SSA § Section 511(i)* Would provide that none of the provisions in Title V of

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	program the definitions of the following terms used in the Promoting Safe and Stable Families Program (Title IV-B, Subpart II of the Social Security Act) apply: "State" (which is defined to include "Indian tribe" and "tribal organization"); and "Indian tribe" and "tribal organization" (see definition of these terms in "Special Provisions for Tribal Entities" above). Note: In general, other provisions of Title IV-B are written so that they apply only to the specific subpart or section in which they are included and thus they would not apply to this program. However, the definitions of terms provided in Section 475 of SSA (under Title IV-E) apply to all of Title IV-B and would be applicable here. Among others, the terms defined in that section include "parents," "legal guardian," and (effective with FY2011) "child."	the Social Security Act apply to a grant made under the home visitation program except those explicitly listed. The listed provisions, which would apply in the same manner as they do to allotments made to states under the MCH block grant are: -- prohibition on payment of funds to health care providers (individuals or entities) that are excluded from participation in federal health care programs; -- permission for the state to use a portion of the grant funds to purchase technical assistance from public or private entities; -- limitation on the amount of funds that may be spent on administering the grant funds (no more than 10%); -- establishment of penalties related to false statements; -- prohibition on discrimination; -- requirements related to federal program administration, which, among other things, include 1) promoting coordination at the federal level of the activities authorized under this title with other relevant health or related programs or grants administered by HHS, including Medicaid, and with related activities funded by the Departments of Agriculture and Education; 2) disseminating information to the states in such areas as preventive health services and advances in the care and treatment of mothers and children; 3) providing technical assistance, upon request, to the states in such areas as program planning, establishment of goals and objectives, standards of care, and evaluation; and in developing consistent and accurate data collection mechanisms; 4) assisting in the preparation of reports to the Congress on the activities funded and accomplishments achieved under the grant; and 5) assisting states in the development of care coordination services; and -- to the extent HHS determines appropriate, a requirement that the state submit annual reports to HHS on activities funded.

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	Federal Program Evaluation *New SSA § 440 (j).* HHS would be required (via grant or contract) to provide for an independent evaluation of the effectiveness of home visiting programs funded with these grant monies. The evaluation would need to examine: 1) The effect of these home visitation programs on child and parent outcomes, including child maltreatment, child health and development, school readiness, and links to community services; and 2) Their effectiveness with regard to different populations, including the extent to which the ability of programs to improve outcomes varies across programs and populations. Within three years of enactment of this home visitation grant program, HHS would be required to submit an interim report to Congress on the evaluation and to make a final report to Congress on the evaluation within five years of that enactment	*New SSA § 511(g)* HHS would be required to appoint an independent advisory panel consisting of experts in program evaluation and research, education, and early childhood development to 1) review and make recommendations on the design of and plan for an evaluation of the early childhood home visitation program; 2) maintain and advise HHS regarding the progress of the evaluation; and 3) comment, if it chooses, on the evaluation report that HHS must submit to Congress. On the basis of the recommendations of the advisory panel, HHS must (via grant, contract, or interagency agreement) conduct an evaluation of the statewide assessments made and the early childhood home visitation grants, including: 1) A state-by-state analysis of the result of statewide needs assessments and state actions in response to the assessments; 2) An assessment of the effect of these home visitation programs on the outcome and process areas benchmarked and the participant outcomes. 3) An assessment of the effectiveness of the early childhood home visitation programs with regard to different populations, including the extent to which the ability of programs to improve outcomes varies across programs and populations; and 4) An assessment of the potential for these activities, if scaled broadly, to improve health care practices, eliminate health disparities, and improve health care system quality and efficiencies, and reduce costs. HHS would be required to submit a report to Congress on the results of this evaluation no later than March 31, 2015 and it must make the report publicly available
	Other HHS Requirements Related to Reports, Research, and Technical Assistance *New SSA § 440 (k)*	*New SSA § 511(h)(3) and (4)* HHS must submit a report to Congress no later than

