Rockefeller Delivery System Reform Amendment #1 to the America's Healthy Future Act

Rockefeller Amendment #D1 to Title III, Subtitle A (Transforming the Health Care Delivery System)

Part II – Strengthening the Quality Infrastructure

Short Title: Clarification of the members of the Quality Improvement Coordinating Council.

Description of Amendment:

This amendment would further define the members of the Quality Improvement Coordinating Council to include the following:

- The Centers for Medicare and Medicaid Services (CMS)
- National Institutes of Health (NIH)
- Centers for Disease Control and Prevention
- Food and Drug Administration (FDA)
- The Department of Health and Human Services (HHS)
- The Health Resources and Services Administration (HRSA)
- The Agency for Healthcare Research and Quality (AHRQ)
- Administration on Children and Families
- The Department of Labor
- The Department of Defense
- The Department of Veterans Affairs
- The Veterans Health Administration
- The Department of Commerce
- The Office of Personnel Management
- The Office of Management and Budget
- The U.S. Coast Guard
- The Federal Bureau of Prisons
- The National Highway Transportation and Safety Administration
- The Federal Trade Commission

- The Social Security Administration

Offset: This amendment should be budget neutral

Rockefeller Delivery System Reform Amendment #2 to the America's Healthy Future Act

Rockefeller Amendment #D2 to Title III, Subtitle A (Transforming the Health Care Delivery System)

Part IV – Strengthening Primary Care and Other Workforce Improvements

Short Title: Re-defining primary care to include geriatricians, palliative care and mental health for the purposes of improving access to primary care.

Description of Amendment:

This amendment would add language to include geriatricians in the definition of primary care providers for the purposes of the primary care bonus and General Surgery bonus.

This amendment would expand the professionals included in the redistribution of graduate medical education spots to define geriatricians, palliative care and mental health professionals as "primary care providers" for the purposes of this section.

This amendment would invest in training and distribution of geriatric specialists, by using language consistent with the concepts included in the Advanced Care Planning and Compassionate Care Act of 2009.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Delivery System Reform Amendment #3 to the America's Healthy Future Act

Rockefeller Amendment #D3 to Title III, Subtitle A (Transforming the Health Care Delivery System)

Short Title: Add a new Part V – Health Information Technology; add free clinics to the list of providers eligible for Medicare and Medicaid incentives under the American Recovery and Reinvestment Act of 2009 (P.L. 111-5)

Description of Amendment:

This amendment would create a new Part V in the mark and amend Title IV under Division B of P.L. 111-5 to add free clinics to the list of providers eligible for both Medicare and Medicaid incentives. Free clinic should be defined as follows:

"Free clinics are safety-net health care organizations that use volunteers to provide a range of medical, dental, pharmacy, and/or behavioral health services to economically disadvantaged individuals the majority of whom are uninsured or underinsured. Free clinics are community based 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization. Entities that otherwise meet the above definition, but charge a nominal fee to patients, may still be considered free clinics provided essential services are delivered regardless of the patient's ability to pay."

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Delivery System Reform Amendment #4 to the America's Healthy Future Act

Rockefeller Amendment #D4 to Title III, Subtitle A (Transforming the Health Care Delivery System)

Short Title: Create a new Part V – Health Information Technology; require third-party audits of health information technology

Description of Amendment:

This amendment would amend current law to require the National Coordinator for Health Information technology to require third-party audits of electronic medical record systems as part of the certification of technology by the Certification Commission for Healthcare Information Technology (CCHIT).

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Delivery System Reform Amendment #5 to the America's Healthy Future Act

Rockefeller Amendment #D5 to Title III, Subtitle A (Transforming the Health Care Delivery System)

Short Title: Create a new Part V – Health Information Technology; add advance planning language

Description of Amendment:

This amendment would require the Secretary of HHS and the National Coordinator for Health IT to implement standards for including advance directives in electronic health records (EHRs), no later than January 1, 2011, using the VA as a model.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Delivery System Reform Amendment #6 to the America's Healthy Future Act

Rockefeller Amendment #D6 to Title III, Subtitle B (Improving Medicare for Patients and Providers)

Part III – Medicare Part D Improvements

Short Title: Eliminate discriminatory prescription drug cost-sharing for individuals with chronic disease.

