

**Summary of Issues Affecting Post Acute and Long Term Care in  
the *Patient Protection and Affordable Care Act* and  
the *Health Care and Education Affordability Act*  
March 22, 2010**

Late on March 21, the U.S. House of Representatives took two historic votes on health care reform. The first was on the Senate health care reform bill, the *Patient Protection and Affordable Care Act* (PPACA) (H.R. 3590), which passed along party lines 219 to 212. The second vote was on the budget reconciliation package, the *Health Care and Education Affordability Act* (H.R. 4872), which passed 220 to 211, again along party lines. Since the identical version of PPACA had passed the Senate on December 24, 2009, the bill has been sent to the White House for the President's signature and will become law in the very near future. PPACA contains the vast majority of the provisions constituting health care reform, including those affecting post acute and long term care.

The budget reconciliation bill, H.R. 4872, contains several changes to PPACA and still must be considered by the Senate. Special rules apply to budget reconciliation bills in that chamber, and such bills only require a simple majority (50+1) to pass and may not be filibustered unlike most other pieces of legislation, which must meet a higher, super majority threshold of 60 votes and can be filibustered. AHCA/NCAL understands that the Senate will take up H.R. 4872 later this week, and if passed, the bill also will be sent to the President for his signature.

The following positive provisions for post acute and long term care were included in the final health care reform bill:

- No targeted reductions to the skilled nursing facility (SNF) market basket for FY 2010 or FY 2011.
- The Wyden MedPAC language, which was added at AHCA's request, stating that Medicaid must be taken into account during its analyses for providers like skilled nursing facilities.
- Elimination of Medicare Part D cost-sharing for assisted living residents covered by Medicaid under Sec. 1115 or 1915 waivers or under a 1915(i) state plan amendment, who otherwise would be admitted to a skilled nursing facility. Copays for dual eligibles receiving services in a Medicaid managed care organization also are eliminated.
- Several provisions improving our nation's health care workforce programs including a demonstration project providing further training opportunities specifically for direct care workers employed in long term care settings.
- The CLASS Act.
- A Sense of the Congress statement on tort reform.
- State demonstration programs to evaluate alternatives to current medical tort litigation.
- New grants under the Elder Justice section for health information technology and workforce training.
- A General Accountability Office study and report on the Five Star Quality Rating System.

The following negative provisions for post acute and long term care were included in the final health care reform bill:

- A productivity adjustment to the skilled nursing facility market basket will be implemented beginning in FY 2012 (October 1, 2011) estimated to total \$14.6 billion over 10 years.

- While implementation of RUG-IV was pushed back a year to October 1, 2011, neither the changes to concurrent therapy requirements nor MDS 3.0 were delayed- they take effect October 1, 2010.
- A new Independent Medicare Advisory Board (IMAB) was created to make recommendations to Congress about issues, such as Medicare payment rates for skilled nursing facilities. IMAB will submit a list of recommendations to Congress, on which Congress can vote to approve or disapprove. Some providers, such as hospitals, received an exemption from IMAB until 2019. Unfortunately SNFs were not given the same exemption.
- New transparency requirements for nursing facilities.
- Additional background check requirements for skilled nursing facility and nursing facility employees with direct patient access.
- Changes to reporting of crimes requirement in the Elder Justice section.
- The impact on employers of the health care insurance requirements.

Below is a summary of provisions of H.R. 3590 impacting post acute and long term care. Where modifications would be made by the reconciliation bill, once signed into law, we have noted them in *red italics and double underlining*.

## **Medicare**

### **Skilled Nursing Facility (SNF) Market Basket Productivity Adjustment (Section 3401)**

Beginning in Fiscal Year (FY) 2012, the Skilled Nursing Facility (SNF) market basket will be reduced by a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private non-farm business multifactor productivity as projected by the Secretary.

*Note that although the Congressional Budget Office did not provide a specific figure for SNF cuts for this bill, in previous versions of the bill, it estimated the cuts to be \$14.6 billion over 10 years.*

### **Revision to Skilled Nursing Facility Prospective Payment System (Section 10325)**

Delays implementation of the RUGs-IV payment system changes for one year to October 1, 2011. However, the implementation of the concurrent therapy adjustment, the look back period change, and MDS 3.0 have not been delayed and will go into effect on October 1, 2010. Note that AHCA was advised by Senate staff that our request for delays on both the concurrent therapy adjustment and MDS 3.0 were not included because the Congressional Budget Office (CBO) calculated such a change as costing approximately \$2 billion.

### **Therapy Caps (Section 3103)**

The current exceptions process for Medicare Part B outpatient therapy services is extended through December 31, 2010.

### **MedPAC Must Consider Medicaid Into Account in Certain Circumstances (Section 1681(b)(3))**

The bill includes language offered as an amendment by Senator Ron Wyden (D-OR) that requires MedPAC to report Medicaid data as to trends in spending, utilization, and financial performance for those providers having a significant portion of either revenue or services from Medicaid. The section also expands MACPAC's mission to include assessment of adult services in Medicaid including those for dual eligibles in conjunction with MedPAC.

### **Assisted Living Part D Copay Partial Elimination (Section 3309)**

This provision of the bill would eliminate Medicare Part D cost-sharing for institutionally eligible dual eligible beneficiaries receiving services under Sec. 1115 or 1915 waivers or under a 1915(i) state plan amendment, as well as for duals receiving services in a Medicaid managed care organization.

### **Independent Medicare Advisory Board (Section 3403)**

An Independent Medicare Advisory Board (IMAB) would be established, comprised of 15 members appointed by the President and confirmed by the Senate, to develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries. Qualifications for members of IMAB would be similar to the qualifications required for members of the Medicare Payment Advisory Commission (MedPAC). Members would serve six-year, staggered terms and would continue to serve until replaced. The Board is tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts. AHCA is concerned that several provider types (acute care hospitals, hospice, inpatient rehabilitation facilities, and inpatient psychiatric hospitals) would be exempt from the recommendations until 2019.

Congress would take up the recommendations under an expedited procedure, with the option of modifying the IPAB recommendations but would have to achieve the same level of savings. If Congress fails to act on the IMAB recommendations, they would go into effect by an established deadline. MedPAC would continue to exist in its current form as an advisory body to Congress.

