

## **Patient Protection and Affordable Care Act** **CRS Summary: Medicare Related Excerpts**

---

### **SUMMARY AS OF:**

3/23/2010--Public Law.

### **Patient Protection and Affordable Care Act -**

...

### **Title II: Role of Public Programs –**

...

**Subtitle H: Improved Coordination for Dual Eligible Beneficiaries** - (Sec. 2601) Declares that any Medicaid waiver for individuals dually eligible for both Medicaid and Medicare may be conducted for a period of five years, with a five-year extension, upon state request, unless the Secretary determines otherwise for specified reasons.

(Sec. 2602) Directs the Secretary to establish a Federal Coordinated Health Care Office to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare and Medicaid Services (CMS) to: (1) integrate Medicaid and Medicare benefits more effectively; and (2) improve the coordination between the federal government and states for dual eligible individuals to ensure that they get full access to the items and services to which they are entitled.

...

**Title III: Improving the Quality and Efficiency of Health Care - Subtitle A: Transforming the Health Care Delivery System - Part I: Linking Payment to Quality Outcomes under the Medicare Program** - (Sec. 3001) Amends SSA title XVIII (Medicare) to direct the Secretary to establish a hospital value-based purchasing program under which value-based incentive payments are made in a fiscal year to hospitals that meet specified performance standards for a certain performance period.

Directs the Secretary to establish value-based purchasing demonstration programs for: (1) inpatient critical access hospital services; and (2) hospitals excluded from the program because of insufficient numbers of measures and cases.

(Sec. 3002) Extends through 2013 the authority for incentive payments under the physician quality reporting system. Prescribes an incentive (penalty) for providers who do not report quality measures satisfactorily, beginning in 2015.

Requires the Secretary to integrate reporting on quality measures with reporting requirements for the meaningful use of electronic health records.

(Sec. 3003) Requires specified new types of reports and data analysis under the physician feedback program.

(Sec. 3004) Requires long-term care hospitals, inpatient rehabilitation hospitals, and hospices, starting in rate year 2014, to submit data on specified quality measures. Requires reduction of the annual update of entities which do not comply.

(Sec. 3005) Directs the Secretary, starting FY2014, to establish quality reporting programs for inpatient cancer hospitals exempt from the prospective payment system.

(Sec. 3006, as modified by Sec. 10301) Directs the Secretary to develop a plan to implement value-based purchasing programs for Medicare payments for skilled nursing facilities (SNFs), home health agencies, and ambulatory surgical centers.

(Sec. 3007) Directs the Secretary to establish a value-based payment modifier, under the physician fee schedule, based upon the quality of care furnished compared to cost.

(Sec. 3008) Subjects hospitals to a penalty adjustment to hospital payments for high rates of hospital acquired conditions.

...

**Part III: Encouraging Development of New Patient Care Models** - (Sec. 3021, as modified by Sec. 10306) Creates within CMS a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. Makes appropriations for FY2010-FY2019.

(Sec. 3022, as modified by Sec. 10307) Directs the Secretary to establish a shared savings program that: (1) promotes accountability for a patient population; (2) coordinates items and services under Medicare parts A and B; and (3) encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

(Sec. 3023, as modified by Sec. 10308) Directs the Secretary to establish a pilot program for integrated care (involving payment bundling) during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services.

(Sec. 3024) Directs the Secretary to conduct a demonstration program to test a payment incentive and service delivery model that utilizes 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 applicable beneficiaries.

(Sec. 3025, as modified by Sec. 10309) Requires the Secretary to establish a hospital readmissions reduction program involving certain payment adjustments, effective for discharges on or after October 1, 2012, for certain potentially preventable Medicare inpatient hospital readmissions.

Directs the Secretary to make available a program for hospitals with a high severity adjusted readmission rate to improve their readmission rates through the use of patient safety organizations.

(Sec. 3026) Directs the Secretary to establish a Community-Based Care Transitions Program which provides funding to eligible entities that furnish improved care transitions services to high-risk Medicare beneficiaries.

(Sec. 3027) Amends the Deficit Reduction Act of 2005 to extend certain Gainsharing Demonstration Projects through FY2011.