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	HHS must annually submit a report to Congress on the home visitation activities funded by this program. The report must describe 1) the high need communities targeted by states for services; 2) service delivery models used; 3) characteristics of program, including staff qualifications and demographics, the number and demographics of families served and family retention and duration of services; 4) outcomes reported; 5) research-based instruction, materials, and activities being used in the grant program; 6) training and technical activities; 7) annual costs of implementing the programs, including cost per family served; and 8) indicators and methods used by the state to monitor the program as designed.	December 31, 2015 regarding the early childhood home visitation programs funded. It must include information on the extent to which states and other grantees demonstrate improvements in outcomes relative to their established benchmarks as well as on technical assistance provided by HHS (in connection with corrective action plans), and recommendations for legislative or administrative actions HHS determines appropriate. HHS would be required (directly or by grant, contract, or cooperative agreement) to carry out a continuous program of research and evaluation designed to increase knowledge about the implementation and effectiveness of home visiting programs. The research must use random assignment designs to the maximum extent feasible. HHS must further ensure that evaluation of a specific program or project is conducted by individuals not directly involved in the operation of that program and that independent researchers, state officials, and developers and providers of home visiting programs are consulted on relevant topics including research design and administrative data matching. *New SSA § 511(c)(4) and (d)(1)(B)(iii)(II)* HHS must provide technical assistance to grantees regarding administering programs or activities funded in whole or part with this federal grant. As part of providing technical assistance specifically to states needing to develop a corrective action plan, HHS must appoint an advisory panel to make recommendations.
	Federal Program Administration Does not specify what agency within HHS would administer this grant program. However, it would add "Support for Quality Home Visitation Programs" to Title IV-B of the Social Security Act and other programs under that part of law are administered by the Administration for Children and Families (ACF) within	*New SSA § 511(h)* Would require HHS to ensure that ACF and the Maternal and Child Health Bureau, which is within the Health Resources and Services Administration (HRSA), and currently administers Title V of the Social Security Act, collaborate fully in all aspects of administering this

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	HHS.	new program. And would require HRSA and ACF to consult with other appropriate federal agencies.
Improved coordination and protection for dual eligibles. Current law: There are no specific requirements under Medicare and Medicaid rules for the programs to coordinate care for dual eligible individuals. Under SSA Sec. 1115, the Secretary has authority to conduct research and demonstration projects without Congressional approval. (SSA Sec. 1115 applies to Medicaid and CHIP as well as other SSA sections). The Medicaid and CHIP requirements that the Secretary may waive include freedom of choice of provider, comparability of services, and state-wide access. The Secretary also may use the Section 1115 waiver authority to provide federal financial participation for costs that would otherwise not be matched under Medicaid rules.	*H. §1905* H. §1905(a) SSA Title XI would be amended by inserting a new section (1150A) with a requirement to establish an identifiable program or office within CMS to improve coordination between Medicare and Medicaid and protection for dual eligible beneficiaries (duals)--individuals eligible for both Medicare and Medicaid.	*S. §2602* S. §2602(a) The Secretary would be required to establish a federal coordinated health care office (CHCO) within the Centers for Medicare and Medicaid Services (CMS).
	No provision.	The CHCO director would be appointed by and be within the direct line of authority to the CMS Administrator.
	CMS' office or program of dual eligible coordination and protection (O/PDECP) would be required to (1) review Medicare and Medicaid enrollment, benefits, service delivery, and payment policies as well as grievance and appeals processes for Medicare Parts A and B, Medicare Advantage, and Medicaid; (2) identify areas of these policies where improved coordination and protection could improve care and reduce costs; (3) issue guidance to states on improving coordination and protection for duals.	No provision.
CHCO Elements	*H. §1905(b)* O/PDECP improved coordination would be required to include efforts to (1) simplify dual eligibles' access to benefits and services under Medicare and Medicaid; (2)	*S. §2602(b)* Purpose and Goals. The purpose of the CHCO would be to bring together officers and employees of the Medicare and Medicaid

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	improve care continuity for duals and ensure safe and effective care transitions; (3) harmonize regulatory conflicts between Medicare and Medicaid rules relating to duals; and (4) improve the total cost and quality of services provided to duals.	programs at CMS to (1) integrate benefits and (2) improve care coordination. The CHCO would have the following goals: (1) to provide dual eligible individuals full access to the benefits to which they are entitled under Medicare and Medicaid; (2) to simplify the processes for dual eligible individuals to access the items and services they are entitled to under Medicare and Medicaid; (3) to improve the quality of health care and long-term services for dual eligible individuals; (4) to increase beneficiaries' understanding of, and satisfaction with, coverage under the Medicare and Medicaid programs; (5) to eliminate regulatory conflicts between rules under Medicare and Medicaid; (6) to improve care continuity and ensure safe and effective care transitions; (7) to eliminate cost-shifting between Medicare and Medicaid and among related health care providers; and (8) to improve the quality of performance of providers of services and suppliers under Medicare and Medicaid.
Secretary's Responsibilities for O/PDECP/CHCO Implementation.	*H. §1905(c)* In implementing the O/PDECP, the Secretary would be required to provide for the following: (1) an examination of Medicare and Medicaid payment systems to develop strategies to foster more integrated and higher quality care; (2) the development of methods to facilitate dual eligibles' access to post-acute and community-based services and to identify actions to improve coordination of community-based care; (3) a study of enrollment in Medicare Savings Program (MSP) and the low-income subsidy program for Part D drug coverage to identify methods to more efficiently	The CHCO would have the following specific responsibilities: (1) to provide states, specialized Medicare Advantage plans for special needs individuals—special needs plans (SNPs), and other entities or individuals qualified to develop programs that align Medicare and Medicaid benefits for dual eligible individuals; (2) to support state efforts to coordinate and align acute care and long term care (LTC) services for dual eligible individuals with other items and services furnished under the Medicare program; (3) to support state and CMS efforts to coordinate contracting and oversight for integrating Medicare and Medicaid programs; (4) to consult with the MedPAC and MACPAC on enrollment and benefit