Description of Amendment:

This amendment would improve the Medicare prescription Drug Program using language consistent with the concepts included in Section 2 of the Affordable Access to Prescription Medications Act of 2009 (S. 1630). This includes sections similar to the following:

Monthly Cap on Out-of-pocket Spending. Beginning plan year 2011, the Secretary shall implement a monthly cap on the cost of any one prescription drug at $200 per 30-day supply. The Secretary shall make the necessary adjustments to make certain this policy is applied to both 60 and 90-day supplies of prescription drugs as well. No co-insurance or co-payment may be greater than the base cost of the prescription drug, as determined by the Secretary. No beneficiary shall pay more then $500 in co-payments or co-insurance in any given month. The amounts noted in this section shall be indexed annually according to the average of CPI and CPI medical.

Expansion of the Exceptions Process. Beginning plan year 2011, the Secretary shall expand the formulary tier exception request process to specialty drugs (Subpart M – Grievances, Coverage Determinations, and Appeals, 42 C.F.R §§423.560 – 423.636) to allow beneficiaries to request an exception to a plan's designation of a drug as non-preferred.

MedPAC Study Regarding the Medicare Part D Anti-Discrimination Clause. Within one year of enactment, the Medicare Payment Advisory Commission (MedPAC) shall report to Congress on various aspects of the Medicare Part D program, and to the greatest extent possible its interaction with beneficiary access to prescription drugs under Medicare Part B. This report should focus specifically on the existence of specialty tiers and their effect on access to care for Medicare beneficiaries and shall consider the following mechanisms in the context of the Medicare Part D Anti-Discrimination Clause:

- Prescription drug specialty tiers;
- Application of segmented coinsurance or copayment structures based on certain categories of prescription drugs or diagnoses; and
- Utilization of other differential benefit structures based on certain conditions and on Medicare beneficiaries under Part D prescription drug plans (PDPs) and Medicare Advantage (MA) organizations, and report on the interaction between these policies and effects with the Medicare Part D anti-discrimination clause.

Based on the findings of this study, the Secretary shall issue revised guidance regarding such practices to all PDP sponsors under Part D and MA organizations in response to such findings.

MedPAC Study Regarding Medicare Parts B and D Prescription Drug Cost-Sharing. Within six months of enactment, the Medicare Payment Advisory Council (MedPAC) shall report to Congress the impact of eliminating cost-sharing for Medicare beneficiaries who incur annual out of pocket prescription drug cost-sharing after the donut hole that exceeds 5 percent of family income and who otherwise do not qualify for the low-income subsidy or other extra help, or cost-sharing relief.

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Delivery System Amendment #7 to America's Healthy Future Act

Rockefeller Amendment #D7 to Title III, Subtitle B (Improving Medicare for Patients and Providers), Part III (Medicare Part D Improvements); and Subtitle C (Medicare Advantage)

Short Title: Improvements to the Medicare prescription drug program

Description:

This amendment would add provisions to the mark consistent with the concepts included in the Medicare Prescription Drug Coverage Improvement Act of 2009 (S. 1634).

Offset: Capping itemized deductions at 35%.

[NOTE – Amendment sponsors reserve the right to modify the amendment for technical, revenue-neutrality, or other purposes.]

Rockefeller Delivery System Amendment #8 to America's Healthy Future Act

Rockefeller Amendment #D8 to Title III, Subtitle B, Part III (Medicare Part D Improvements); and Subtitle C (Medicare Advantage)

Short Title: NCQA Quality standards for Medicare Advantage Special Needs Plans (SNPs)

Description:

This amendment would add provisions to the mark consistent with the concepts included in Section 103 of the Medicare Prescription Drug Coverage Improvement Act of 2009 (S. 1634).

Rockefeller Delivery System Amendment #9 to America's Healthy Future Act

Rockefeller Amendment #D9 to Title III, Subtitle C (Medicare Advantage)

Short Title: Eliminate all overpayments to Medicare Advantage private plans

Description:

This amendment would eliminate all overpayments to private Medicare Advantage plans, effective January 1, 2011.

