



## **Summary of H.R. 3590 Patient Protection and Affordable Care Act (as introduced)**

### **Employers**

Establishes a reinsurance plan for companies that provide health coverage to retirees too young for Medicare

Individuals and small groups could not be charged higher premiums than larger groups. Premiums may only vary according to family structure, geography, actuarial value of the benefit, age (older beneficiaries may be required to pay premiums up to three times higher than younger beneficiaries), and tobacco use (smokers' premiums may be 1.5 times higher than non-smokers').

States would establish Health Benefit Exchanges to facilitate the purchase of affordable health insurance coverage, including a special exchange for small businesses

Requires individuals to obtain health care coverage. A refundable tax credit to help with the cost of coverage would be available to individuals with incomes under 400% of the federal poverty level. Penalties would be imposed on individuals who fail to obtain coverage.

Employers with more than 200 employees are required to automatically enroll new full-time employees in coverage. Employees may opt out.

Employers with more than 50 full-time employees will be required to pay a fee of \$750 per full-time employee if the company does not provide health care coverage.

A sliding-scale tax credit for the cost of health insurance premiums would be available to employers, including non-profits, with 25 or fewer employees.

Prohibits federal and state health programs from discriminating against health care providers who refuse to provide assisted suicide or euthanasia.

### **Medicaid**

Beginning in 2011, states would have the option to provide Medicaid coverage to all low-income individuals through a state plan amendment. States would have to cover individuals with incomes at or under 133 percent of the federal poverty level beginning in 2014.



From 2014 to 2016, the federal government would pay 100% of the cost of Medicaid coverage for the newly eligible. Thereafter, states would receive an FMAP increase of 31.3% to 34.3% of the cost of coverage for the newly eligible in 2017 and 2018, and an FMAP increase of 32.3% of the cost of the coverage in 2019 and subsequent years.

States would be required to offer premium assistance and wrap-around benefits to Medicaid beneficiaries offered employer-provided insurance if it is cost effective.

Removes barbiturates and benzodiazepines from Medicaid's excludable drug list beginning in 2014

### **Medicaid coverage of long-term services and supports**

Community First Choice option: allows states to cover community-based attendant services to Medicaid beneficiaries with disabilities if the beneficiary otherwise would require hospital- or nursing home-level care.

Allows states to cover more kinds of home- and community-based services through a state plan amendment rather than a waiver, for individuals with higher levels of need.

Extends the Money Follows the Person Medicaid rebalancing demonstration program through 2016.

As of 2014, requires states to give Medicaid beneficiaries receiving services in the community the same protection against spousal impoverishment that beneficiaries living in nursing homes have.

Appropriates \$10 million in each fiscal year 2010 through 2014 for Aging and Disability Resource Centers.

Expresses the sense of the Senate that Congress should address long-term services and supports issues in a comprehensive way.

Allows Medicaid waivers for coordinating services for dual eligibles to continue for up to five years

Requires CMS to establish a Federal Coordinated Care Health Office to integrate Medicare and Medicaid benefits and improve coordination between federal and state agencies for individuals eligible for coverage under both programs

### **Quality**

Prohibits Medicaid payment for services related to a "health care-acquired" condition. CMS will develop a list of the conditions based on current Medicare and state practices.

By 2012, CMS must report to Congress on the appropriateness of applying a health-care acquired Medicare payment policy to nursing facilities and other health care providers (the bill provides a payment penalty for hospitals in the top 25 percentile of rates of hospital-acquired, high-cost and common conditions.)



Gives states the option to enroll Medicaid beneficiaries with chronic conditions in “health homes” under which they would receive team-based, comprehensive medical services, including care coordination.

## **Medicare**

Skilled nursing facilities receive the full payment update in 2010 and 2011.

Beginning in 2012, the SNF market basket update will be reduced by a productivity factor based on “the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity.” (Estimated to be about a 1% reduction in the market basket, but the bill allows the productivity adjustment to reduce payment rates to below the previous year’s level.)

Home health agencies receive the full market basket adjustment in 2010. In 2011 and 2012, the home health market basket adjustment would be reduced by 1 percent. Beginning in 2015, the home health market basket would be reduced by the same productivity factor applied to skilled nursing facilities.