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	and effectively reach and enroll dual eligibles; (4) an assessment of communication strategies aimed at dual eligibles, including the Medicare website, 1-800-MEDICARE, and the Medicare handbook; (5) research and evaluation of areas where service utilization, quality, and access to cost sharing protection could be improved and an assessment of factors relating to enrollee satisfaction with services and delivery; (6) collection and dissemination to the public of data and a database that describes eligibility, benefits, and cost-sharing assistance available to dual eligibles by state; (7) support for coordination of state and federal contracting oversight for dual eligible coordination programs; (8) support for state Medicaid agencies by providing technical assistance for Medicaid and Medicare coordination initiatives to improve integration of acute and long-term care services for duals; (9) monitoring total combined Medicare and Medicaid program costs in serving dual eligibles and making recommendations to optimize total quality and cost performance across both programs; and (10) coordination of Medicare Advantage plan activities under Medicare and Medicaid.	policies for dual eligible individuals; and (5) to study the provision of drug coverage for new full-benefit dual eligibles and to monitor and report on total annual expenditures, health outcomes, and access to benefits for all dual eligibles.
Reporting.	*H. §1905(d)* O/PDECP would be required to work with relevant state agencies and appropriate quality measurement entities to improve and coordinate Medicare and Medicaid reporting requirements. O/PDECP would seek to minimize duplicate reporting requirements and identify ways to combine assessment requirements. O/PDECP would seek to identify quality metrics and assessment requirements that facilitate quality comparisons across fee-for-service (FFS) Medicare,	Sec. 2602 would require the Secretary to submit an annual report to Congress under the annual budget transmittal. The report would at least contain recommendations for legislation that could improve care coordination and benefits for dual eligible individuals.

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	Medicare Advantage, FFS Medicaid, and Medicaid managed care. *H. §1905(e)* The Secretary would be required to seek endorsement from a quality metrics entity (contractor) described in the quality metrics and benchmarks section of H.R. 3962 (see H.R. 3962 Sec. 3014, Quality Measurement). In general, Sec. 3014 would require the Secretary to seek input from a multi-stakeholder group on quality measurements and metrics. *H. §1905(f)* O/PDECP would be required to consult with relevant stakeholders in the development of policies related to integrated Medicare and Medicaid programs for duals. Stakeholders would include dual eligibles' representatives, health plans, providers, and relevant state agencies. *H. §1905(g)* Within one year of enactment of H.R. 3962 and every three subsequent years the Secretary would be required to submit a report to Congress documenting progress and activities of the O/PDECP.	
Effective Date	Effective date. No specific date was identified for establishing the O/PDECP.	Effective date. The Secretary would be required to establish the CHCO by March 1, 2010.
Assessment of Medicare cost-intensive diseases and conditions Current law: No provision.	*H.§1906.* The Secretary of Health and Human Services would conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program and, to the extent possible, assess the diseases and conditions that could become cost-intensive for Medicare in the future. In conducting the assessment, the Secretary would include the input of relevant research agencies, including the NIH, the AHRQ, the FDA, and the CMS. Not later than January 1, 2011, the	No provision.

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	Secretary would transmit a report to the Committees on Energy and Commerce, Ways and Means, and Appropriations of the House of Representatives and the Committees on Health, Education, Labor and Pensions, Finance, and Appropriations of the Senate on the assessment. The report would (a) include the assessment of current and future trends of cost-intensive diseases and conditions, (b) address whether current research priorities are appropriately addressing current and future cost-intensive conditions so identified, and (c) include recommendations concerning research in HHS that should be funded to improve the prevention, treatment, or cure of such cost-intensive diseases and conditions. Not later than January 1, 2013, and biennially thereafter, the Secretary would (1) review and update the assessment and recommendations, and (2) submit a report to the Committees on the updated assessment and recommendations.	
Establishment of Center for Medicare and Medicaid Innovation within CMS. Current Law: The Social Security Amendments of 1967, as amended by the Social Security Amendments of 1972, provide the Secretary with broad authority to develop and engage in experiments and demonstrations to test new approaches to paying providers, delivering health care services, or providing benefits to beneficiaries participating in federal health care programs. In accordance with the law, demonstrations are required to determine whether or not changes in reimbursement would increase the efficiency and economy of health care services without adversely affecting quality. The Secretary has the authority to waive compliance with requirements related to reimbursement and payment under Titles XVIII and XIX in conducting these demonstrations. All demonstrations are required to be budget neutral and be approved by the Office of Management and Budget (OMB) prior to implementation.	*H. §1907.* This provision would create a Center for Medicare and Medicaid Innovation (the CMI) within CMS by January 1, 2011. **Scope:** The purpose of the CMI would be to test innovative payment and health care delivery models to improve the coordination, quality, and efficiency of services provided to Medicare and Medicaid beneficiaries. **Testing (Phase I)**: The Secretary would be required to give preference to testing models for which there is evidence, as determined by the CMS Administrator, that the model would address a defined population with poor clinical outcomes or avoidable expenditures. The	*S. §3021 as modified by §10306.* Similar except for the following key differences: **Scope:** The provision emphasizes reducing spending as the purpose of conducting demonstrations. Specifically, the provision states that the purpose of the CMI is to test innovative payment and service delivery models designed to reduce program expenditures in Medicare and Medicaid while preserving and enhancing quality. Additionally, the provision would give the CMI the authority to test demonstration models in CHIP in addition to Medicare and Medicaid. **Testing (Phase I):** Similar except the Secretary would be required to select, as opposed to give preference to, models that address a defined population with poor clinical outcomes or avoidable expenditures. Models would be expected to reduce costs while preserving or

