Imaging Payment Reforms

Equipment Utilization
The Chairman's Mark would increase the utilization rate assumption for calculating the payment for advanced imaging equipment from 50 percent to 65 percent for 2010 through 2013. The rate would be further increased to 75 percent beginning in 2014. The Secretary of HHS would be required to conduct a study by January 1, 2013 on the estimated impact of the utilization rate change on the following: (1) beneficiary access, including in rural areas; (2) utilization of advanced diagnostic imaging services; and (3) the estimated savings to the Medicare program over the period of 2010 through 2019.

Contiguous Body Parts
The mark would increase the technical component payment reduction for sequential imaging services on contiguous body parts during the same visit from 25 percent to 50 percent.

Stark In Office Ancillary Services Exception (this provision applies to advanced diagnostic imaging services)
The in-office ancillary exception would include a requirement that with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services as determined by the Secretary, the referring physician must inform the individual at the time of the referral that the individual may obtain the services from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice. The individual must be provided with a written list of suppliers who furnish services in the area in which the individual resides. This new requirement would apply to services furnished after January 1, 2010.

Overall Payment Reforms

Sustainable Growth Rate (SGR) Physician Payment Update
Under the Chairman's mark, the annual update to the conversion factor used in the determination of the Medicare fee schedule would be a 0.5 percent increase in 2010. The conversion factor for 2011 and subsequent years would be computed as if the increase in 2010 had never applied. This translates to large cuts in 2011 and beyond.

Review of Potentially Misvalued Physician Services
The Secretary of Health and Human Services would be required to periodically identify physician services as being potentially misvalued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. For purposes of identifying potentially misvalued services, the Secretary shall examine codes for which there has been the fastest growth; codes that have experienced substantial changes in practice expenses; codes for new technologies or services after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS; and such other codes determined to be appropriate

by the Secretary. Adjustments to misvalued procedures would be subject to budget neutrality requirements.

Malpractice

The Chairman's Mark would express the Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. The Mark would further express the Sense of the Senate that states should be encouraged to develop and test alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court. The mark would express the Sense of the Senate that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system.

Payment Bundling

Pilot Program

The Chairman's mark would require the Secretary of Health and Human Services to develop, test and evaluate alternative payment methodologies through a national, voluntary pilot program that is designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting in 2013. If evaluations find that the pilot program achieves goals of improving patient outcomes, reducing costs and improving efficiency, then the Secretary would be required to submit an implementation plan to Congress on making the pilot a permanent part of the Medicare program.

The Secretary would test alternative payment methodologies, which would include bundled payments or arrangements in which providers continue to receive reimbursement under current payment systems, but are held jointly accountable for the quality and cost of care provided to Medicare patients. Payments would be adjusted for patient severity of illness and other patient characteristics, including having a major diagnosis of substance abuse or mental illness, resources needed to provide care as well as adjustments for differences in hospital average hourly wages, physician work, practice expense, malpractice expense, and geographic adjustment factors. The pilot program's payment methodology would also take into account the provision of services such as care coordination, medication reconciliation, discharge planning and transitional care services and other patient-centered activities as defined appropriate by the Secretary.

The pilot program's bundled payment would be made to a Medicare provider or other entity comprised of multiple providers to cover the costs of acute care inpatient and outpatient hospital services, physician services and post-acute care. The comprehensive bundled payment would include the costs of any re-hospitalizations that occur during the covered period. The bundled payment for each of the eight selected conditions would be based on the average hospital, physician, and post-acute care payments made over the hospitalization period for patient.

Value Based Purchasing

Physicians

The Chairman's mark would create a new PQRI option. Beginning with the 2011 reporting period, CMS would be required to make PQRI incentive payments available for two successive years to eligible professionals who voluntarily complete the following on a biennial (every two years) basis. The Secretary shall allow eligible professionals to qualify if they: (1) participate in a qualified American Board of Medical Specialties certification, known as Maintenance of Certification (MOC), or equivalent programs; and (2) complete a qualified MOC practice assessment. A qualified MOC practice assessment would include an initial assessment of a participant's practice, designed to demonstrate the physician's use of evidence-based medicine, and would seek to improve quality of care through follow-up assessments. The methods, measures, and data used for the MOC would be submitted by the Boards to CMS in accordance with requirements established by the Secretary in consultation with the Boards. As part of this consultation, the Secretary would ensure that methods, measures and data to be submitted allow for innovation and appropriateness by specialty. As part of this consultation, the Secretary would ensure that methods, measures and data to be submitted allow for innovation and appropriateness by specialty.