### **Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-term Care Settings (Section 3310)**

For plan years beginning on or after January 1, 2012, the bill would require Medicare Part D prescription drug and Medicare Advantage prescription drug plans to employ utilization management techniques, such as weekly, daily or automated dose dispensing, when providing medications to beneficiaries residing in long-term care facilities in order to reduce waste associated with 30-day fills.

### **National Pilot Program on Payment Bundling (Section 3023)**

By January 1, 2013, the Secretary will implement a national, voluntary pilot program to coordinate care for Medicare beneficiaries not covered under Part C during an entire episode of care for eight conditions to be specified by the Secretary. Services to be included in the bundle are: acute care inpatient hospital services; physician services delivered inside and outside of the acute care hospital setting; outpatient hospital services, including emergency department visits; services associated with acute care hospital readmissions; post acute care services including

home health, skilled nursing, inpatient rehabilitation, long term care hospital; and other services that the Secretary determines appropriate. The Secretary must take the following into account: whether the specified conditions include both chronic and acute; whether there is a mix of surgical and medical conditions; whether a condition allows providers and suppliers to improve the quality of care while reducing total expenditures; whether there is significant variation in the number of readmissions, the amount of expenditures for post-acute care; whether a condition “has high volume and high post acute care expenditures; and which conditions the Secretary decides are most “amenable to bundling across the spectrum of care given practice patterns”. The episode of care established in the pilot program would start three days prior to a qualifying admission to the hospital and span the length of the hospital stay and 30 days following the patient discharge, unless the Secretary determines another timeframe is more appropriate for purposes of the pilot. The Secretary must decide which patient assessment tool as well as which quality measures, for both episodes of care and post acute care, are to be used in the pilot. The post-acute care quality measures must be site neutral. The Secretary would develop policies to ensure the traditional fee-for-service program provides payment for post-acute care (PAC) services in the appropriate setting for those patients who require continued PAC services after the 30th day following the discharge. The pilot must be conducted for five years, and if it improves patient outcomes, reduces costs and improves efficiency, then the Secretary would be required to submit a plan to Congress to make the program permanent. The Secretary is given the authority to expand the program if it is found to improve quality and reduce costs. Also, the Secretary is directed to test bundled payment arrangements involving continuing care hospitals within the bundling pilot program.

#### **Value-Based Purchasing (Section 3006)**

By October 1, 2011, the HHS Secretary is required to submit to Congress a Medicare value-based purchasing implementation plan for Skilled Nursing Facilities. The plan must consider the following: (1) the development, selection, and modification process of measures to the extent feasible and practical of all dimensions of quality and efficiency; (2) the reporting, collection, and validation of quality data; (3) the structure of proposed value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments; (4) methods for publicly disclosing performance information on performance; and (5) any other issues as determined by the Secretary. In developing each plan, the Secretary would be required to consult with relevant stakeholders and take into consideration experiences with demonstrations that are relevant to value-based purchasing in SNFs.

#### **Payment Adjustment for Conditions Acquired in Hospitals (Section 3008)**

Starting in FY 2015, hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare. This provision also requires the Secretary to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a health care acquired condition policy related to other providers participating in Medicare, including nursing homes, inpatient rehabilitation facilities, long-term care hospitals, outpatient hospital departments, ambulatory surgical centers, and health clinics.

#### **Maximum Period for Submission of Medicare Claims (Section 6408)**

Beginning January 2010, the maximum period for submission of Medicare claims would be reduced to not more than 12 months.

### **Recovery Audit Contractors (Section 6411)**

Medicare Parts C and D, as well as Medicaid, would be included in the Recovery Audit Contractors (RACs) Program, which collects and identifies underpayments and overpayments currently for Medicare Parts A and B.

### **Ability of Physician Assistants to Certify Need for Post Acute Care (Section 3108)**

Provides the authority for physician assistants to certify the need for post-hospital extended care services.

### **Establishment of Center for Medicare and Medicaid Innovation within CMS (Section 3021)**

Establishes within the Centers for Medicare and Medicaid Services (CMS) a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare. Successful models can be expanded nationally.

### **Medicare Shared Savings Program (Section 3022)**

Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program.

### **Hospital Readmissions Reduction Program (Section 3025)**

Beginning in FY 2012, this provision would adjust payments for hospitals paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum. Also, provides the Secretary authority to expand the policy to additional conditions in future years and directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions.

### **Community-based Care Transitions Program (Section 3026)**

Provides funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission.

### **Extension of Gainsharing Demonstration (Section 3027)**

The *Deficit Reduction Act of 2005* authorized a demonstration to evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries. This provision would extend the demonstration through September 30, 2011 and extend the date for the final report to Congress on the demonstration to September 30, 2012. Additional funding would be provided for this purpose.

### **Immediate Reduction in Coverage Gap for 2010 (Section 3315)**

The bill contains language that, beginning on January 1, 2010, the initial coverage limit for Medicare Part D plans would be increased by \$500.00. Procedures would be established for retroactive reimbursement of beneficiaries for the costs incurred before implementation.

### **MedPAC Study of Payment Adequacy for Rural Providers (Section 3127)**

The Medicare Payment Advisory Commission (MedPAC) must examine the adequacy of payments for items and services provided under Medicare in rural areas and report to Congress by January 1, 2011 on any recommendations for administrative or legislative action. The study must analyze the following: any payment adjustments; access to items and services; the adequacy of payments to providers and suppliers serving rural areas; and the quality of care furnished.

### **Independence at Home Demonstration Program (Section 3024)**

Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes.

### **Face-to-Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare (Section 6407)**

Requires physicians to have a face-to-face encounter with the individual prior to issuing a certification for home health services or DME. The Secretary would be authorized to apply the 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.

### **Adjustments to the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Acquisition Program (Section 6410)**

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

## **Medicaid**

**Incentives for States to offer Home and Community Based Services as a Long-Term Care alternative to nursing homes (Section 10202)** This provision adds a new policy creating financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS). The provision provides Federal Medical Assistance Percentage (FMAP) increases to States to rebalance their spending between nursing homes and HCBS by October 1, 2015.