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Section 1115 of the SSA provides the Secretary with broad authority to conduct research and demonstration projects under several programs authorized in the SSA, including Title XIX (Medicaid) and Title XXI (CHIP). Under Section 1115, the Secretary may waive any Medicaid requirements contained in Section 1902 (including but not limited to what is known as "freedom of choice" of provider, "comparability," and "statewideness").' Section 2107(e)(2)(A) of the SSA states that Section 1115 of the Act, pertaining to research and demonstration waivers, applies to CHIP. For CHIP, no specific sections or requirements are cited as "waiveable." CMS's research, demonstration, and evaluation activities are funded by the agency's program management account, which is annually appropriated by Congress. For FY2009, Congress appropriated $30.2 million to support the Research, Demonstration, and Evaluation program. The total program management appropriation for FY2009 was $3.4 billion.	provision would eliminate the requirement that, as a condition for testing, models demonstrate budget neutrality. The CMI would be required to consult with representatives from Federal agencies, clinical and medical experts, health care management professionals, and States in carrying out its functions. Demonstrations would be prohibited from operating for more than 7 years. **Evaluation:** The provision would require the Secretary to conduct an evaluation analyzing quality and spending outcomes for each model tested. To the extent feasible, the Secretary would be required to select measures that reflect national priorities for quality improvement and patient-centered care. The Secretary would be required to make all evaluations publicly available in a timely fashion. **Termination authority:** The provision would require the Secretary to terminate or modify demonstrations that do <u>not</u> meet one of three conditions: 1) improve quality without increasing spending; 2) reduce spending without reducing quality; or 3) improve quality and reduce spending. **Expansion authority (Phase II):** The Secretary would have the authority to expand the duration and scope of a demonstration, including nationwide, if the Secretary determines that an expansion would meet the above criteria. The OACT would be required to certify that the proposed expansion would reduce net program spending (or not increase spending) under applicable titles (Medicare and Medicaid). **Waiver authority:** The provision would grant the	enhancing quality. The provision would provide the Secretary with the authority to limit testing to certain geographic areas and select demonstration models that address a variety of themes, including medical homes, coordinated care, alternative payment mechanisms, HIT, medication management, patient education, integrated care for dual-eligibles, care for cancer patients, post-acute care, chronic care management, and collaboration among mixed provider types. The provision does not include a prohibition on demonstrations that extend beyond 7 years. **Evaluation:** Similar except that in addition to making all evaluations publicly available in a timely fashion, the Secretary would be required to establish requirements for States to collect and report information necessary to evaluate these models. The provision does not require that the Secretary select measures that reflect national priorities for quality improvement and patient-centered care. **Termination authority:** Identical. **Expansion authority (Phase II):** Substantially similar except includes an additional condition for expansion – the Secretary determines that the expansion would not deny or limit coverage. **Waiver authority:** Substantially similar except the

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	Secretary the authority to waive requirements of Titles XI, Titles XVIII, and sections 1902 and 1903(m) as necessary to conduct these demonstrations. The provision would also exempt the testing, evaluation, and expansion of demonstrations from Chapter 35 of title 44, the Paperwork Reduction Act (PRA), which requires federal agencies to receive OMB approval for each collection of information request.	provision would grant the Secretary the authority to waive requirements of Titles XI, Titles XVIII, and sections 1902(a)(1), 1902(a)(13), and 1902(m)(2)(A)(iii) as necessary to conduct these demonstrations.
	Funding: The provision would require $350 million for FY2010, $440 million for FY2011, and $550 million for FY2012 to be available until expended. Monies would be equally divided between the Medicare Part A and B Trust Funds. For each subsequent fiscal year, the provision would provide an amount equal to the previous year's amount increased by the percentage rate of increase in total expenditures as estimated by the Board of Trustees. The provision would authorize that these funds be used to pay any additional benefits provided under these demonstrations and for their research, design, implementation, and evaluation. Beginning with FY2010, the provision would appropriate from the Treasury to the CMS Program Management Account, $25 million to cover any administrative costs associated with carrying out these demonstrations in the Medicaid program.	**Funding:** The provision would appropriate $5 million for the design, implementation, and evaluation of models for FY2010; $10 billion for the activities under this section for the years 2011 through 2019; and $10 billion for the activities initiated under this section for each subsequent 10-year fiscal period beginning with 2020. Funding would be appropriated from the Treasury as opposed to the Medicare Trust Funds. The provision would also require that at least $25 million of this appropriation be allocated to design, implement, and evaluate the specific models identified in this provision (*see Testing section above*). The provision does not appropriate funds to the CMS program management account for administrative costs associated with carrying out these demonstrations in Medicaid.
	Oversight: Beginning in 2012, the Secretary would be required to submit to Congress, at least once every two years, a report on the activities performed by the CMI. Reports would be required to include a description of the demonstrations, the number of Medicare and Medicaid participants, the amount of payments made on behalf of these participants, models chosen for expansion, and evaluation results. Reports would also be required to include recommendations for legislative action to facilitate the development and expansion of such models nationwide.	**Oversight:** Identical