Rockefeller Delivery System Reform Amendment #10 to the America's Healthy Future Act

Rockefeller Amendment #D10 to Title III Subtitle E (Ensuring Medicare Sustainability)

Short Title: Amendment to the Medicare Commission provision

Description of Amendment:

The amendment would strike the description of the Commission and add the language consistent with the concepts included in the following sections of the MedPAC Reform Act of 2009 (S. 1380), with a modification to replace all references to "MedPAC" with "the Commission":

- Section 1(b), with a modification to require that Commissioners are "free of any current conflicts and held to the highest standards of disclosure and accountability"
- Section 1(b), with a modification to include Administrator of the Health Resources and Services Administration (HRSA) as an ex-officio member of the Commission
- Section 2(g) MACPAC Technical Amendments
- Section 2(h) Lobbying Cooling-Off Period

This amendment would strike the process for the Commission and the HHS Secretary to submit proposals to Congress to decrease excess cost growth (Beginning on Page 157, paragraph two). In its place, beginning in 2014, the Commission would be required to implement policies that successfully reduce cost growth in Medicare by at least 1.5 percent annually. This maintains the protections described on page 156 in the second paragraph of the Chairman's description of the Commission, but clarifies that the Commission has no authority to increase premiums or deductibles. In the event that the CMS actuaries determine as part of their annual report to Congress, that the Medicare program is solvent according to the short range test for financial adequacy, MedPAC is no longer required to meet the 1.5 percent reduction in Medicare cost growth. In the event that these proposal are not found by the CMS actuaries to achieve the goals set forth, the Secretary of HHS would be provided the authority to make up the balance of the decrease necessary through a cumulative reduction in provider reimbursement.

The role of Congress would be amended using language consistent with the concepts included in *Section 2(d) Congressional Action* of the MedPAC Reform Act (S. 1380) with a modification to replace all references to "MedPAC" with "the Commission".

The provision on page 158 of the mark to reauthorize the Commission in 2019 would be removed, there would be no sunset of the Commission, and it would remain a permnanent entity.

This provision would add language consistent with the concepts included in included in the following Sections of the MedPAC Reform Act of 2009 (S. 1380) with a modification to replace all references to "MedPAC" with "the Commission":

- Section 2(e) Research, Information Access, and Demonstration Projects
- Section 2(f) Additional Resources to Carry Out Duties

This amendment would also add the following advisory councils:

- **Council of Health and Economic Advisers:** Consisting of acknowledged experts in health care and economics, including some of MedPAC's previous Commissioners, (the new) MedPAC's panel of health and economic advisers is chosen by the Commission (except for the initial advisers) to advise the Commission on its development, analyses, and implementation of Medicare payment policy.

- **Consumer Advisory Council:** Composed of 10 consumer representatives (from the ten regions established by the Centers for Medicare and Medicaid Services), the council advises the Board on the impact of Medicare payment policies on consumers. The council membership represents the interests of consumers and particular communities. Members are appointed by the Government Accountability Office and serve staggered three-year terms. Subject to the call of the Commission, the council meets at least two times a year in Washington, D.C., and the meetings are open to the public. The members elect their own officers.

- **Federal Health Advisory Council:** Composed of 10 representatives from the health care industry, the council consults with and advises the Commission on all matters within MedPAC's jurisdiction. Subject to the call of the Commission, the council meets a minimum of two times a year in Washington, D.C., and meetings are open to the public. Each year, the GAO chooses one person to represent each of the ten CMS regions. The

members of the council are limited to three one-year terms. The members elect their own officers.

Offset: This amendment is a net-saver.

Rockefeller Delivery System Reform Amendment #11 to the America's Healthy Future Act

Rockefeller Amendment #D11 to Title III Subtitle I (Sense of the Senate Regarding Long-Term Care)

Short Title: Create a New Subtitle I – Sense of the Senate Regarding Long-Term

Description of Amendment:

Chairman's Mark

The Chairman's Title III, Improving the Quality and Efficiency of Health Care does not have a specific plan for long term care that will guarantee that individuals with disabilities have the right to choose to receive their long-term services and supports in the community.

Explanation of the Provision

Nearly two decades have passed since Congress seriously considered long-term care reform. The U.S. Bipartisan Commission on Comprehensive Health Care – also know as the Pepper Commission – released its "Call for Action" blueprint for health reform in September 1990. In the 20 years since those recommendations were made Congress has never acted on the report.