### **Medicaid Presumptive Eligibility Determinations by Hospitals (Section 2202)**

Starting on January 1, 2014, this provision would allow any hospital the option, based off preliminary information, to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

### **Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries (Section 2602)**

Requires the Secretary to establish a Federal Coordinated Health Care Office (CHCO) within CMS by March 1, 2010. The purpose of the CHCO would be to bring together officials of the Medicare and Medicaid programs to (1) more effectively integrate benefits under those programs, and (2) improve the coordination between the Federal and State governments for individuals eligible for benefits under both Medicare and Medicaid (dual eligibles) to ensure that dual eligibles have full access to the items and services, including long term care, to which they are entitled.

### **Medicaid Bundled Payments Demonstration Project (Section 2704)**

A Medicaid bundled payment demonstration project would be established in eight states to begin on January 1, 2012 through December 31, 2014. Services included would encompass acute care hospital, concurrent physician, and post acute care services. Hospitals would receive a single bundled payment from Medicaid for such services.

### **Changes to the Medicaid and CHIP Payment and Access Commission (MACPAC) (Section 2801)**

In FY 2010, MACPAC is to receive \$11 million in funding, \$9 million from Medicaid funds and \$2 million from CHIP. The proposal expands MACPAC's mission to include assessment of adult services in Medicaid, including dual eligibles. Issues to be examined by MACPAC include payments, access to services, quality of care, and interactions with Medicare and Medicaid. The bill also requires MACPAC to consult regularly with MedPAC and other stakeholders such as states.

### **Medicaid Reimbursement for Health Care Acquired Conditions (Section 2702)**

As of July 1, 2011, Medicaid would no longer provide payments to states for services related to health care acquired conditions (HCACs). The HCAC definition under Medicaid would be consistent with the Medicare definition, but will be expanded to include conditions acquired in facilities other than hospitals. Differences between the Medicare and Medicaid programs, and their beneficiaries, would also be considered in the HCACs definition, as would current state practices. No denial of care must result from enforcement of this section.

### **Provider Participation Termination Under Medicaid if Terminated Under Medicare or Other State Plan (Section 6501)**

This provision would require States to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another State's Medicaid program.

### **Medicaid Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliations (Section 6502)**

Individuals or entities are temporarily excluded from participating in Medicaid if the entity has unpaid overpayments. This exclusion extends to affiliated entities under management, control, or ownership of entities that are excluded from participation.

### **Billing Agents and Other Alternate Payees Required to Register Under Medicaid (Section 6503)**

Requires any agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers to register with the State and the Secretary in a form and manner specified by the Secretary.

### **Medicaid Overpayments (Section 6506)**

Extends the period for States to repay Medicaid overpayments to one year when a final determination of the amount of the overpayment has not been determined due to an ongoing judicial or administrative process. When overpayments due to fraud are pending, State repayments of the Federal portion would not be due until 30 days after the date of the final judgment.

### **Mandatory State Use of National Correct Coding Initiative (Section 6508)**

Medicaid claims filed on or after October 1, 2010 will be subject to compatible methodologies of the National Correct Coding Initiative (NCCI) currently administered by CMS. The current program is designed to promote correct coding methodologies and to control improper coding leading to inappropriate payment in Medicare Part B claims. This new initiative would apply these same principles to Medicaid claims.

### **Elimination of Exclusion of Coverage of Certain Drugs (Section 2502)**

As of January 1, 2014, the following pharmaceuticals will be removed from Medicaid's excludable drug list: barbiturates, benzodiazepines, and smoking cessation drugs.

### **Medicaid Global Payment System Demonstration (Section 2705)**

A Medicaid Global Payments demonstration project would be established in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment system from a fee-for-service structure to a global capitated payment structure. The CMS Innovation Center would conduct an evaluation of each demonstration project examining any changes in health care quality outcomes and spending. The Innovation Center would be exempted from budget-neutrality requirements for an initial testing period. The Innovation Center also would be given the authority to terminate or modify the demonstration project during the testing period. The Secretary would be required to conduct and analysis of the demonstration project and report her findings to Congress.

**H.R. 4872 contains the following provision: FMAP Adjustment for Newly Eligible Individuals (Section 1201)**

Eliminates the provision of the Senate bill providing for a 100% federal matching rate just for Nebraska to cover the costs of newly eligible individuals to the Medicaid program. Substitutes federal Medicaid matching payments to all states, except expansion ones, for the costs of services to newly eligible individuals at the following rates: 100% in 2014, 2015, and 2016; 95% in 2017; 94% in 2018; 93% in 2019; and 90% thereafter. For expansion states, the state share of the costs of covering nonpregnant childless adults is reduced by 50% in 2014, 60% in 2015, 70% in 2016, 80% in 2017, 90% in 2018. Beginning in 2019 and thereafter, expansion states would revert to the same state share for newly eligible individuals as non-expansion states.

**Nursing Home Transparency**

**Required Disclosure of Ownership and Additional Disclosable Parties (Section 6101)**

The bill requires SNF/NFs to disclose information on their organizational structures as well as information on officers, directors, trustees, or managing employees, including names, titles, and start date of service. The term “managing employee” means an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

The bill requires disclosure of owners of a whole or part interest in any mortgage, deed or other obligation exceeding 5 percent of a facility’s total property/assets. Additional disclosable parties include entities that provide policies or procedures for any of the operations of the facility, provide financial or cash management services, or provide management or administrative services, management or clinical consulting services, or accounting or financial services to the facility. However, the provision was amended in this bill, and in earlier iterations of the Senate Finance bill, to exclude a requirement for facilities to disclose parties that lend funds or provide financial guarantees of any amount to facilities. The bill also requires disclosure of limited liability company information and any limited partners of the limited partnership who have an ownership interest in the limited partnership, which is equal to or exceeds 10 percent.

The bill requires a facility to make all disclosable parties’ information available to the public upon request and update the information as necessary to reflect changes. Facilities are required to certify to the Secretary, the Inspector General that the information submitted upon request is, to the best of the facility’s knowledge, “accurate and current”, and the Secretary must develop a standardized format for the information within two years of date of enactment.