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Application of emergency services laws. Current Law: The Emergency Medical Treatment and Labor Act (EMTALA; SSA Sec. 1867) requires hospital emergency departments to examine and treat any individual who comes to the hospital with an emergency medical condition, and any woman who is in labor. EMTALA further requires hospitals to offer treatment, within their capacity and with the individual's consent, to stabilize the emergency condition, or transfer the individual to another medical facility, subject to certain restrictions. EMTALA does not preempt state or local laws unless they directly conflict with its specific requirements. In addition, the Act prohibits discrimination and delay in examining or treating emergency patients, and provides protections to whistleblowers who report violations of its provisions.	*H. §1908.* This section would clarify that nothing in the bill relieves any health care provider from providing emergency services as required by federal and state laws, including EMTALA.	No provision.
Disregard under the Supplemental Security Income Program of compensation for participation in clinical trials for rare diseases or conditions. Current law: Supplemental Security Income (SSI) is a means-tested program that provides cash benefits to aged, blind and disabled individuals. A person's eligibility for SSI benefits is based on his or her countable income and resources and the amount of an SSI recipient's monthly benefit is based on his or her countable income. Under current law, compensation received for participation in a clinical trial is counted as both income and resources under SSI program rules. Generally, an SSI recipient is also eligible for Medicaid, either automatically or through a separate application based on state law and policy. In addition, SSI's income and resource counting rules are used to determine eligibility for persons age 65 and older and persons with disabilities under Medicaid's SSI-related eligibility pathways	*H. §1909* This provision would disregard, from the income and resources counted to determine SSI eligibility and benefit levels, the first $2,000 earned in a year in exchange for a person's participation in a clinical trial to test a treatment for a rare disease or condition, as defined by Section 5(b)(2) of the Orphan Drug Act. This provision would be required to become effective for calendar months beginning after the earlier of the date the Commissioner of Social Security promulgates regulations or a 180-day period that begins with this bill's enactment.	No provision.

Provision and Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Health care power of attorney Under the federal foster care program (Title IV-E of the SSA) a state is required to have in place a case review system for each child in foster care, which among other things, must ensure that a transition plan is developed for (and with) any youth in foster care for whom the state's responsibility is expected to end because the youth has reached the age of majority (i.e., 18 years of age or a later age, up to age 21, if elected by the state). This transition plan must be developed during the 90-day period immediately prior to date on which the youth is expected to age out of foster care and it must include specific options on housing, health insurance, education, local opportunities for mentors and continuing support services, and workforce supports and employment services. Under the Chafee Foster Care Independence Program (CFCIP)(Section 477 of the SSA) states receive funds to provide independent living services to youth who are expected to age out of foster care or for those who have already aged out of care. As part of their application for these funds, states must provide certain certifications regarding how the programs will be carried out. Finally, under the Stephanie Tubbs Jones Child Welfare Services Program (Title IV-B, Subpart 1 of the Social Security Act), states are required to develop a plan for the ongoing oversight and coordination of health care services for children in foster care. The state child welfare agency and the state agency that administers Medicaid must coordinate and collaborate in the development of this plan and the plan must outline specific steps to ensure that children in foster care have their health care needs identified and appropriately met; and that medical information for children in foster care is updated and appropriately shared.	No Provision.	*S. § 2955* This provision would require that the mandatory transition plan for a youth who is about to age out of foster care must include information about the importance of designating another individual to make health care treatment decisions on behalf of the youth if he or she becomes unable to participate in these decisions and does not have a relative who would be authorized to make these decisions under state law, or he or she does not want that relative to make those decisions. In addition, the transition plan would also be required to provide the youth with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under state law. The provision would also require states, as part of their application for CFCIP funds, to certify that foster care or former foster care adolescents receiving independent living services are educated about (1) the importance of designating an individual to make health care treatment decisions for them (should they become unable to do so, have no relatives authorized under state law to do so, or not want such relatives to make those decisions); (2) whether a health care power of attorney, health care proxy, or other similar document is recognized under state law; and (3) how to execute such a document. Additionally, the provision would require that the health care oversight plan developed collaboratively between the state child welfare agency and the state Medicaid agency outline steps to ensure that the health-care related components of the transition plan for youth aging out of foster care are met. These include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized by state law, and the option to execute such a document. All of these requirements would become effective on October 1, 2010.