Home health care payments would be rebased beginning in 2013. Caps reimbursement any provider may receive from outliers at 10%. Reinstates rural payment add-on from 4/1/10 through 2015.

Hospice providers receive full payment updates in 2010, 2011 and 2012. Beginning in 2013, hospice payment update will be reduced by the productivity factor applied to nursing facilities. For each fiscal year 2013 through 2019, the payment update would be reduced by 0.5 percent in addition to the application of the productivity factor.

CMS is required to update hospice payment forms and cost reports by 2011. On the basis of updated information, requires CMS to reform the payment system to improve accuracy by 2013.

Establishes a three-year demonstration program at up to 15 sites, allowing beneficiaries eligible for hospice to also receive all other Medicare-covered services concurrently.

Bundling – requires CMS to establish a national, voluntary pilot program by 2013 encouraging doctors, hospitals and post-acute providers to improve services and achieve savings through bundled payments. CMS will be required to develop a plan for expanding this pilot by 2016 if the pilot appears to be achieving its goals.

Value-based purchasing: CMS would have to submit a plan to Congress by 2012 for instituting value-based purchasing for skilled nursing facilities and home health agencies. For hospices, CMS would be required to implement quality measure reporting programs by 2014, and providers failing to report would be subject to reductions in their market basket update.

Establishes a Center for Medicare and Medicaid Innovation within CMS to test new payment and service delivery systems. Funds are authorized to test models providing services not now covered under Medicare.

Establishes the Independence at Home demonstration program for chronically ill Medicare beneficiaries, testing payment incentives and community-based team care approaches to reduce spending and improve health outcomes.



Establishes a community-based care transitions program, funding hospitals and community-based entities that provide transition services to Medicare beneficiaries at high risk for readmission following discharge from a hospital.

Provides grants for the creation of community health teams to develop medical homes by increasing access to comprehensive, community-based coordinated care. Grants also authorized for medication management services in treatment of chronic disease.

Extends the Medicare therapy caps exceptions process through the end of calendar 2010.

Authorizes physician assistants to order skilled nursing services, beginning in 2011.

Requires MedPAC to study the adequacy of Medicare payments to health care providers in rural areas.

Establishes a 15-member independent Medicare Advisory Board to provide Congress with comprehensive proposals for reducing Medicare cost growth and improving quality. The recommendations would take effect in years when Medicare costs “are projected to be unsustainable”. The board’s recommendations could not include proposals that would affect consumers or raise payroll taxes or Part B premiums.

### **Medicare Advantage**

Eliminates the 114% subsidy, basing payment rates on the average of bids from Advantage plans in each market area. Plans could receive a bonus for care coordination, care management and high quality ranking. Provides a longer transition of the amount of extra benefits available from plans to beneficiaries in areas where the level of extra benefits is highest relative to other areas.

Extends the special needs plan program through 2013 and allows CMS to give a frailty payment adjustment to plans that enroll frail, dually eligible populations.

Allows demonstration programs that serve residents in continuing care retirement communities to operate under the Medicare Advantage program.

### **Medicare Part D**

Reduces but does not eliminate the doughnut hole in Medicare coverage of prescription drug costs.

Eliminates cost-sharing for dual eligibles receiving care under a home- and community-based waiver program who would otherwise require institutional care (dual eligibles living in nursing homes already are exempt from cost-sharing).

Requires Part D plans to develop drug dispensing techniques to reduce prescription drug waste in long-term care facilities.

Healthy aging: establishes a pilot program of Centers for Disease Control grants to improve health status of the pre-Medicare-eligible population aged 55 to 64.

Advances research and treatment for pain care management.



## **Workforce**

Establishes a national commission to review projected workforce needs and recommend ways to align federal healthcare workforce resources to meet them. Grants would be available for states to do comprehensive workforce planning and development.

Increases loan amounts in the nursing student loan program.

Authorizes three years of funding for new training opportunities for direct-care workers providing long-term services and supports.

Authorizes funds for geriatric education centers for training in geriatrics, chronic care management and long-term care for faculty in health professions schools and for family caregivers. Also to expand geriatric care awards to advanced practice nurses, clinical social workers, pharmacists and psychologists and establish traineeships for individuals preparing for advanced degrees in geriatric nursing.