**Compliance Program (Section 6102)**

The bill requires nursing facilities/skilled nursing facilities have a compliance and ethics program in operation 36 months after enactment of the concept paper. The compliance/ethics program must be effective in preventing and detecting criminal, civil, and administrative violations and in promoting quality of care. Three years after the date of the promulgation of regulations under this section, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subsection and will submit a report to Congress on this evaluation.

### **Nursing Home Compare Medicare Website (Section 6103)**

The legislation requires Secretary to ensure that information provided for comparison of nursing homes be posted on the Nursing Home Compare website in a manner that is prominent, easily accessible, updated on a timely basis, readily understandable to consumers of long-term care services, and searchable. The website must also include summary information on the number, type, severity, and outcome of adjudicated instances of criminal violations by a facility or the employees of a facility that were committed inside the facility and the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

The bill would also require that additional information on the Special Focus Facility Program be posted on the Nursing Home Compare website. States must also maintain a consumer-oriented website providing info on SNFs/NFs in the state including State inspection reports, facilities plan of correction, and any other information that the state or the Secretary considers useful to the public.

In reviewing and modifying the website, the Secretary must now consult with State long-term care ombudsman programs, consumer advocacy groups, and provider stakeholder groups.

### **Reporting of Expenditures (Section 6104)**

The bill would require SNFs/NFs to report expenditures separately for direct care services, indirect care services, capital assets, and administrative costs on cost reports for cost reporting periods beginning on or after two years after date of enactment. The Secretary, in consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports, shall redesign such reports.

### **Standardized Complaint Form (Section 6105)**

The bill requires the Secretary to develop a standardized complaint form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program.

### **Ensuring Staffing Accountability (Section 6106)**

The bill requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, including information on agency or contract staff. Effective two years after date of enactment.

### **GAO Study and Report on Five-Star Quality Rating System (Section 6107)**

The bill directs the Comptroller General to conduct a study of the CMS 5-Star system. The study will evaluate how the system is being implemented, and problems associated with the system, and how the system may be improved. The Comptroller must issue a report of the study's findings to Congress two years after enactment of this bill.

### **Civil Money Penalties (CMPs) (Section 6111)**

The bill states that Secretary may reduce civil money penalties (CMPs) up to 50 percent in the case where a facility self-reports and promptly corrects a deficiency within 10 days. Reductions would not be made for self-reported deficiencies citing an immediate jeopardy or actual harm

violation. With respect to repeat deficiencies, the Secretary can not reduce these penalties if the Secretary had reduced a penalty imposed on the facility in the preceding year.

Thirty days after imposition of civil penalty, the bill gives the facility an opportunity to participate in independent formal dispute resolution, but this opportunity does not affect the responsibility of the State survey agency for making final recommendations for penalties.

The Secretary would have the authority to place CMPs imposed, for deficiencies citing an immediate jeopardy or actual harm violation, in an escrow account following completion of the informal dispute resolution process, or the date that is 90 days after the date of the imposition of the CMP.

The Secretary would be authorized to use a portion of collected CMPs to fund activities that benefit residents. Such funds would also be used for facility improvement initiatives approved by the Secretary, including joint training of facility staff and surveyors and technical assistance for facilities implementing quality assurance programs.

#### **National Independent Monitor Demonstration Project (Section 6112)**

The bill requires HHS Secretary along with the Office of the Inspector General to establish a demonstration project to develop, test, and implement use of independent monitoring program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities. Chains would be responsible for a portion of the costs associated with appointment of independent monitors. HHS OIG would evaluate the demonstration project after two years.

#### **Notification of Facility Closure (Section 6113)**

The bill imposes sanctions for a facility's failure to comply with the Facility Closure Notification requirements, including CMPs of \$100,000 as well as possible exclusion from participating in any federal health care program.

#### **National Demonstration Project on Cultural Change and Use of Information Technology (Section 6114)**

The bill requires the Secretary to conduct two demonstration projects, one for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement and one for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care. The demonstration projects will be implemented no less than 1 year after the enactment of the bill. The Secretary will award one or more grants to facility-based settings for the development of best practices

#### **Dementia and Abuse Prevention Training (Section 6121)**

Requires facilities to include dementia management and abuse prevention training as part of pre-employment initial training for permanent and contract or agency staff, and if the Secretary determines appropriate, as part of ongoing in-service training.

## **Nationwide Program for Background Checks (Section 6201)**

The bill also includes the entire text of the *Patient Safety and Abuse Prevention Act* (S. 631). The Secretary must establish a nationwide program for national and State background checks on direct patient access employees of certain long-term care (LTC) facilities or providers and provide Federal matching funds to States to conduct these activities. States that enter into an agreement with the Secretary would be responsible for monitoring compliance with the requirements of the nationwide program and have specified compliance procedures in place. The HHS Inspector General would be required to conduct an evaluation of the nationwide program and submit a report to Congress no later than 180 days after completion of the national program in FY 2012.

LTC providers (including assisted living/residential care providers) that participate in either the Medicare or Medicaid programs would be required to obtain state and national criminal history and other background checks on their prospective employees through such means as the Secretary determines appropriate. To conduct these checks, states would utilize a search of state-based abuse and neglect registries and specified state and federal databases and records, including a fingerprint check. There is a 60-day grace period during which newly hired staff may be given provisional employment, pending the completion of the criminal background check.

## **Quality**

### **National Strategy to Improve Health Care Quality (Section 3011)**

The HHS Secretary is directed to create a national quality improvement strategy addressing the following priorities: delivery of health care services, patient health outcomes, and population health. This strategy must be submitted to Congress for review by January 1, 2011. The Secretary is tasked with identifying national priorities and must consider: high-cost chronic diseases; patient safety improvements and medical errors, preventable hospital admissions and readmissions, health care-associated infections; reduce health disparities across health disparity populations and geographic areas; and other areas as determined appropriate by the Secretary. Once the priorities are established, a strategic plan must be created taking into account the following: coordination among agencies to minimize duplication and utilization of common quality measures; agency-specific strategic plans; a regular status reporting process; establishment of annual benchmarks for each participating agency; strategies to align incentives among public and private payors for quality and patient safety efforts; incorporating quality improvement and measures for HIT. A website must be created so that the public may access the details of the strategy.