The mark would require CMS to provide timely feedback to eligible professionals on their performance with respect to satisfactorily submitting data on quality measures. Second, CMS would be required to establish an appeals process for providers who participate in the PQRI program but do not qualify for incentive payments during their performance period.

The mark would extend PQRI incentive payments beyond 2010. Eligible professionals who successfully report in 2010 would receive a two percent bonus in 2011. Eligible professionals who failed to participate successfully in the program would face a 1 percent payment penalty in 2012, based on their 2011 reporting period. The incentive payments and adjustments in payment would be based on the allowed charges for all covered services furnished by the eligible professional, based on the applicable percent of the fee schedule amount. For 2012, the applicable percent would be calculated as 99 percent of their total allowed charges. For reporting periods 2012 and in subsequent years, the penalties for non-reporting would be two percent, calculated as 98 percent of their total allowed charges. The penalty would be assessed on an annual basis and would not be cumulative.

Physician Resource Use Measurement

The Chairman's mark would require the Secretary, beginning in 2012, to provide reports to physicians that compare their resource use with that of other physicians or groups of physicians caring for patients with similar conditions. Resource use would be measured based on the items and services furnished or ordered by physicians or groups of physicians. Feedback reports would be based on an episode-grouper methodology established by the Secretary that would combine separate but clinically-related services into an episode of care for which the physician is accountable. The episode-grouper would be required to be developed by January 1, 2012. The Secretary would be required to make the methodology available to the public, and the Secretary would be required to seek endorsement of the episode-grouper by the entity with a contract with the Secretary under section 1890(a) of the Social Security Act.

In preparing feedback reports, the Secretary would be required to make appropriate data adjustments, including adjustments to (1) account for differences in the demographic characteristics and health status of individuals so as not to penalize those physicians who tend to serve less healthy individual who may require more intensive interventions, and (2) eliminate the effect of geographic adjustments in payment rates.
The Secretary would have the authority to exclude certain information regarding an item or service from feedback reports if the Secretary determines that there is insufficient information relating to such item or service to provide a valid assessment of utilization. The Secretary would be required to provide for education and outreach activities to physicians on how the feedback program operates and the methodologies used.

Beginning in 2015, payment would be reduced by five percent if an aggregation of the physician's resource use is at or above the 90th percentile of national utilization. After five years, the Secretary would have the authority to convert the 90th percentile threshold for payment reductions to a standard measure of utilization, such as deviations from the national mean.

Hospitals
The Chairman's mark would establish a Hospital Value-Based Purchasing (VBP) program in Medicare that moves beyond pay-for-reporting on quality measures, to paying for hospitals' actual performance on these measures. This value-based purchasing program would provide value-based incentive payments to acute care IPPS hospitals that meet certain quality performance standards beginning in FY2012. The first year of the program would be a data collection/performance year. Beginning in FY2013, hospital payments would be adjusted based on performance under the VBP program.

Development of New Patient Care Models

Accountable Care Organizations (ACOS)
The Chairman's mark would establish ACOs under the Medicare program, groups of providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicare program. Beginning on Jan. 1, 2012, eligible ACOs would have the opportunity to qualify for an incentive bonus.

Eligible ACOs would be defined as groups of providers and suppliers who have an established mechanism for joint decision making, such as for capital purchases. The following groups of providers and suppliers would be eligible for participation: practitioners in group practice arrangements; networks of practices; partnerships or joint-venture arrangements between hospitals and practitioners; hospitals employing practitioners; and such other groups of providers of services and suppliers as the Secretary determines appropriate. Practitioners would be defined as physicians, nurse practitioners, physician assistants, clinical nurse specialists, and other practitioners or suppliers as the Secretary determines appropriate.