**Subtitle B: Improving Medicare for Patients and Providers - Part 1: Ensuring Beneficiary Access to Physician Care and Other Services** - (Sec. 3101, deleted by section 10310) (Sec. 3102) Extends through calendar 2010 the floor on geographic indexing adjustments to the work portion of the physician fee schedule. Revises requirements for calculation of the practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011. Directs the Secretary to analyze current methods of establishing practice expense geographic adjustments and make appropriate further adjustments (a new methodology) to such adjustments for 2010 and subsequent years.

(Sec. 3103) Extends the process allowing exceptions to limitations on medically necessary therapy caps through December 31, 2010.

(Sec. 3104) Amends the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 to extend until January 1, 2010, an exception to a payment rule that permits laboratories to receive direct Medicare reimbursement when providing the technical component of certain physician pathology services that had been outsourced by certain (rural) hospitals.

(Sec. 3105, as modified by Sec. 10311) Amends SSA title XVIII (Medicare) to extend the bonus and increased payments for ground ambulance services until January 1, 2011.

Amends the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to extend the payment of certain urban air ambulance services until January 1, 2011.

(Sec. 3106, as modified by Sec. 10312) Amends the Medicare, Medicaid, and SCHIP Extension Act of 2007, as modified by the American Recovery and Reinvestment Act, to extend for two years: (1) certain payment rules for long-term care hospital services; and (2) a certain moratorium on the establishment of certain hospitals and facilities.

(Sec. 3107) Amends MIPPA to extend the physician fee schedule mental health add-on payment provision through December 31, 2010.

(Sec. 3108) Allows a physician assistant who does not have an 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.

(Sec. 3109) Amends title XVIII, as modified by MIPPA, to exempt certain pharmacies from accreditation requirements until the Secretary develops pharmacy-specific standards.

(Sec. 3110) Creates a special part B enrollment period for military retirees, their spouses (including widows/ widowers), and dependent children, who are otherwise eligible for TRICARE (the health care plan under the Department of Defense [DOD]) and entitled to Medicare part A (Hospital Insurance) based on disability or end stage renal disease, but who have declined Medicare part B (Supplementary Medical Insurance).

(Sec. 3111) Sets payments for dual-energy x-ray absorptiometry services in 2010 and 2011 at 70% of the 2006 reimbursement rates. Directs 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 such services on beneficiary access to bone mass measurement benefits.

(Sec. 3112) Eliminates funding in the Medicare Improvement Fund FY2014.

(Sec. 3113) Directs the Secretary to conduct a demonstration project under Medicare part B of separate payments for complex diagnostic laboratory tests provided to individuals.

(Sec. 3114) Increases from 65% to 100% of the fee schedule amount provided for the same service performed by a physician the fee schedule for certified-midwife services provided on or after January 1, 2011.

**Part II: Rural Protections** - (Sec. 3121) Extends through 2010 hold harmless provisions under the prospective payment system for hospital outpatient department services.

Removes the 100-bed limitation for sole community hospitals so all such hospitals receive an 85% increase in the payment difference in 2010.

(Sec. 3122) Amends the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as modified by other federal law, to extend from July 1, 2010, until July 1, 2011, the reasonable cost reimbursement for clinical diagnostic laboratory service for qualifying rural hospitals with under 50 beds.

(Sec. 3123, as modified by Sec. 10313) Extends the Rural Community Hospital Demonstration Program for five additional years. Expands the maximum number of participating hospitals to 30, and to 20 the number of demonstration states with low population densities.

(Sec. 3124) Extends the Medicare-dependent Hospital Program through FY2012.

(Sec. 3125, as modified by Sec. 10314) Modifies the Medicare inpatient hospital payment adjustment for low-volume hospitals for FY2011-FY2012.

(Sec. 3126) Revises requirements for the Demonstration Project on Community Health Integration Models in Certain Rural Counties to allow additional counties as well as physicians to participate.

(Sec. 3127) Directs MEDPAC to study and report to Congress on the adequacy of payments for items and services furnished by service providers and suppliers in rural areas under the Medicare program.

(Sec. 3128) Allows a critical access hospital to continue to be eligible to receive 101% of reasonable costs for providing: (1) outpatient care regardless of the eligible billing method such hospital uses; and (2) qualifying ambulance services.