In 1999 under the U.S. Supreme Court's *Olmstead* decision, individuals with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

Despite the Pepper Commission and *Olmstead* decision, the long-term care provided to our nation's elderly and disabled has not improved. In fact, for many, it has gotten far worse.

In 2007, 69 percent of Medicaid long-term care spending for older people and adults with physical disabilities paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for older people and adults with physical disabilities while 1/2 of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 older people and adults with physical disabilities in home and community-based services for every person in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

It is a Sense of the Senate that Congress should enact a comprehensive long term care policy by December 31, 2010.

Offset: Sense of the Senate, no offset required.

Rockefeller Delivery System Reform Amendment #12 to the America's Healthy Future Act

Rockefeller Amendment #D12 to Title V (Fraud, Waste, and Abuse)

Short Title: Creation of an All Payer Anti-Fraud Program with a Revolving Fund to Provide Incentives for Anti-Fraud Activities for the States and for Health Plans -- Inclusion of Additional Aggressive Private Sector Anti-fraud Measures

Explanation of Provision:

Anti-fraud programs are grossly underfunded by insurers, the states, and the federal government. The National Health Care Anti-Fraud Association collected data on anti-fraud efforts from 55 private insurers who account for nearly $250 billion in benefits – all told, those insurers are spending a total of $82 million on their anti-fraud units. Increasing spending on anti-fraud activities will produce billions in savings. The HHS IG reports that as much as $17 is returned to the government for every $1 spent on anti-fraud efforts. Both the public and private sectors need to get serious about anti-fraud efforts. This all payer fund would finance anti-fraud efforts and a portion of the money recouped will be returned to states and private insurers to encourage their efforts.

Description of the Amendment:

1. **Create All-Payer Anti-fraud Program**

    a. Amend the definition of "Federal health care program" in §1128B(f) of the Social Security Act to include any plan or program that provides health benefits, whether directly, through insurance, or otherwise, *which receives federal funds through affordability credits or is offered through a Health Insurance Exchange.*
    b. Amend the definition of "Federal health care program" in §1128B(f) of the Social Security Act to include any plan or program that provides health benefits, whether directly, through insurance, or otherwise, *which is an employee welfare benefit plan under ERISA.*

c. As necessary, clarify that the amended definition of "Federal health care program" (as defined in §1128B(f) of the Social Security Act as amended in subparagraphs a and b, above) extends to all such plans or programs all civil, criminal, and programmatic sanctions for violations of federal law related to fraud and abuse.
    i. Amend the False Claims Act (§3729 of title 31, U.S.C.), to provide that false claims for payments by any Federal health care program shall be considered false claims subject to the provisions of the False Claims Act.
    ii. Require mandatory exclusion from participation in any Federal health care program for not less than 5 years of providers who commit fraud against any Federal health care program.
    iii. Apply to all Federal health care programs all criminal sanctions and civil monetary penalties related to acts in violation of federal antifraud and abuse provisions.

2. Require Robust Private Sector Antifraud Programs

a. Encourage or require states (for example, as a condition of participation in the subsidies, Exchanges, or Medicaid program) to enact statutes requiring health insurers to operate a fraud protection and prevention program to include at least the following activities: fraud prevention measures; fraud investigation procedures; fraud prevention personnel; a fraud prevention organization; fraud data reporting; fraud statistics analysis; and any other fraud prevention activities required by state law or the state insurance Commissioner.
b. Require each employee welfare benefit health plan or program sponsor or their administrative services organization or third party administrator to establish a fraud prevention and protection program to include at least the following activities: fraud prevention measures; fraud investigation procedures; fraud prevention personnel; a fraud prevention organization; fraud data reporting; fraud statistics analysis; and any other fraud prevention activities required by the Secretary of the Department of Labor.
c. Require that in carrying out the requirements of subparagraphs a or b, each insurer or health plan sponsor (through their or their administrative services organization or third party administrator) shall expend annually on those activities an amount equal to not less than 0.1% of the total health benefits paid under government health programs.