Medicare Innovation Center
The Chairman's mark would require the Secretary to create an Innovation Center within the Centers for Medicaid and Medicare Services (CMS). The Innovation Center will be a new office established within CMS that is authorized to test, evaluate, and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth.

The Center would be required to conduct an evaluation of each model tested, including an analysis of the extent to which the model results in: (1) coordination of health care services across treatment settings; (2) reduction of preventable hospitalizations; (3) prevention of hospital readmissions; (4) reduction of emergency room visits; (5) improvement in quality and health outcomes; (6) improvement in the efficiency of care; (7) reduction in the cost of health care services covered under this title; and (8) achievement of beneficiary and family-caregiver satisfaction.

National Quality Improvement Strategy

Development of National Quality Improvement Plan
The Chairman's mark would direct the Secretary to establish a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health through a transparent and collaborative process. In developing these priorities, the Secretary would consider how the priorities would: address health care needs of those with high-cost chronic diseases; improve strategies and best practices to improve patient safety and reduce medical errors, preventable hospital admissions and readmissions, and health care-associated infections; have the greatest potential for improving the health outcomes, efficiency and patient-centeredness of health care; reduce health care disparities across populations and geographic areas; address gaps in quality, efficiency and outcomes measures and data aggregation techniques; identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care; improve payment policy under Federal health programs to emphasize quality and efficiency; enhance the use of health care data to improve quality, efficiency, transparency, and outcomes; and other areas as determined appropriate by the Secretary.

Quality Measures
The Secretary of HHS would be required to assess quality measures every three years, identify gaps, and develop measures where gaps exist.

Insurance Reforms

Benefit Options
Currently, there is no Federal law regarding actuarially equivalent benefit options in group and individual private health insurance. However, states may have such standards.

The Chairman's mark would require the creation of four benefit categories: bronze, silver, gold and platinum. No policies could be issued in the individual or small group market (other than grandfathered plans) that did not meet the actuarial standards described below. All health insurance plans in the individual and small group market would be required, at a minimum, to offer coverage in the silver and gold categories. All plans must provide preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by Federal and state laws.

In addition, plans could charge no cost-sharing (e.g., deductibles, copayments) for preventive care services, except in cases where value-based insurance design is used**.** Plans could also not include lifetime limits on coverage or annual limits on any benefits**.** Any insurer that rates on tobacco use must also provide coverage for comprehensive tobacco cessation programs.

Pre-Existing Conditions
Within a year of enactment, any uninsured individual who has been denied health care coverage due to a pre-existing condition can enroll in a high-risk pool. Currently covered individuals must be uninsured for six months before gaining access to the high-risk pool. The high-risk pool will exist until 2013 and $5 billion in funding will be provided to subsidize premiums in the pool.

Mandatory Coverage Requirement
Beginning in 2013, all U.S. citizens and legal residents would be required to obtain coverage and document proof of coverage on their tax returns.

Employer Requirements
The Chairman's mark upholds current law. An employer would not be required to offer health insurance coverage. If an employee is offered health insurance coverage by his or her employer and chooses to enroll in the coverage, the exclusion from gross income would apply to the employer provided portion of the coverage. The tax treatment would be the same whether the employer offers coverage outside of a state exchange or the employer offers a coverage option through a state exchange

Health CO-OPS
Establishes health co-op opportunities for certain non-profit organizations

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Prevention and Wellness

Medicare Annual Wellness Exam
Beginning in 2011, Medicare beneficiaries would have access to a comprehensive health risk assessment (HRA) based on guidelines developed by the Secretary in consultation with relevant groups and entities. The assessment would identify chronic diseases, modifiable risk factors, and emergency or urgent health needs. The assessment could be provided through an interactive telephonic or web-based program or during an encounter with a health

professional. The Secretary would also set standards for the electronic tools that could be used to deliver the assessment. All enrolled beneficiaries would be eligible for the wellness visit once every year. No co-payment or deductible would apply.