### **Interagency Working Group on Health Care Quality (Section 3012)**

A "Working Group" with the following goals would have to be convened. Goals include:

- 1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models and timetables consistent with the national priorities under the Public Health Service Act.

- 2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.
- 3) Assess alignment of quality efforts in the public sector with private sector initiatives.

The Working Group would be composed of senior level representatives from HHS, CMS, HRSA, AHRQ, etc. Not later than December 31, 2010, and annually thereafter, the Working Group must submit to the relevant Committees of Congress, and post on a public website, a report describing the progress and recommendations of the Working Group in meeting its goals.

### **Quality Measure Development (Section 3013)**

As part of the National Strategy to Improve Health Care Quality, the term quality measure is defined as “a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.” At least every three years, the Secretary must do an analysis to identify where there are no existing quality measures or where existing ones need improvement, updating, or expansion. The results of the analysis must be posted on a publicly available website. Grants will be awarded to: improve, update, or expand quality measures with priority given to those assessing health outcomes, functional status, coordination across episodes of care and transitions; meaningful use of HIT; safety, effectiveness, patient centeredness, appropriateness and timeliness of care; efficiency of care; health disparities; patient satisfaction; and other areas as determined by the Secretary.

### **Quality Measure Endorsement (Section 3014)**

Grants will be awarded to a consensus-based entity to make annual recommendations to the Secretary on the aforementioned national priorities and identify gaps. In the process of making these recommendations in a transparent way, the entity must convene voluntary “multi-stakeholder groups”, which must involve representatives from a broad range of interested parties including; post acute providers, health care professionals, hospitals, quality alliances, health plans, labor, employers and public purchasers, licensing and credentialing organizations; government agencies and consumer representatives. These multi-stakeholder groups will provide guidance on the selection of quality measures and must provide information to the Secretary by February 1 of each year beginning in 2012, such as whether the group has endorsed a particular quality measure. A pre-rulemaking process also will be established for these activities. The Secretary takes the endorsement of such measures under advisement, and may only use a non-endorsed measure in certain circumstances and by following a specific procedure, which includes publication of the rationale in the *Federal Register*. The Secretary must also disseminate these quality measures so that they may be used in workforce programs, training curricula, and payment programs among others.

### **Quality Data Collection and Public Reporting (Section 3015)**

The Secretary is required to collect and compile consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information. Grants may be awarded to conduct this activity. The collection, aggregation, and analysis systems must encompass a wide variety of patient populations, providers, and geographic areas. The Secretary must make this data publicly available in addition to performance information, tailored for the needs of individual types of

providers. The data must include clinical conditions and be provider-specific, although disaggregated.

### **Medicaid Adult Health Quality Measures (Section 2701)**

Directs the Secretary of HHS to develop a core set of quality measures for Medicaid eligible adults similar to that in place for the Children's Health Insurance Program. The Secretary and the States will report on the development of and improvements to the quality measurement program on a regular basis.

### **Quality Reporting for Long Term Care Hospitals, Inpatient Rehabilitation Hospitals and Hospice Programs (Section 3004)**

The bill contains language that, for each of these providers for the rate year 2014 and each subsequent rate year, if the provider does not submit quality data to the Secretary, any annual update to a standard Federal rate for discharges shall be reduced by 2 percentage points. Not later than October 1, 2012, the Secretary shall publish the quality measures to be used. Quality measures would be reported on the CMS web site.

### **Health Care Delivery System Research: Quality Improvement Technical Assistance (Section 3501)**

The Center for Quality Improvement and Patient Safety of the AHRQ (referred to as the "Center") would conduct or support activities related to best practices for quality improvement in delivering health care services; assess research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery; and build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs. The Center may establish a Quality Improvement Network Research Program that would develop practice recommendations applicable to a variety of settings. Recommendations would include practical methods to address health care associated infections, reducing preventable hospital admissions and readmissions, etc.

## **Fraud, Waste and Abuse – Medicare, Medicaid Program Integrity Provisions**

### **Provider Screening (Section 6401)**

The bill would require that the Secretary, in consultation with the Office of Inspector General (OIG), to screen all providers and suppliers before granting Medicare, Medicaid, and CHIP billing privileges and at time of revalidation. At a minimum all providers and suppliers would be subject to licensure checks. Certain groups of providers and suppliers would be subject to additional screening measures according to risk, as defined by the Secretary. The additional types of screening measures could include submission of fingerprints, criminal background checks, multistate data base inquiries, and random or unannounced site visits. The screening requirement would begin one year from the date of enactment.

An application fee of \$200 for individual practitioners, adjusted for inflation beginning in 2011, and \$500 for institutional providers and suppliers adjusted for inflation beginning in 2011, would be imposed to cover the costs of screening each time they re-verify their enrollment (every five years).

States failing to create effective screening programs would be subjected to a financial penalty through a reduction in their Federal Medical Assistance Percentage (FMAP). A hardship exception to the fee would be permitted, as would waiver of the fee for Medicaid providers for whom the state can demonstrate the fee would impede beneficiary access to care.

### **Disclosure Requirements (Section 6401)**

The bill would also impose new disclosure requirements on providers and suppliers enrolling or re-enrolling in Medicare or Medicaid. Applicants would be required to disclose current or previous affiliations with any provider or supplier that has uncollected Medicare or Medicaid debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked. The Secretary would be authorized to deny enrollment in Medicare if these affiliations pose an undue risk to the program.

### **Compliance Programs (Section 6401)**

By a date determined by the Secretary, certain providers and suppliers would be required to establish a compliance program. The requirements for the compliance program would be developed by the Secretary and the HHS OIG.