(Sec. 3129) Extends through FY2012 FLEX grants under the Medicare Rural Hospital Flexibility Program. Allows the use of grant funding to assist small rural hospitals to participate in delivery system reforms.

**Part III: Improving Payment Accuracy** - (Sec. 3131, as modified by Sec. 10315) Requires the Secretary, starting in 2014, to rebase home health payments by an appropriate percentage, among other things, to reflect the number, mix, and level of intensity of home health services in an episode, and the average cost of providing care.

Directs the Secretary to study and report to Congress on home health 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. Authorizes a Medicare demonstration project based on the study results.

(Sec. 3132) Requires the Secretary, by January 1, 2011, to begin collecting additional data and information needed to revise payments for hospice care.

Directs the Secretary, not earlier than October 1, 2013, to implement, by regulation, budget neutral revisions to the methodology for determining hospice payments for routine home care and other services, which may include per diem payments reflecting changes in resource intensity in providing such care and services during the course of an entire episode of hospice care.

Requires the Secretary to impose new requirements on hospice providers participating in Medicare, including requirements for: (1) a hospice physician or nurse practitioner to have a face-to-face encounter with the individual regarding eligibility and recertification; and (2) a medical review of any stays exceeding 180 days, where the number of such cases exceeds a specified percentage of them for all hospice programs.

(Sec. 3133, as modified by Sec. 10316) Specifies reductions to Medicare DSH payments for FY2015 and ensuing fiscal years, especially to subsection (d) hospitals, to reflect lower uncompensated care costs relative to increases in the number of insured. (Generally, a subsection [d] hospital is an acute care hospital, particularly one that receives payments under Medicare's inpatient prospective payment system when providing covered inpatient services to eligible beneficiaries.)

(Sec. 3134) Directs the Secretary periodically to identify physician services as being potentially misvalued and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule.

(Sec. 3135) Increases the presumed utilization rate for calculating the payment for advanced imaging equipment other than low-tech imaging such as ultrasound, x-rays and EKGs.

Increases the technical component payment "discount" for sequential imaging services on contiguous body parts during the same visit.

(Sec. 3136) Restricts the lump-sum payment option for new or replacement chairs to the complex, rehabilitative power-driven wheelchairs only. Eliminates the lump-sum payment option for all other power-driven wheelchairs. Makes the rental payment for power-driven wheelchairs 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%).

(Sec. 3137, as modified by Sec. 10317) Amends the Tax Relief and Health Care Act of 2006, as modified by other federal law, to extend "Section 508" hospital reclassifications until September 30, 2010, with a special rule for FY2010. ("Section 508" refers to Section 508 of the Medicare Modernization Act of 2003, which allows the temporary reclassification of a hospital with a low Medicare area wage index, for reimbursement purposes, to a nearby location with a higher Medicare area wage index, so that the "Section 508 hospital" will receive the higher Medicare reimbursement rate.)

Directs the Secretary to report to Congress a plan to reform the hospital wage index system.

(Sec. 3138) Requires the Secretary to determine if the outpatient costs incurred by inpatient prospective payment system-exempt cancer hospitals, including those for drugs and biologicals, with respect to

Medicare ambulatory payment classification groups, exceed those costs incurred by other hospitals reimbursed under the outpatient prospective payment system (OPPS). Requires the Secretary, if this is so, to provide for an appropriate OPPS adjustment to reflect such higher costs for services furnished on or after January 1, 2011.

(Sec. 3139) Allows a biosimilar biological product to be reimbursed at 6% of the average sales price of the brand biological product.

(Sec. 3140) Directs the Secretary to establish a Medicare Hospice Concurrent Care demonstration program under which Medicare beneficiaries are furnished, during the same period, hospice care and any other Medicare items or services from Medicare funds otherwise paid to such hospice programs.

(Sec. 3141) Requires application of the budget neutrality requirement associated with the effect of the imputed rural floor on the area wage index under the Balanced Budget Act of 1997 through a uniform national, instead of state-by-state, adjustment to the area hospital wage index floor.

(Sec. 3142) Directs the Secretary to study and report to Congress on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under Medicare.