Removal of Cost Sharing from Medicare Preventive Benefits
The Chairman's mark would encourage beneficiaries to receive preventive screenings by removing cost-sharing (co-payment and deductible) for services covered by Medicare and recommended (rated ―A and ―B) by the U.S. Preventive Services Task Force (USPSTF). Programs would also be created to increase education about Medicare's preventive benefits and to further incentivize participation.

Patient Centered Research
The Chairman's mark would authorize the establishment of a private, non-profit corporation that would be known as the ―Patient-Centered Outcomes Research Institute, to assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis. The research would focus on the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed, and would consider variations in patient subpopulations. Research conducted would compare the clinical effectiveness, risk and benefits of two or more medical treatments, services or items. The Mark would define treatment, services and items as: health care interventions, protocols for treatment, care management and delivery, procedures, medical devices, diagnostics tools, pharmaceuticals (including drugs and biological), and any strategies or items used in the treatment, management, and diagnosis of, or prevention of illness or injury, in patients.

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) study and report on the feasibility of conducting research in-house, (4) collect appropriate data from CMS, (5) appoint advisory panels, (6) support patient and consumer representatives, (7) establish a methodology committee, (8) provide for a peer-review process for primary research, (9) disseminate research findings, (10) adopt priorities, standards, processes, and protocols, (11) coordinate research and resources and build capacity for research, and (12) submit annual reports to the Congress, the President, and the public.

The Chairman's mark would charge the Institute with identifying national priorities for comparative clinical effectiveness research and establishing a research project agenda. The Institute would consider the need for a systematic review of existing research before providing for the conduct of new research. In setting priorities, the Institute would consider the following: disease incidence and prevalence in the U.S.; evidence gaps, in terms of clinical outcomes; practice variations; the potential for new evidence to improve health and quality of care; expenditures associated with a health care treatment strategy or health condition; patient needs, outcomes, and preferences, including quality of life; and relevance to assisting patients and clinicians in making informed health decisions.

The Institute would be required to use the following methods to provide for the conduct of research and synthesis of evidence: (1) systematic reviews and assessments of existing evidence; (2) primary research, such as randomized clinical trials, molecularly informed trials, and observational studies; and (3) any other methodologies recommended by the methodology committee and adopted by the Board. The research and evidence synthesis would only be conducted in accordance with the methodological standards adopted by the Board.

The Chairman's mark would require the Institute to establish a process for peer-review of primary research, under which evidence would be reviewed to assess scientific integrity and adherence to the methodological standards adopted by the Institute. The Institute would make public a list of names of individuals contributing to any peer-review process during the preceding year or years and include the list in the Institute's annual reports.
Any peer-review process would be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers; the reviews would be conducted by experts in the scientific field relevant to the research under review. The Institute would be allowed to utilize existing peer-review processes already utilized by entities with which the Institute contracts. This would include the option to utilize the peer-review process of appropriate medical journals, if these review processes met the Institute's own requirements for a peer-review process.

Transparency

Elimination of Stark Whole Hospital Exception
Beginning no later than 18 months after the date of enactment, only hospitals meeting certain requirements would be exempt from the prohibition on self-referral. Hospitals that have physician ownership and a provider agreement in operation on November 1, 2009 and that met other specified requirements would be exempt from this self-referral ban. These requirements would address conflict of interest, bona fide investments, and patient safety. In addition, the hospital could not have converted from an ambulatory surgical center to a hospital after the date of enactment.

Sunshine Reporting on Physician Payments
Specifically, the mark would require any manufacturer of a covered drug, device, biological, or medical supply that makes a payment or another transfer of value to a physician, a physician medical practice, a physician group practice, or a hospital with an approved medical residency training program to report annually, in electronic form, specified information on such transactions to the Secretary of HHS. The report would include the transfer recipient's name, business address, amount of the payment, date of the payment, a description of the form of the payment, a description of the nature of the payment, if the payment is related to marketing, education, or research specific to a covered drug, device, biological or medical supply the name of that product, and any other category of information that the Secretary determines appropriate. This reporting requirement would begin on March 31, 2012 and continue on the 90th day of each subsequent calendar year.

Stiff monetary penalties would apply for each payment or transfer not required by a manufacturer or group purchasing organization.