### ***H.R. 4872 contains the following provisions: Medicare Prepayment Medical Review Limitations (Section 1302)***

*In order to streamline procedures for conducting Medicare prepayment reviews to facilitate additional fraud and abuse reviews, Section 1847A of the Social Security Act is repealed. That section permits the Secretary of Health and Human Services (HHS) to enter into contracts with any eligible entity to serve as a Medicare Administrative Contractor (MAC) and process Medicare Part A and B Fee for Service (FSS) claims.*

### **Enhanced Medicare and Medicaid Program Integrity Provisions (Section 6402)**

- **Integrated Data Repository** Requires CMS to include in the integrated data repository (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), the Social Security Administration, and the Indian Health Service (IHS).
- **Access to Data** The Secretary would be required to enter into data-sharing agreements with the Commissioner of Social Security, the Secretaries of the VA and DOD, and the Director of the IHS to help identify fraud, waste, and abuse. The Committee Bill would grant the HHS OIG and the Department of Justice (DOJ) access to the IDR for the purposes of conducting law and oversight activities consistent with applicable privacy, security, and disclosure laws.
- **Overpayments** In the bill, the Secretary would have increased authority allowing for suspensions of payment during credible investigations of fraud; and new procedures for disclosure and repayment of overpayments. Further, the 60 days providers and suppliers have to repay Medicare overpayments would be modified to either 60 days after the date on which the overpayment was made or the date the corresponding cost

report is due. Providers and suppliers would be required to repay any Medicare or Medicaid overpayment identified through an internal compliance audit. The bill 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.

- **National Provider Identifier** Requires the Secretary to issue a regulation mandating that all Medicare, Medicaid, and CHIP providers include their NPI on enrollment applications.
- **Medicaid Management Information System** Authorizes the Secretary to withhold the Federal matching payment to States for medical assistance expenditures when the State does not report enrollee encounter data in a timely manner to the State's Medicaid Management Information System (MMIS).
- **Permissive Exclusions** Subjects providers and suppliers to exclusion for providing false information on any application to enroll or participate in a Federal health care program.
- **Civil Monetary Penalties** Expands the use of Civil Monetary Penalties (CMPs) to excluded individuals who order or prescribe an item or service, make false statements on applications or contracts to participate in a Federal health care program, or who know of an overpayment and do not return the overpayment. Each violation would be subject to CMPs of up to \$50,000.
- **Testimonial Subpoena Authority** 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.
- **Surety Bonds** Requires that the Secretary take into account the volume of billing for a DME supplier or home health agency when determining the size of the surety bond. The Secretary would have the authority to impose this requirement on other providers and suppliers considered to be at risk by the Secretary.
- **Payment Suspensions** Authorizes the Secretary to suspend payments to a provider or supplier pending a fraud investigation.
- **Health Care Fraud and Abuse Control Account** Increases Health Care Fraud and Abuse Control (HCFAC) funding by \$10 million each year for fiscal years 2011 through 2020. The provision would also permanently apply the CPI-U adjustment to HCFAC and Medicare Integrity Program (MIP) funding.
- **Medicare and Medicaid Integrity Programs** Requires Medicare and Medicaid Integrity Program contractors to provide the Secretary and the HHS 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.

**H.R. 4872 contains the following provision: Funding to Fight Fraud, Waste and Abuse (Section 1304)**

**Increases funding for the Health Care Fraud and Abuse Control Fund by \$250 million through FY 2016. Indexes funds to fight Medicaid fraud based on the increase in the Consumer Price Index.**

**Elimination of Duplication Between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank (Section 6403)**

Requires the Secretary to maintain a national health care fraud and abuse data collection program for reporting certain adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB). The Secretary would also be required to establish a process to terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in the HIPDB is transferred to the NPDB.

**Enhanced Penalties (Section 6408)**

Subjects persons who fail to grant HHS OIG timely access to documents, for the purpose of audits, investigations, evaluations, or other statutory functions, to CMPs of \$15,000 for each day of failure. Also, persons who knowingly make, use, or cause to be made or used any false statement to a Federal health care program would be subject to a CMP of \$50,000 for each violation. The violations that could be subject to the imposition of sanctions and CMPs by the Secretary would include Medicare Advantage (MA) or Part D plans that: (1) enroll individuals in a 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. Penalties for MA and Part D plans that misrepresent or falsify information

**Medicare Provider Self-Disclosure Protocol (SRDP) (Section 6409)**

The Secretary would be required to establish, within 180 days, a mechanism for providers to disclose voluntarily specific information regarding actual and potential violations of the physician self-referral law. The mechanism would be similar to the Provider Self-Disclosure Protocol (SRDP) operated by the HHS OIG.

The Secretary shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to a SRDP.

The mechanism would be available to all health care providers and would not be limited to a particular industry, specialty, or service. The mechanism would also offer an incentive to encourage providers to participate, such as a damage calculation near the lower-end of the statutory spectrum.

The Secretary would not be required to resolve all matters disclosed in this manner. However, the Secretary would be required to work closely with providers that come forward in good faith seeking a resolution. Neither the HHS OIG nor the DOJ would be precluded from opening an investigation into a provider while the disclosure protocol is being implemented. Any resolution

entered into by the Secretary and the provider would not be binding on the DOJ or other Federal or state agency.

### **Health Care Fraud Enforcement (Section 10606)**

The Sentencing Commission is directed to increase the guidelines range for health care fraud offenses. The amendment includes all health care crimes within the definition of "health care fraud offense" regardless of where they are codified. The amendment removes any ambiguity that "kickbacks" are a health care fraud offense and changes the intent requirement for fraud under the anti-kickback statute.

### **Whistleblower (Section 10104)**

This provision substantially narrows the application of the False Claims Act's public disclosure bar. To be deemed "public" under the amended provision, a disclosure would have to be made in a Federal proceeding (civil, criminal or administrative) in which "the Government or its agent is a party" or come "from" the news media. This change means that whistleblowers can base fraud allegations from a publicly aired in a state proceeding or state audit reports and file the allegations in federal court.

This provision also would amend the "original source" exception to the public disclosure bar allowing whistleblowers to go forward with an FCA case that includes allegations publicly disclosed only if the whistleblower has voluntarily reported the fraud to the Government before filing an action or if the whistleblower provides information to the Government that "materially adds" to the publicly disclosed information.

The provision gives also gives the Federal government a veto, enabling the government to decide to allow certain whistleblowers to go forward regardless of a disclosure bar.

### **Tort Reform**

#### **Sense of the Congress Provision (Section 6801)**

The bill would express the Sense of the Congress that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. In addition, it states that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system.

#### **State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation (Section 10607)**

The HHS Secretary is authorized to award demonstration grants to States, not exceed \$500,000 per State, for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. Note there is no explicit prohibition on a State's eligibility for incentive payments if it limits attorneys' fees or imposes caps on damages in these alternatives. The State alternative models would be required to emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes. Patients would be able to opt-out of these alternatives at any time.