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Independent Medicare Advisory Board Current Law: No provision.	No provision.	*S. §3403* as modified by *S. §10320.* This provision would establish an Independent Payment Advisory Board to develop and submit detailed proposals to Congress and the President to reduce Medicare spending. The Board would consist of 15 members with expertise in health care financing, delivery, and organization. All members would be appointed by the President and confirmed by the Senate. Proposals would primarily focus on payments to MA and PDP plans and reimbursement rates for certain providers. The Board would be prohibited from developing proposals related to Medicare benefits, eligibility, or financing. Proposals, which would only be required in certain years, would have to meet specific savings targets. Recommendations made by the Board would automatically go into effect unless Congress enacted specific legislation to prevent their implementation. The first year the Board's proposals could take effect would be 2015. **Membership and Structure.** The Board would be composed of 15 members, appointed by the President with the advice and consent of the Senate. Members of the Board would serve six-year, staggered terms. Members could not serve more than 2 full consecutive terms. The Senate Majority Leader, the Speaker of the House, the Senate Minority Leader, and the House Minority Leader would each present three recommendations for appointees to the President. The President, with the advice and consent of the Senate, would also be required to appoint a Chair for the Board, from among members. The Board would elect a Vice Chairman. Members could only be removed by the President for neglect of duty or malfeasance in office. In addition to the 15 members of the Board, the Secretary of HHS, the Administrator of CMS, and the Administrator of the Health Resources and Services Administration (HRSA) would serve as ex-officio, non-

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		voting members of the Board. Qualifications for membership would be similar to the qualifications required for members of the Medicare Payment Advisory Board (MedPAC). Individuals involved in the delivery or management of health care services could not constitute a majority of the Board. In addition to these qualifications, the President would be required to establish a system for publicly disclosing any financial or other conflicts of interests relating to members. Individuals that engage in any other business, vocation, or employment could not serve as appointed members of the Board. Members would be considered officers in the executive branch for purposes of applying Title I of the Ethics in Government Act of 1978. After serving on the Board, former members would be barred from lobbying the Board and other relevant executive branch departments and agencies and relevant congressional committees for one year. The Chair would be responsible for exercising all of the Board's executive and administrative functions, including those related to the appointment and supervision of employees and the use of funds. All requests for discretionary appropriations to fund the Board's activities must be approved by a majority vote. **Requirements for Proposal Submission.** The provision would require that the Board submit proposals to the President and Congress for years in which the projected rate of growth in Medicare spending per beneficiary exceeds a target growth rate. Determinations of the projected and target growth rates would be made by the CMS Office of the Actuary (OACT) beginning in 2013. The Board would be required to submit its first proposal to the President and Congress by January 15th, 2014 for implementation in 2015. If the Board fails to submit a proposal by the January 15th deadline for a particular year, the Secretary

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		would be required to submit a contingent proposal to Congress, meeting the same fiscal policy requirements, by no later than January 25th of that year. For years 2014 through 2017, the Board would be required to submit proposals for years in which the projected rate of growth in Medicare spending per beneficiary exceeds the average of the projected percentage increase in the Consumer Price Index for All Urban Consumers (CPI-U) and the Consumer Price Index for Medical Care (CPI-M). Beginning in 2018, proposals would only be required for years in which the projected rate of growth in Medicare spending exceeds the Gross Domestic Product (GDP) per capita plus 1.0%. Proposals would not be required in 2019 and beyond if the OACT determined that the rate of growth in per capita National Health Expenditures (NHE) exceeded the rate of growth in per capita Medicare spending. Recommendations proposed by the Board would be required to reduce Medicare spending by the lesser of 0.5 percentage points in 2015, 1.0 percentage points in 2016, 1.25 percentage points in 2017, 1.5 percentage points in 2018, or any other subsequent implementation year, and the amount by which the rate of growth in Medicare spending exceeds the target growth rate. Proposals could not increase net Medicare spending over the 10-year period starting with the implementation year. **Scope of Proposals.** The provision lays out a number of specific fiscal and policy criteria which the Board would be required to meet in making its recommendations. When developing and submitting proposals, the Board would be required, to the extent feasible, to: (1) prioritize recommendations that would extend Medicare solvency and target reductions to sources of excess cost growth; (2) include

