

**HIGHLIGHTS OF THE HOUSE TRI-COMMITTEE HEALTH CARE REFORM BILL – “AMERICA’S AFFORDABLE HEALTH CHOICE ACT OF 2009”, H.R. 3200**

- 1. Physician Payment** – reforms the Sustainable Growth Rate formula that annually updates reimbursement rates for physician services in Medicare and completely eliminates any projected deficits. In 2010, updates payment rates by using the Medicare Economic Index, which will provide at least a 1% increase. Also, does not reduce payment rates for increases in spending on drugs or lab services. In 2011 and beyond, two “buckets” are created, one for primary care, E & M and preventive services with payment based on the Gross Domestic Product (GDP) + 2 and one for all other services with payment based on GDP + 1.
- 2. AAA Screening** – requires the Health and Human Services (HHS) Secretary to report to Congress within 12 months on beneficiary barriers to AAA screening in Medicare and makes the education of physicians and patients about the risk factors for AAA and when beneficiaries should be screened a priority.
- 3. Misvalued Codes** – directs the HHS Secretary to regularly review fee schedule rates for physician services paid for by Medicare, including services that have experienced high growth rates and strengthens the Secretary’s authority to adjust fee schedule rates that are found to be misvalued or inaccurate.
- 4. Physician Quality Report Initiative (PQRI)** – extends the PQRI through 2012, which provides payment incentives to physicians who report quality data to Medicare. The program remains voluntary, with no penalties for those who do not participate.
- 5. Payment for Imaging Services** – increases the practice expense units for imaging services to reflect a presumed utilization rate of 75% instead of 50%, but excludes ultrasound from this adjustment.
- 6. Waiver of Cost Sharing for Preventive Services** – eliminates Medicare beneficiary co-pays for all preventive services, including AAA screening and the Welcome to Medicare Physical Exam.
- 7. U.S. Preventive Services Task Force (USPSTF)** – converts the USPSTF into the Task Force on Clinical Prevention Services. Staffed by the Agency for Healthcare Research and Quality (AHRQ), non-governmental experts will conduct evidence-based systematic reviews of data and literature to determine what clinical preventive services are scientifically proven to be effective.
- 8. Comparative Effectiveness Research** – establishes a Center for Comparative Effectiveness Research within AHRQ to conduct, support and synthesize research relevant to the comparative effectiveness of the full spectrum of health care services and systems. Also establishes a 17 member Commission that will

include the AHRQ Director, Centers for Medicare and Medicaid Services (CMS) Chief Medical Officer, clinicians, patients, researchers, third-party payers and consumers.

- 9. Accountable Care Organizations (ACOs)** – creates an alternative payment model within fee-for-service Medicare to reward physician-led organizations that take responsibility for the costs and quality of care received by their patients. ACOs can include groups of physicians organized around a common delivery system, an independent practice association, a group practice or other common practice organizations. ACOs that reduce costs relative to a spending benchmark are rewarded with a share of the programmatic savings.
- 10. Medicare Home Pilot Program** – reorients the medical home demonstration in Medicare by creating two models: the independent patient-centered medical home that is structured around a primary or principal care provider and targets high need Medicare beneficiaries with multiple chronic diseases and the community-based medical home that targets a broader population of beneficiaries with chronic diseases and allows for state-based or non-profit entities to provide care-management supervised by primary care providers.
- 11. Payment Incentive for Selected Primary Care Services** – increases the Medicare payment rate by 5% for primary care services of physicians, which is defined both by specialty and by share of a practice in primary care.
- 12. Quality Measurement** – directs the Secretary to establish national priorities for quality improvement, incorporating recommendations from outside entities. Based on national priorities, the Secretary will develop, test and update new patient-centered and population-based quality measures for the assessment of health services. Provides for stakeholder input into the use of quality measures for payment purposes and ensures that quality measures are endorsed by a consensus-based entity. By 2013, the focus will be outcomes measures.
- 13. Physician Payments Sunshine Provisions** – requires manufacturers or distributors to electronically report to HHS any payments or other transfers of value above \$5 to covered recipients, which include physicians, physician group practices, sponsors of continuing medical education (CME) programs and organizations of health care professionals. This pre-empts state sunshine acts. Representative Baron Hill (D-IN) may introduce an amendment that would remove CME sponsors and health care organizations from this list.
- 14. Graduate Medical Education** – directs the Secretary to redistribute residency positions that have been unfilled for the prior three cost reports and direct those slots for training of primary care physicians. Allows hospitals to count resident time for didactic and scholarly activities.

- 15. Liability Reform** – provides incentive payments to states to encourage them to implement one or more medical liability litigation alternatives.
- 16. Health Benefits Advisory Committee** – requires at least 25% of the members of the private-public Health Benefits Advisory Committee, chaired by the Surgeon General, to be health care practitioners who practice in rural areas and have done so for five years and the proportion of Medicare Payment Advisory Commission members who represent rural providers be proportional to the total number of Medicare beneficiaries who reside in rural areas.
- 17. Public Plan** – allows physicians to opt-out. Prohibits taxpayer bailouts to subsidize the plan. Blue Dog amendments agreed to include:
- a.** Requiring the HHS Secretary to negotiate payment rates in the public plan so that they would not be lower than Medicare or higher than the average rates paid by private plans in the Health Care Exchange. The Exchange would allow consumers to choose between public and private competing health insurance plans;
  - b.** Establishing a Consumer Operated and Oriented Plan (CO-OP) program through which grants and loans will be made for the creation and initial operation of not-for-profit, member run health insurance co-ops that provide insurance through the Exchange;
  - c.** Making those who are offered insurance by their employers ineligible for subsidies in the Exchange unless their premiums equal 12% of their income. Also, small businesses (\$500,000 or under in payroll) would be exempt from the pay-or-play mandate;
  - d.** Allowing dissemination of information on end-of-life planning by qualified health benefits plan entities, including options to establish advanced directives and physicians' orders for life-sustaining treatment;
  - e.** Establishing a CMS Payment Innovation to test the effect of payment models on spending and quality of life under Medicare. The HHS Secretary may implement the model nationwide if it improves quality without increasing spending and/or reduces spending without reducing quality.

**\* 71 amendments were not discussed by the Energy and Commerce Committee – some will be considered after the August recess**