The alternatives must not conflict with State law at the time of the application or limit patient's existing legal rights and ability to file a claim in or access a State's legal system.

## **Workforce**

### **National Health Care Workforce Commission (Section 5101)**

Establishes a national commission tasked with reviewing health care workforce and projected workforce needs, with the goal of providing comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources.

### **State Health Care Workforce Development Grants (Section 5102)**

Competitive grants are created to enable State partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels. Grants will support innovative approaches to increase the number of skilled health care workers such as health care career pathways for young people and adults.

### **Health Care Workforce Assessment (Section 5103)**

Codifies the existing national center and establishes several regional centers for health workforce analysis to collect, analyze, and report data related to Title VII (of the Public Health Service Act) primary care workforce programs. The centers will coordinate with State and local agencies in collecting labor and workforce statistical information and provide analyses and reports on Title VII to the Commission.

### **Workforce Demonstration Project (Section 5507)**

A new HHS demonstration project would be established for low-income individuals who would like to obtain education and training for those health care occupations that are in high demand or are experiencing shortages. Grants would be made to states, local workforce investment boards, or community based organizations. The demonstration will determine the efficacy of developing core training competencies in the following areas: the role of the personal or home care aide; consumer rights, ethics, and confidentiality; communication, cultural, and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills; personal care skills; health care support; nutritional support; infection control; safety and emergency training; training specific to an individual consumer's needs; and self-care. The project will also evaluate the methods used to implement these competencies including length of training, appropriate student to trainer ratio, time spent in the classroom compared to on-site, trainer qualifications, content for hands-on training and written certification exam, and continuing education requirements. A personal care aide is defined as one "who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer's disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual."

### **Graduate Nurse Education Demonstration Program (Section 5509)**

The bill would establish a graduate nurse education demonstration program under Medicare in order to increase the supply of highly skilled advanced practice nurses. Participating hospitals would receive reasonable costs reimbursement from Medicare for the educational costs (including faculty salaries, any student stipends, clinical instruction costs, and other direct and indirect costs) of a hospital and affiliated schools attributable to the training of advanced practice nurses. The demonstration aims to provide these nurses with skills necessary to provide primary and preventive care, transitional care, chronic care management, and other appropriate nursing services through affiliation with one or more accredited nursing schools and in partnership with two or more non-hospital community-based patient care settings where at least half of all clinical training occurs. The Secretary would be able to waive the requirement for affiliation with accredited nursing schools for clinical training of advanced practice registered nurses in rural and medically underserved areas. The term “advanced practice nurse” under this section would include a clinical nurse specialist, nurse practitioner, certified registered nurse anesthetist, and certified nurse midwife.

### **Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education (Section 5305)**

Authorizes funding to geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools and family caregivers; develop curricula and best practices in geriatrics; expand the geriatric career awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; and establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing.

### **Training Opportunities for Direct Care Workers (Section 5302)**

The bill would establish grants to institutions of higher education to provide training opportunities to direct care workers employed in long term care settings, e.g. ALFs, SNFs, ICFs/MR, HCB settings, etc. Once an individual has completed the training, he/she must work in the field of geriatrics, disability services, long term services and supports, or chronic care management for at least 2 years.

### **Protection for Employees (Section 1558)**

Amends the Fair Labor Standards Act to ensure that no employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee has received a premium tax credit or for other reasons.

### **Other Issues of Specific Interest to Long Term Care, Post Acute Care, and Assisted Living**

#### **Elder Justice Act Amendment (Sections 1911 – 1913)**

The legislation includes the entire text of the *Elder Justice Act* (S. 795), which amends the Social Security Act to establish an Elder Justice program under Title XX Block Grants to States for Social Services. It also establishes within the Office of the Secretary of Health and Human

Services (HHS) an Elder Justice Coordinating Council (EJCC) as well as an Advisory Board on Elder Abuse, Neglect, and Exploitation. The HHS Secretary is directed to make grants to eligible entities to establish stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation. In addition, the Secretary must provide incentives for individuals to train for, seek, and maintain employment providing direct care in a long term care (LTC) facility. Grants will be made to LTC facilities to: (1) offer continuing training and varying levels of certification to employees who provide direct care to LTC facility residents; and (2) provide bonuses or other benefits to employees who achieve certification. Other grants also will be made to assist LTC facilities in offsetting the costs for standardized clinical health care informatics systems designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors. HHS must not only provide funding to state and local adult protective services offices that investigate reports of elder abuse, neglect, and exploitation; but also collect and disseminate related data in coordination with the Department of Justice. A program of annual adult protective services grants to states must also be created. Moreover, the Secretary must make grants to eligible entities to improve the capacity of state LTC ombudsman programs to respond to and resolve abuse and neglect complaints; and conduct pilot programs with state or local LTC ombudsman offices. Programs must be established to both provide and improve ombudsman training for national organizations and state LTC ombudsman programs. Additionally, each individual owner, operator, employee, manager, agent, or contractor of an LTC facility receiving certain federal support must report to the Secretary and local law enforcement entities any reasonable suspicion of crimes occurring in such facility. Additionally the owner or operator of such an LTC facility must notify the Secretary and the appropriate state regulatory agency of a facility's impending closure, as well as establish a plan for the transfer and adequate relocation of facility residents. The Secretary must also study and report to the EJCC and appropriate congressional committees on establishing a national nurse aide registry.

### **Establishment of a National Voluntary Insurance Program for Purchasing Community Living Assistance Services and Support (CLASS Program) (Section 8002)**

A new, voluntary, public long-term care insurance program called the CLASS Independence Benefit Plan is established, so that individuals with functional limitations can purchase community living assistance services and supports. The Secretary must make sure that the Plan is actuarially sound and that it ensures solvency for 75 years; allows for a five year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of \$50 per day. For institutionalized eligible beneficiaries enrolled in Medicaid, the beneficiary shall retain 5% of the cash benefit (in addition to the Medicaid personal needs allowance) and the rest shall be applied toward the facility's cost of providing care. Medicaid shall be secondary payor. For beneficiaries receiving home- and community-based (HCB) services, they retain 50% of the cash benefit and the remainder shall be applied to the cost of the state of providing Medicaid assistance. Medicaid provides secondary coverage subject to various conditions. The definition of HCB services includes HCB services under Medicaid waivers and 1915(i) HCB State Plan Option. A Personal Care Attendants Advisory Panel must be established no later than 90 days after the Act is enacted. The Panel will examine and advise the Secretary and Congress on workforce issues related to personal care attendant workers, including the adequacy of the number of such workers, and access by individuals to the services provided by such workers.