(Sec. 3143) Declares that nothing in this Act shall result in the reduction of guaranteed home health benefits under the Medicare program.

**Subtitle C: Provisions Relating to Part C** - (Sec. 3201, as modified by Sec. 10318) Bases the MedicareAdvantage (MA) benchmark on the average of the bids from MA plans in each market.

Revises the formula for calculating the annual Medicare+Choice capitation rate to reduce the national MA per capita Medicare+Choice growth percentage used to increase benchmarks in 2011.

Increases the monthly MA plan rebates from 75% to 100% of the average per capita savings.

Requires that bid information which MA plans are required to submit to the Secretary be certified by a member of the American Academy of Actuaries and meet actuarial guidelines and rules established by the Secretary.

Directs the Secretary, acting through the CMS Chief Actuary, to establish actuarial guidelines for the submission of bid information and bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

Directs the Secretary to: (1) establish new MA payment areas for urban areas based on the Core Based Statistical Area; and (2) make monthly care coordination and management performance bonus payments, quality performance bonus payments, and quality bonuses for new and low enrollment MA plans, to MA plans that meet certain criteria.

Directs the Secretary to provide transitional rebates for the provision of extra benefits to enrollees.

(Sec. 3202) Prohibits MA plans from charging beneficiaries cost sharing for chemotherapy administration services, renal dialysis services, or skilled nursing care that is greater than what is charged under the traditional fee-for-service program.

Requires MA plans to apply the full amount of rebates, bonuses, and supplemental premiums according to the following order: (1) reduction of cost sharing, (2) coverage of preventive care and wellness benefits, and (3) other benefits not covered under the original Medicare fee-for-service program.

(Sec. 3203) Requires the Secretary to analyze the differences in coding patterns between MA and the original Medicare fee-for-service programs. Authorizes the Secretary to incorporate the results of the analysis into risk scores for 2014 and subsequent years.

(Sec. 3204) Allows beneficiaries to disenroll from an MA plan and return to the traditional Medicare fee-for-service program from January 1 to March 15 of each year.

Revises requirements for annual beneficiary election periods.

(Sec. 3205) Amends SSA title XVIII (Medicare), as modified by MIPPA, to extend special needs plan (SNP) authority through December 31, 2013.

Authorizes the Secretary to establish a frailty payment adjustment under PACE payment rules for fully-integrated, dual-eligible SNPs.

Extends authority through calendar 2012 for SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service areas.

Directs the Secretary to require an MA organization offering a specialized MA plan for special needs individuals to be approved by the National Committee for Quality Assurance.

Requires the Secretary to use a risk score reflecting the known underlying risk profile and chronic health status of similar individuals, instead of the default risk score, for new enrollees in MA plans that are not specialized MA SNPs.

(Sec. 3206) Extends through calendar 2012 the length of time reasonable cost plans may continue operating regardless of any other MA plans serving the area.

(Sec. 3208) Creates a new type of MA plan called an MA Senior Housing Facility Plan, which would be allowed to limit its service area to a senior housing facility (continuing care retirement community) within a geographic area.

(Sec. 3209) Declares that the Secretary is not required to accept any or every bid submitted by an MA plan or Medicare part D prescription drug plan that proposes to increase significantly any beneficiary cost sharing or decrease benefits offered.

(Sec. 3210) Directs the Secretary to request the National Association of Insurance Commissioners (NAIC) to develop new standards for certain Medigap plans.

**Subtitle D: Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans** - (Sec. 3301) Amends Medicare part D (Voluntary Prescription Drug Benefit Program) to establish conditions for the availability of coverage for part D drugs. Requires the manufacturer to participate in the Medicare coverage gap discount program.

Directs the Secretary to establish such a program.

(Sec. 3302) Excludes the MA rebate amounts and quality bonus payments from calculation of the regional low-income subsidy benchmark premium for MA monthly prescription drug beneficiaries.

(Sec. 3303) Directs the Secretary to permit a prescription drug plan or an MA-PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is *de minimis*. Provides that, if such premium is waived, the Secretary shall not reassign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount.

Authorizes the Secretary to auto-enroll subsidy eligible individuals in plans that waive *de minimis* premiums.