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		recommendations that improve the health care delivery system, including the promotion of integrated care, care coordination, prevention and wellness and quality improvement and protect beneficiary access to care, including in rural and frontier areas; (3) consider the effects of changes in provider and supplier payments on beneficiaries; (4) consider the effects of proposals on any provider who has, or is projected to have, negative profit margins or payment updates; (5) consider the unique needs of individuals dually eligible for Medicare and Medicaid, and (6) include recommendations for administrative funding to carry out its recommendations. As appropriate, each proposal would be required to include recommendations that would reduce spending in Medicare Parts C and D. Reductions could be obtained by reducing Medicare payments for administrative expenses to MA and PDP plans, denying or removing high bids for drug coverage from the calculation of the monthly bid amount for Part D plans, and reducing performance bonuses for MA plans. Recommendations could not affect the base beneficiary premium percentage or the full premium subsidy for Part D plans. The Board would be prohibited from making recommendations that would ration care, raise revenues, increase beneficiary premiums, increase beneficiary cost-sharing, restrict benefits, or modify eligibility. Additionally, proposals submitted before December 2018 for implementation in 2020, could not include recommendations that would reduce payments to providers and suppliers scheduled to receive a reduction in their payment updates in excess of a reduction due to productivity. **Submission of Proposals to the President and Congress.** At the beginning of the year, following a determination by the Secretary, the Advisory Board is required to submit its recommendations to the

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		President and Congress. The Senate Bill dictates certain information which must accompany the Advisory Board's submission, including a requirement for a legislative propoal implementing the recommendations. **Congressional Consideration.** Section 3403 directs the Secretary to automatically implement the Board's recommendations unless Congress, by August 15 of the year in which the recommendations are submitted, enacts legislation superseding the Board's proposal. The Senate Bill establishes special "fast track," parliamentary procedures governing congressional consideration of legislation implementing the Board's recommendations. These fast track procedures differ from the normal parliamentary mechanisms used by the chambers to consider most legislation and are designed to ensure that Congress, should it choose to do so, can act quickly on the proposal put forth by the Advisory Board. The fast track procedures established by the Senate Bill mandate the introduction of the Board's legislative proposal by the House and Senate majority leaders "by request" on the day it is submitted to Congress. When introduced, such legislation is to be referred to the Senate Committee on Finance and to the House Committees on Energy and Commerce and Ways and Means. These committees may mark up the measure, and must report it to their respective chambers not later than April 1 or be discharged of its further consideration. The expedited procedure established by the Senate's amendment waives the provisions of Senate Rule XV which would ordinarily bar the Finance Committee from reporting a committee amendment containing significant matter not in its jurisdiction so long as the amendment in question "is relevant" to a proposal in the Advisory Board bill. The Senate Bill includes provisions which are intended to restrict the House or Senate from considering any

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		amendment (including committee amendment), bill, or conference report which would repeal or change the Board's recommendations unless those changes meet the same fiscal and policy criteria (described above) which the Board was required to meet in developing its recommendations. This restriction may be waived solely by a vote of three-fifths of the Members duly chosen and sworn, and in addition, the substitute prohibits the consideration of legislation that would repeal or modify this restriction. No expedited procedures are established for initial House floor consideration of the Board's legislation. In the Senate, a motion to proceed to consider the legislation is privileged and not debatable. Amendments offered to the legislation on the Senate floor must be germane and may not reduce the savings in Medicare per capita growth below established targets. Debate in the Senate on each amendment to the bill is limited and overall Senate consideration of the legislation may not exceed 30 hours, after which a final vote will be taken on it. The Senate Bill also includes "fast track" provisions which are intended to facilitate the exchange of legislation between the House and Senate by establishing an automatic "hookup" of the versions passed by the two chambers. In the event that there is a need to resolve bicameral differences on the legislation, debate on any conference report or amendment exchange is limited to no more than 10 hours, after which a final vote will occur. Should the measure be vetoed, Senate debate on a veto message is limited to one hour. **Fast Track Consideration of Legislation to Discontinue Payment Advisory Board.** The Senate Bill establishes an additional set of fast track parliamentary procedures governing House and Senate consideration of a joint resolution to discontinue the

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		Independent Payment Advisory Board and the "automatic" process of implementation described above. These procedures ensure that the House and Senate may act promptly on such a measure by limiting debate and amendment at the committee and floor level. The procedures also establish a supermajority requirement of three-fifths of Members duly chosen and sworn for passage of such a joint resolution in each chamber. **Implementation by the Secretary.** The Secretary would be required to implement the Board's recommendations by August 15th of the year in which the proposal was submitted. Any recommendation that would change a provider's payment rate would apply on the first day of the first fiscal year, calendar year, or rate year (which varies depending on provider type) after August 15th. Beginning in 2019, the Secretary would be prohibited from implementing the Board's recommendations if two conditions are met: 1) the Board was required to submit a proposal to Congress in the preceding year, and 2) the OACT determined that the rate of growth in per capita NHE exceeded the rate of growth in per capita Medicare spending. These restrictions would not affect requirements pertaining to the Board's submission of proposals to Congress or the rules related to Congressional consideration of these proposals. **Additional Review Procedures.** The Board must submit a draft copy of each proposal it develops to the Medicare Payment Advisory Commission (MedPAC) and to the Secretary for review. **Advisory Functions.** Beginning in 2014, for any year the Board is not required to submit a proposal to the President and Congress, the Board would be required to submit to Congress advisory reports on matters related to the Medicare program. Prior to 2020, these reports