## **HIPAA Administrative Simplification (Section 1104)**

Accelerates HHS adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans governed under the Health Insurance Portability and Accountability Act (HIPAA). Establishes a process to update regularly the standards and operating rules for electronic transactions. The goal of this section is to make the health system more efficient by reducing the clerical burden on providers, patients and health plans.

## **Long Term Care Services and Supports**

A series of amendments discussing long term care services and supports were included in the bill language.

- **Community First Choice Option (Section 2401)** —The bill would establish the Community First Choice Option, which would create a state plan option under section 1915 of the Social Security Act to provide community based attendant supports and services to individuals with disabilities who are Medicaid eligible and who require an institutional level of care. These services and supports include assistance to individuals with disabilities in accomplishing activities of daily living, instrumental activities of daily living, health related tasks and additional supports such as voluntary training on how to select manage, and dismiss attendants. Services and supports may be provided by family members, agencies and others. Beginning on October 1, 2010, states would be required to provide these services under a “person-centered” plan and services would be “consumer controlled,” meaning that the individual or his/her representative would have maximum control of HCB attendant services, “regardless of who may act as the employer of record.” States would have to establish Development and Implementation Councils. Under the Community First Choice Option, services must be provided without regard to age, type or severity of disability or form of HCB services required to lead an independent life. States who choose the Community First Choice Option would be eligible for enhanced federal match rate of an additional six percentage points for reimbursable expenses in the program. The Community First Choice Option also would require data collection. [H.R. 4872 would delay implementation of this program until October 1, 2011.](#)
- **Spousal Impoverishment (Section 2404)** – The bill would protect against spousal impoverishment in all Medicaid home and community based services programs by requiring states to apply the same spousal impoverishment rules currently provided to the spouses of nursing home residents in Medicaid. The provision would sunset after five years.
- **Removal of Barriers to Providing Home and Community-Based Services (Section 2402)** This would remove barriers to providing HCBS by giving states the option to provide more types of HCBS through a state plan amendment to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment.
- **Money Follows the Person Rebalancing Demonstration (Section 2403)** This provision would extend the current Money Follows the Person Demonstration grant program for an additional 5 years until 2016. It would change the requirement that a

qualifying individual has been in an institution from not less than 6 months to not less than 90 consecutive days and it also excludes rehab stays.

#### **Clarification of Definition of Medical Assistance (Section 2304)**

The bill would clarify the original intent of Congress that the term “medical assistance” as used in various sections of the *Social Security Act* encompasses both payment for services provided and the services themselves.

#### **Sense of the Senate Amendment on Long Term Services and Supports (Section 2406)**

The bill expresses the Sense of the Senate that this Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need and that long term services and supports should be made available in the community in addition to in institutions.

#### **State Option to Provide Health Homes for Enrollees with Chronic Conditions (Section 2703)**

The bill states that, beginning January 1, 2011, under a State plan amendment a state may provide medical assistance to eligible individuals with chronic conditions who select a designated provider, a team of health care professionals operating with such a provider, or a health team as the individual’s “health home” to provide individual with health home services. Services may include comprehensive care management; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; referral to community and social support services, etc. Providers may include physicians, physician practices, community health centers, home health agencies, or other entities deemed by both the HHS Secretary and the State that have the infrastructure in place to provide home health services. Payments made to the provider shall be treated as medical assistance except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the FMAP applicable to such payments shall be equal to 90 percent. The total amount of payments made to States shall not exceed \$25,000,000.00.

#### **Hospital Wage Index Amendments (Section 3137)**

By December 31, 2011, the Secretary is to submit a report to Congress that includes a plan to reform the hospital wage index system. Changes to the hospital wage index that are not hospital specific, are generally adopted in the SNF and other PAC settings the following year. The bill includes additional hospital-specific language that may indirectly have an impact on nursing homes. Since these changes are implemented in a budget neutral manner, there will not be an overall gain or loss for the industry, but various geographic areas may be somewhat affected positively and others negatively.

#### **Hospice Reform (Section 3132)**

The bill states that beginning no later than January 1, 2011, the Secretary shall collect additional data and information [than as is currently collected] as appropriate to revise payments for hospice care. Data may include information on charges and payments; the number of hospice visits; the type of practitioner providing the visit; etc. Hospice programs and the Medicare Payment Advisory Commission (MedPAC) will be consulted regarding the data and information to be collected. Not earlier than October 1, 2013, the Secretary would, through regulation,

implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care. Revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing care and services during the entire episode of care. MedPAC's hospice program eligibility recertification recommendations would be adopted.

### **Removing Barriers and Improving Access to Wellness for Individuals with Disabilities (Section 4203)**

The bill would require that no later than 24 months after enactment of the Act that the Architectural and Transportation Barriers Compliance Board consult with the Commissioner of the FDA to create minimum technical criteria for medical diagnostic equipment. The equipment would have to be accessible to, and usable by, individuals with accessibility needs and allow them independent entry to, use of, and exit from the equipment.

### **Program to Facilitate Shared Decision Making (Section 3506)**

Establishes a program at HHS for the development, testing, and disseminating of educational tools to help patients, caregivers, and authorized representatives understand their treatment options.

### **Nondiscrimination (Section 1557)**

Protects individuals against discrimination under the Civil Rights Act, the Education Amendments Act, the Age Discrimination Act, and the Rehabilitation Act, through exclusion from participation in or denial of benefits under any health program or activity.

### **Oversight (Section 1559)**

The Inspector General of the Department of HHS shall have oversight authority with respect to the administration and implementation of this title as it relates to such Department.

### **Rules of Construction (Section 1560)**

Nothing in this title shall be construed to modify, impair, or supersede the operation of any antitrust laws.