(Sec. 3304) Sets forth a special rule for widows and widowers regarding eligibility for low-income assistance. Allows the surviving spouse of an eligible couple to delay redetermination of eligibility for one year after the death of a spouse.

(Sec. 3305) Directs the Secretary, in the case of a subsidy eligible individual enrolled in one prescription drug plan but subsequently reassigned by the Secretary to a new prescription drug plan, to provide the individual with: (1) information on formulary differences between the individual's former plan and the new plan with respect to the individual's drug regimens; and (2) a description of the individual's right to request a coverage determination, exception, or reconsideration, bring an appeal, or resolve a grievance.

(Sec. 3306) Amends MIPPA to provide additional funding for FY2010-FY2012 for outreach and education activities related to specified Medicare low-income assistance programs.

(Sec. 3307) Authorizes the Secretary to identify classes of clinical concern through rulemaking, including anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for the treatment of transplant rejection. Requires prescription drug plan sponsors to include all drugs in these classes in their formularies.

(Sec. 3308) Requires part D enrollees who exceed certain income thresholds to pay higher premiums. Revises the current authority of the IRS to disclose income information to the Social Security Administration for purposes of adjusting the part B subsidy.

(Sec. 3309) Eliminates cost sharing for certain dual eligible individuals receiving care under a home and community-based waiver program who would otherwise require institutional care.

(Sec. 3310) Directs the Secretary to require sponsors of prescription drug plans to utilize specific, uniform techniques for dispensing covered part D drugs to enrollees who reside in an long-term care facility in order to reduce waste associated with 30-day refills.

(Sec. 3311) Directs the Secretary to develop and maintain an easy to use complaint system to collect and maintain information on MA-PD plan and prescription drug complaints received by the Secretary until the complaint is resolved.

(Sec. 3312) Requires a prescription drug plan sponsor to: (1) use a single, uniform exceptions and appeals process for determination of a plan enrollee's prescription drug coverage; and (2) provide instant access to this process through a toll-free telephone number and an Internet website.

(Sec. 3313) Requires the HHS Inspector General to study and report to Congress on the inclusion in formularies of: (1) drugs commonly used by dual eligibles; and (2) prescription drug prices under Medicare part D and Medicaid.

(Sec. 3314) Allows the costs incurred by AIDS drug assistance programs and by IHS in providing prescription drugs to count toward the annual out-of-pocket threshold.

(Sec. 3315) Increases by \$500 the 2010 standard initial coverage limit (thus decreasing the time that a part D enrollee would be in the coverage gap).

**Subtitle E: Ensuring Medicare Sustainability** - (Sec. 3401, as modified by Sec. 10319 and Sec. 10322) Revises certain market basket updates and incorporates a full productivity adjustment into any updates that do not already incorporate such adjustments, including inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals, inpatient rehabilitation facilities, and Part B providers.

Establishes a quality measure reporting program for psychiatric hospitals beginning in FY2014.

(Sec. 3402) Revises requirements for reduction of the Medicare part B premium subsidy based on income. Maintains the current 2010 income thresholds for the period of 2011 through 2019.

(Sec. 3403, as modified by Sec. 10320) Establishes an Independent Medicare Advisory Board to develop and submit detailed proposals to reduce the per capita rate of growth in Medicare spending to the President for Congress to consider. Establishes a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

...

**Subtitle G: Protecting and Improving Guaranteed Medicare Benefits** - (Sec. 3601) Provides that nothing in this Act shall result in a reduction of guaranteed benefits under the Medicare program.

States that savings generated for the Medicare program under this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.

(Sec. 3602) Declares that nothing in this Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in MA plans.

**Title IV: Prevention of Chronic Disease and Improving Public Health –**

...

**Subtitle B: Increasing Access to Clinical Preventive Services –**

...

(Sec. 4103, as modified by Sec. 10402) Amends SSA title XVIII (Medicare) to provide coverage of personalized prevention plan services, including a health risk assessment, for individuals. Prohibits cost-sharing for such services.

(Sec. 4104, as modified by Sec. 10406) Eliminates cost-sharing for certain preventive services recommended by the United States Preventive Services Task Force.

(Sec. 4105) Authorizes the Secretary to modify Medicare coverage of any preventive service consistent with the recommendations of such Task Force.

...