## **Nursing Home Transparency**

Requires disclosure of ownership information, including a description of the governing body and organizational structure.

Requires nursing facilities to implement compliance and ethics programs for a facility's employees and agents.

Requires CMS to add information on standardized staffing data, a summary of substantiated complaints, and the number of adjudicated criminal violations by a facility or its employees to Nursing Home Compare.

Requires separate reporting of staffing expenditures on Medicare cost reports.

Requires CMS to develop a mechanism for nursing facilities to report staffing information in a uniform format based on payroll data, also reflecting use of contract or agency staff.

Requires Government Accountability Office to study the 5-star quality rating system.

Allows CMS to discount civil monetary penalties by 50 percent for self-reported deficiencies corrected within ten days.

Civil monetary penalties for deficiencies cited at the actual harm and immediate jeopardy level could be placed in escrow following completion of informal dispute resolution or 90 days after the CMPs were imposed, whichever date is earlier. If a facility's appeal is successful, the CMPs would be returned with interest. If the appeal is unsuccessful, a portion of the CMPs could be used to benefit residents.

Requires CMS to establish a demonstration project to develop an independent monitor program to maintain oversight of interstate and large intrastate nursing home chains.

Requires facilities to give residents and the state 60 days notice of any plans to close and to ensure safe transfer of all residents to an alternative facility or other setting appropriate to their needs.



Establishes demonstration programs on culture change and on use of information technology in nursing homes.

Requires training on dementia care and abuse prevention for nursing home staff.

Requires CMS to establish a nation-wide program of criminal background checks for employees of long-term care providers who have direct access to patients. Program to be based on previously-authorized and ongoing demonstration projects.

### **Patient Outcomes Research**

Establishes a private, non-profit institute to establish priorities and provide for the conduct of comparative outcomes research. Findings are not to be construed as health care practice guidelines or coverage decisions. Includes patient safeguards against discriminatory coverage decisions based on age, terminal illness, disability or quality of life considerations.

### **Waste/Fraud/Abuse**

Requires CMS to develop procedures for screening health care providers participating in Medicare and Medicaid that at minimum would include licensure checks, but which could also include criminal background checks, fingerprinting, multi-state database inquiries, and random or unannounced site visits. Application fees of \$200 for individual providers and \$500 for institutional providers would be imposed each time they verify their enrollment (every five years).

Providers reenrolling in Medicare and Medicaid would be required to disclose current or previous affiliations with any provider or supplier that has uncollected debt, has had payments suspended, has been excluded from the programs, or has had billing privileges revoked.

Maximum period for submission of Medicare claims reduced to twelve months.

Home health services and durable medical equipment must be ordered by a health care professional or doctor enrolled in Medicare. Order must be in writing based on a face-to-face encounter between the doctor/health care professional and the Medicare beneficiary.

Expands the number of metropolitan statistical areas to be included in round two of the competitive bidding program for durable medical equipment, prosthetics, orthotics and supplies.

Expands the recovery audit contractor (RAC) program to state Medicaid programs and to Medicare Parts C and D.

Elder Justice Act: Requires CMS to cooperation with the Departments of Justice and Labor to award grants protecting nursing home residents and provide incentives for individuals to train and work in nursing facilities.

Malpractice – expresses the sense of the Senate that states should develop and test alternatives to the present litigation system and that Congress should consider and evaluate state alternatives.

Long-term services and supports: Includes the CLASS program of voluntary, self-funded public long-term care insurance.

Revenue offsets

Excise tax of 40% imposed on health coverage plans with premiums over \$8,500 for single coverage and \$23,000 for family coverage. Thresholds adjusted for inflation. Tax applies to the amount of the premium in excess of the threshold.

\$2,500 annual limit on contributions to flexible spending arrangements.

Annual fee of \$6.7 billion imposed on health care insurers.

Increases adjusted gross income threshold for claiming the medical expense deduction to 10%.

Increases Medicare payroll tax by 0.5% for individuals earning over \$200,000 and couples earning over \$250,000.

Five percent excise tax on cosmetic surgery

*December 2009*  
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