3. Create Revolving Fund with Incentives to Strengthen Antifraud Activities

a. Require that each insurer or health plan sponsor (through their administrative services organization or third party administrator) shall deposit annually into the Health Care Fraud and Abuse Control Account (established under §201(b) of the Health Insurance Portability and Accountability Act) an amount equal to not less

than 0.1% of the total health benefits paid to out under government health programs.

i. The Secretary of the Department of Health and Human Services shall annually rebate to such insurer or health plan sponsor from recoveries obtained pursuant to activities carried out under the Health Care Fraud and Abuse Control Program an amount that bears the same proportion as the amount deposited by such insurer or health plan sponsor in the previous year bears to the total of such deposits by all insurers or health plan sponsors.
ii. Total rebated payments to all such insurers or health plan sponsors are not to exceed one-half of all such recoveries; not less than one-fourth of the balance from recoveries is to remain in the Health Care Fraud and Abuse Control Account and the other one-fourth is to be distributed pro-rata to the Insurance Commissioners or fraud control bureaus in the several states to fund the fraud protection and prevention program described in subparagraph 2.a., above.

4. Expand Access to Current or Future Databases and Information Applicable to Combating Fraud

For purposes of law enforcement activity, and to the extent consistent with applicable disclosure, privacy, and security laws, the Attorney General, in conjunction with the Inspector General of the Department of Health and Human Services, in consultation with the Centers for Medicare & Medicaid Services, shall make available to state insurance fraud bureaus claims, payment and other data necessary to identify or prevent fraud under Federal health care programs within the jurisdiction of state insurance fraud bureaus.

5. Provide whistleblower protection by prohibiting reprisals against anyone who discloses fraud or abuse.

a. Any employer that participates in, or benefits from, a federal health care program may not discharge, demote, or otherwise discriminate against anyone as a reprisal for disclosing fraud or abuse.

b. Whistleblowers may submit complaints of reprisal to the Inspector General for the Department of Health and Human Services. Unless certain exceptions apply, the Inspector General shall be required to investigate the complaint and submit a report of the findings of the investigation to the person, the person's employer, and the Health Care Fraud and Abuse Control Program.

c. If the Health Care Fraud and Abuse Program determines that an employer has subjected any person to a reprisal for disclosing fraud or abuse, it can order the employer to take affirmative action to abate the reprisal, order compensatory damages be paid by the employer to the whistleblower, and order the employer to pay the whistleblower all costs related to bringing the complaint.

d. The whistleblower may file a case against the employer in federal district court if the Inspector General does not conduct the investigation and issue findings by certain deadlines.

Offset: As stated in amendment.

Conrad Amendment #D1 on the CMS Innovation Center

Short Title: Expand CMS Innovation Center Criteria to Promote Quality Improvement and Efficiency

Description of Amendment: This amendment would expand the list of criteria for payment models tested by the CMS Innovation Center to include the following:

- Promote improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions charged with: (1) developing, documenting and disseminating best practices and proven care methods; (2) implementing these techniques within their own institutions to demonstrate further improvements in quality and efficiency; and (3) providing assistance to other institutions on how best to employ these techniques to improve health care quality and lower costs.

Offset: N/A

Conrad Amendment #D2 on a Medicare Quality and Efficiency Pilot Program

Short Title: Medicare Pilot Program to Improve Patient Care and Achieve Cost Savings

Description of Amendment:

Establish a five-year Medicare pilot program, called the "Collaborative", to demonstrably improve patient care and achieve cost savings. The Secretary would form a collaborative of high-quality, low-cost health care institutions to develop, document and disseminate best practices and proven care methods. The demonstration would begin with a limited number of organizations documented to be currently delivering high-quality care, efficiently and effectively, and expand over a five-year period to add additional participants, representing a diversity of location, population base, practice settings, and past performance including those that are below national averages for efficiency of cost and care. In order to fund the development, documentation and dissemination of best practices and proven care methods, the pilot program would provide funding of up to $200 million over five years. In exchange, the initial members of the collaborative would be required to reduce growth in health care costs to CPI within 2 years; the additional organizations would be required to reduce costs within 5 years to CPI. For meeting these spending targets, Collaborative members would receive bonus payments; Collaborative members that did not meet these spending targets would receive penalty payments.