### **Subtitle C: Creating Healthier Communities –**

...

(Sec. 4202) ...Requires the Secretary to: (1) 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 (2) evaluate community prevention and wellness programs that have demonstrated potential to help Medicare beneficiaries reduce their risk of disease, disability, and injury by making healthy lifestyle choices.

...

(Sec. 4204) Authorizes the Secretary to negotiate and enter into contracts with vaccine manufacturers for the purchase and delivery of vaccines for adults. Allows a state to purchase additional quantities of adult vaccines from manufacturers at the applicable price negotiated by the Secretary. Requires the Secretary, acting through the Director of CDC, to establish a demonstration program to award grants to states to improve the provision of recommended immunizations for children and adults through the use of evidence-based, population-based interventions for high-risk populations.

Reauthorizes appropriations for preventive health service programs to immunize children and adults against vaccine-preventable diseases without charge.

Requires the Comptroller General to study the ability of Medicare beneficiaries who are 65 years or older to access routinely recommended vaccines covered under the prescription drug program since its establishment.

...

**Title VI: Transparency and Program Integrity - Subtitle A: Physician Ownership and Other Transparency** - (Sec. 6001, as modified by Sec. 10601) Amends SSA title XVIII (Medicare) to prohibit physician-owned hospitals that do not have a provider agreement by August 1, 2010, to participate in Medicare. Allows their participation in Medicare under a rural provider and hospital exception to the ownership or investment prohibition if they meet certain requirements addressing conflict of interest, bona fide investments, patient safety issues, and expansion limitations.

...

(Sec. 6003) Amends SSA title XVIII (Medicare), with respect to the Medicare in-office ancillary exception to the prohibition against physician self-referrals, to require a referring physician to inform the patient in writing that the patient may obtain a specified imaging service 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 directly supervised by the physician or by another physician in the group practice. Requires

the referring physician also to provide the patient with a written list of suppliers who furnish such services in the area in which the patient resides.

...

**Subtitle B: Nursing Home Transparency and Improvement - Part I: Improving Transparency of Information** - (Sec. 6101) Amends SSA title XI to require SNFs under Medicare and nursing facilities (NFs) under Medicaid to make available, upon request by the Secretary, the HHS Inspector General, the states, or a state long-term care ombudsman, information on ownership of the SNF or NF, including a description of the facility's governing body and organizational structure, as well as information regarding additional disclosable parties.

(Sec. 6102) Requires SNFs and NFs to operate a compliance and ethics program effective in preventing and detecting criminal, civil, and administrative violations.

Directs the Secretary to establish and implement a quality assurance and performance improvement program for SNFs and NFs, including multi-unit chains of facilities.

(Sec. 6103) Amends SSA title XVIII (Medicare) to require the Secretary to publish on the Nursing Home Compare Medicare website: (1) standardized staffing data; (2) links to state websites regarding state survey and certification programs; (3) the model standardized complaint form; (4) a summary of substantiated complaints; and (5) the number of adjudicated instances of criminal violations by a facility or its employees.

(Sec. 6104) Requires SNFs to report separately expenditures on wages and benefits for direct care staff, breaking out registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff.

(Sec. 6105) Requires the Secretary to develop a standardized complaint form for use by residents (or a person acting on a resident's behalf) in filing complaints with a state survey and certification agency and a state long-term care ombudsman program. Requires states to establish complaint resolution processes.

(Sec. 6106) Amends SSA title XI to require the Secretary to develop a program for facilities to report direct care staffing information on payroll and other verifiable and auditable data in a uniform format based.

(Sec. 6107) Requires the Comptroller General to study and report to Congress on the Five-Star Quality Rating System for nursing homes of CMS.

**Part II: Targeting Enforcement** - (Sec. 6111) Amends SSA title XVIII (Medicare) to authorize the Secretary to reduce civil monetary penalties by 50% for certain SNFs and NFs that self-report and promptly correct deficiencies within 10 calendar days of imposition of the penalty. Directs the Secretary to issue regulations providing for an informal dispute resolution process after imposition of a penalty, as well as an escrow account for money penalties pending resolution of any appeals.

(Sec. 6112) Directs the Secretary to establish a demonstration project for developing, testing, and implementing a national independent monitor program to oversee interstate and large intrastate chains of SNFs and NFs.