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		may include recommendations to improve payment systems for those providers and suppliers exempted from the Board's recommendations. Beginning in 2015, the provision would also require the Board to submit to Congress and the President advisory recommendations to slow the rate of growth in NHE. These recommendations could not target expenditures in federal health care programs. The Board would be required to coordinate these recommendations, which must be made available to the public, with those contained in other Board proposals and advisory reports. Recommendations, which would be required at a minimum once every two years, could be implemented either administratively by the Secretary or legislatively by Congress. These advisory reports would not be subject to the rules for congressional consideration. **Funding.** The provision would appropriate $15 million to the Board to carry out its functions beginning in year 2012. This amount would increase by the rate of inflation for each year thereafter. Sixty percent of the appropriation would come from the Part A Medicare Trust Fund and 40 percent from the Part B Trust Fund. **Oversight Mechanisms.** The provision would establish a consumer advisory council to advise the Board on the impact of payment policies on consumers. The Council would be composed of 10 consumer representatives appointed by the Comptroller General of the United States, one from among each of the 10 regions established by the Secretary. Beginning July 1, 2014, the provision would also require the Board to annually produce a public report containing standardized information on health care costs, access, utilization, and quality. The report would allow for a comparison by region as well as by service, provider type, and payer. Information with respect to the

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		following areas would be required to be included: the quality and cost of care at a local level, beneficiary and consumer access to care, cost sharing and out-of-pocket costs, demographic changes, the utilization of health care technologies, and other areas as determined by the Board. **GAO Study.** The provision would require the GAO to conduct a study on changes in payment policies, methodologies, rates, and coverage policies under Medicare resulting from the Board's proposal. Specifically, the study would provide an assessment of the effect of the Board's proposal on Medicare beneficiary's access to providers, affordability of premiums and cost-sharing, the potential impact of changes on other government or private sector purchasers of care, and the quality of care provided. The report would be due by July 1, 2015. The GAO would conduct additional studies as appropriate.
Protecting and improving guaranteed Medicare benefits. Current Law: No provision.	No provision.	*S.§3601.* This section would require that that no provisions in the Senate bill could result in a reduction in Medicare benefits currently guaranteed under Title XVIII. this provision would also require that Medicare savings achieved under the Senate bill are to be used to extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, improve or expand guaranteed Medicare benefits, and protect access to Medicare providers.
Additional Hospital Insurance tax on high-income taxpayers. *Current law: E*mployees and employers each pay a payroll tax of 1.45% to finance Medicare Part A.	No provision.	*S. §9015 as modified by S. §10906.* The Senate bill would amend Section 3101(b) of the Internal Revenue Code of 1986 and impose an additional tax of 0.9% on high-income workers with wages over $200,000 for single filers and $250,000 for joint filers effective for taxable years after December 31, 2012. Since employers would not know the wages of a spouse, they would be directed to collect these revenues from all workers with wages exceeding $200,000 and then the

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		individuals would have to reconcile any excess withholding on their tax return. The 0.9% tax would also be levied on the self-employed if their incomes exceed the specified thresholds. The self-employed would not be allowed to deduct this additional tax as a business expense.
Medicare coverage for individuals exposed to environmental health hazards. Current Law: To be eligible for Medicare, one must be (1) 65 years or older and eligible to receive Social Security; or (2) under 65, permanently disabled, and have received Social Security disability insurance payments for at least 2 years; or (3) have Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's disease); or (4) have end-stage renal disease (ESRD).	No provision.	*S. §10323* This provision would provide Medicare coverage and medical screening services to certain individuals exposed to environmental health hazards. An individual with one or more specified lung diseases or types of cancer who lived for 6 months during a specified period prior to diagnosis in an area subject to a public health emergency declaration by the Environmental Protection Agency (EPA) as of June 17, 2009, would be deemed entitled to benefits under Part A and eligible to enroll in Part B. The Secretary would be required to establish a pilot program, with appropriate reimbursement methodologies, to provide comprehensive, coordinated, and cost-effective care to such individuals who enroll in Part B. Further, the Secretary would have the authority to so deem any other individual diagnosed with an illness caused by an environmental hazard to which an EPA emergency declaration applies who lived for 6 months in the affected area during a period determined by the Secretary. The Secretary also would be authorized to establish pilot programs to provide comprehensive, coordinated, and cost-effective care to those individuals. Finally, the Secretary would be required to establish a new competitive grant program under SSA Title XX to (1) provide screening for specified lung diseases or types of cancer to individuals who have lived for 6 months during a specified prior period in an area subject to an EPA emergency declaration; and (2) disseminate public information on the screening program, the detection and treatment of environmental health conditions, and the availability of Medicare benefits to certain individuals diagnosed with such conditions. There would be

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		appropriated $23 million for the period FY2010 through FY2014, and $20 million for each 5-fiscal year period thereafter, to carry out the screening and public information dissemination program.