(Sec. 6113) Requires the administrator of a SNF or a NF that is preparing to close to notify in writing residents, legal representatives of residents or other responsible parties, the Secretary, and the state long-term care ombudsman program in advance of the closure by at least 60 days. Requires the notice to include a plan for the transfer and adequate relocation of residents to another facility or alternative setting. Requires the state to ensure a successful relocation of residents.

(Sec. 6114) Requires the Secretary to conduct two SNF- and NF-based demonstration projects to develop best practice models in two areas: (1) one for facilities involved in the “culture change” movement; and (2) one for the use of information technology to improve resident care.

**Part III: Improving Staff Training** - (Sec. 6121) Requires SNFs and NFs to include dementia management and abuse prevention training as part of pre-employment initial training and, if appropriate, as part of ongoing in-service training for permanent and contract or agency staff.

...

**Subtitle E: Medicare, Medicaid, and CHIP Program Integrity Provisions** - (Sec. 6401, as modified by Sec. 10603) Amends SSA title XVIII (Medicare) to require the Secretary to: (1) establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP; and (2) determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier.

Requires providers and suppliers applying for enrollment or revalidation of enrollment in Medicare, Medicaid, or CHIP to disclose current or previous affiliations with any provider or supplier that: (1) has uncollected debt; (2) has had its payments suspended; (3) has been excluded from participating in a federal health care program; or (4) has had billing privileges revoked. Authorizes the Secretary to deny enrollment in a program if these affiliations pose an undue risk to it.

Requires providers and suppliers to establish a compliance program containing specified core elements.

Directs the CMS Administrator to establish a process for making available to each state agency with responsibility for administering a state Medicaid plan or a child health plan under SSA title XXI the identity of any provider or supplier under Medicare or CHIP who is terminated.

(Sec. 6402) Requires CMS to include in the integrated data repository claims and payment data from Medicare, Medicaid, CHIP, and health-related programs administered by the Departments of Veterans Affairs (VA) and DOD, the Social Security Administration, and IHS.

Directs the Secretary to enter into data-sharing agreements with the Commissioner of Social Security, the VA and DOD Secretaries, and the IHS Director to help identify fraud, waste, and abuse.

Requires that overpayments be reported and returned within 60 days from the date the overpayment was identified or by the date a corresponding cost report was due, whichever is later.

Directs the Secretary to issue a regulation requiring all Medicare, Medicaid, and CHIP providers to include their National Provider Identifier on enrollment applications.

Authorizes the Secretary to withhold the federal matching payment to states for medical assistance expenditures whenever a state does not report enrollee encounter data in a timely manner to the state's Medicaid Management Information System.

Authorizes the Secretary to exclude providers and suppliers participation in any federal health care program for providing false information on any application to enroll or participate.

Subjects to civil monetary penalties excluded individuals who: (1) order or prescribe an item or service; (2) make false statements on applications or contracts to participate in a federal health care program; or (3) know of an overpayment and do not return it. Subjects the latter offense to civil monetary penalties of up to \$50,000 or triple the total amount of the claim involved.

Authorizes the Secretary 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.

Requires the Secretary take into account the volume of billing for a durable medical equipment (DME) supplier or home health agency when determining the size of the supplier's and agency's surety bond. Authorizes the Secretary to require other providers and suppliers to post a surety bond if the Secretary considers them to be at risk.

Authorizes the Secretary to suspend payments to a provider or supplier pending a fraud investigation.

Appropriates an additional \$10 million, adjusted for inflation, to the Health Care Fraud and Abuse Control each of FY2011-FY2020. Applies inflation adjustments as well to Medicare Integrity Program funding.

Requires the Medicaid Integrity Program and Program contractors to provide the Secretary and the HHS Office of Inspector General with performance statistics, including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment for such activities.

(Sec. 6403) Requires the Secretary to furnish the National Practitioner Data Bank (NPDB) with all information reported to the national health care fraud and abuse data collection program on certain final adverse actions taken against health care providers, suppliers, and practitioners.

Requires the Secretary to establish a process to terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in it is transferred to the NPDB.

(Sec. 6404) Reduces from three years to one year after the date of service the maximum period for submission of Medicare claims.

(Sec. 6405, as modified by Sec. 10604) Requires DME or home health services to be ordered by an enrolled Medicare eligible professional or physician. Authorizes the Secretary to extend these requirements to other Medicare items and services to reduce fraud, waste, and abuse.

(Sec. 6406) Authorizes the Secretary to disenroll, for up to 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.

Authorizes the Secretary to exclude from participation in any federal health care program any individual or entity ordering, referring for furnishing, or certifying the need for an item or service that fails to provide adequate documentation to verify payment.

(Sec. 6407, as modified by Sec. 10605) Requires a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant to have a face-to-face encounter with an individual before issuing a certification for home health services or DME.

Authorizes the Secretary to apply the same face-to-face encounter requirement to other items and services based upon a finding that doing so would reduce the risk of fraud, waste, and abuse. Applies the same requirement, as well, to physicians making certifications for home health services under Medicaid.

(Sec. 6408) Revises civil monetary penalties for making false statements or delaying inspections.

Applies specified enhanced sanctions and civil monetary penalties to MA or Part D plans that: (1) enroll individuals in an MA or Part D plan without their consent; (2) transfer an individual from one plan to another for the purpose of earning a commission; (3) fail to comply with marketing requirements and CMS guidance; or (4) employ or contract with an individual or entity that commits a violation.

(Sec. 6409) Requires the Secretary to establish a self-referral disclosure protocol to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral law.

Authorizes the Secretary to reduce the amount due and owing for all violations of such law.

(Sec. 6410) Requires the Secretary to: (1) expand the number of areas to be included in round two of the competitive bidding program from 79 to 100 of the largest metropolitan statistical areas; and (2) use competitively bid prices in all areas by 2016.

(Sec. 6411) Requires states to establish contracts with one or more Recovery Audit Contractors (RACs), which shall identify underpayments and overpayments and recoup overpayments made for services provided under state Medicaid plans as well as state plan waivers.

Requires the Secretary to expand the RAC program to Medicare parts C (Medicare+Choice) and D (Prescription Drug Program).

...

## **Title X: Strengthening Quality, Affordable Health Care for All Americans –**

...

**Subtitle C: Provisions Relating to Title III -** (Sec. 10301) Revises provisions of Subtitles A through G of Title III of this Act (as reflected in the summary of those provisions).

(Sec. 10323) Amends SSA title XVIII (Medicare) to deem eligible for Medicare coverage certain individuals exposed to environmental health hazards.

Directs the Secretary to establish a pilot program for care of certain individuals residing in emergency declaration areas.

Amends SSA title XX (Block Grants to States for Social Services) to direct the Secretary to establish a program for early detection of certain medical conditions related to environmental health hazards. Makes appropriations for FY2012-FY2019.

...

(Sec. 10327) Authorizes an additional incentive payment under the physician quality reporting system in 2011 through 2014 to eligible professionals who report quality measures to CMS via a qualified Maintenance of Certification program. Eliminates the Medicare Advantage Regional Plan Stabilization Fund.

(Sec. 10328) Requires Medicare part D prescription drug plans to include a comprehensive review of medications as part of their medication therapy management programs. Requires automatic quarterly enrollment of qualified beneficiaries, with an allowance for them to opt out.

...

(Sec. 10331) Requires the Secretary to: (1) develop a Physician Compare website with information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting Initiative; and (2) implement a plan to make information on physician performance public through Physician Compare, particularly quality and patient experience measures.

Authorizes the Secretary to provide financial incentives to Medicare beneficiaries furnished services by high quality physicians.

(Sec. 10332) Directs the Secretary to make available to qualified entities standardized extracts of Medicare claims data for the evaluation of the performance of service providers and suppliers.

...

(Sec. 10336) Directs the Comptroller General to study and report to Congress on the impact on Medicare beneficiary access to high-quality dialysis services of including specified oral drugs furnished to them for the treatment of end stage renal disease in the related bundled prospective payment system.

...

*Full summary available at:* <http://thomas.loc.gov/cgi-bin/bdquery/D?d111:5:./temp/~bd9cGG:@@D&summ2=m&/bss/d111query.html>