Offset: TBD

Conrad Amendment #D3 on a Rural Care Coordination under the CMS Innovation Center

Short Title: Expand the CMS Innovation Center to Facilitate Local Inpatient Treatment of Acutely Ill Medicare Beneficiaries

Description of Amendment:

This amendment would encourage the CMS Innovation Center to test projects in inpatient settings (including intensive care units) that facilitate the treatment of Medicare beneficiaries in their local hospitals through consultation and coordination with specialists at integrated health systems. These care coordination models would allow rural Medicare beneficiaries to receive acute inpatient services, including intensive care, at their local hospital with consultation from integrated health systems.

This amendment would expand the list of criteria for care coordination models to be tested by the CMS Innovation Center to include the following:

"14. Facilitate inpatient care, including intensive care, of hospitalized Medicare beneficiaries at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems."

Offset: This amendment has no cost.

Conrad Amendment #D4 to Increase the Medicare Payment Rate for Nurse-Midwives

Short Title: Nurse Midwifery Access and Reimbursement Equity

Description of Amendment: Amend the Social Security Act to increase the Medicare payment rate for nurse-midwives for covered services from 65 percent of the rate that would be paid were a physician performing a service to the full rate.

Offset: TBD

Conrad Amendment #D5 to extend Super Rural Ambulance Payments under Medicare

Short Title: Two-Year Extension of "Super Rural" Bonus Payment for Ambulance Services

Description of Amendment: Extends until January 1, 2012 a provision (originally section 414(c) of the Medicare Modernization Act (MMA)) that provides bonus payments under Medicare to ambulance service providers which serve the most rural quartile of counties ("super rural" areas).

Effective date: January 1, 2010

Offset: TBD

Conrad Amendment #D6 on the Medicare Commission

Short Title: Ensuring Long-Term Health Savings

Description of Amendment:

Title III, Subtitle E, of the Chairman's Mark establishes an independent Medicare Commission to develop and submit proposals to Congress to reduce excess cost growth and improve the quality of care for Medicare beneficiaries. Under the Mark, the Commission's activities would sunset unless the Congress votes in 2019 to continue them. The Mark provides for a fast-track procedure and guaranteed vote on this question.

The Conrad amendment would eliminate the sunset on the Medicare Commission and set the growth target beyond 2019 at GDP per capita +1%. Under the amendment, Congress would still be required to hold a vote in 2019 under fast-track procedures on the Commission's future, but the Commission would continue unless Congress affirmatively votes to terminate it.

The amendment would not affect health spending in the ten-year budget window (2010-2019), but could reduce spending in years after 2019.

Conrad Amendment #D7 on the Medicare Part D Coverage Gap

Short Title: Medicare Part D Limited Manufacturer Cost Sharing Assistance

Description of Amendment:

Effective January 1, 2010, the Amendment would allow manufacturers to provide assistance to individuals enrolled in a Medicare Part D plan with very substantial out-of-pocket costs through the use of coupons, copayment cards and other non-cash instruments. This manufacturer cost sharing assistance would count toward TrOOP. Manufacturer cost sharing assistance would only be available for categories or classes of drugs that were found to result in lower spending per enrollee in the Medicare Replacement Drug Demonstration that was authorized by section 641 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173), or other products that the Secretary determines would result in lower Medicare expenditures or would improve access to treatment. The Amendment would create an exception to the anti-kickback statute for manufacturer cost sharing assistance and would exempt the assistance from inclusion in the determination of "best price" under the Medicaid statute.

Offset: TBD

Bingaman Amendment # D-1 to America's Healthy Future Act of 2009

Technical Amendment for 340B Discount Drugs

Summary:
Makes a technical change to the Chairman's Mark to exempt drugs purchased through the 340B Program from being subject to rebates collected on behalf of Medicaid Managed Care Organizations (MCOs). This amendment is endorsed by Safety Net Hospitals for Pharmaceutical Access, National Association of Community Health Centers, and the Association for Community Affiliated Health Plans.

Score/Offset: Budget Neutral

Background:

This amendment makes a technical change to the Chairman's Mark to clarify that "covered outpatient drugs are not subject to the requirements of this section if such drugs are subject to discounts under section 340B of the Public Health Service Act." This mirrors language in S. 547, the legislation originally proposing an extension of the Medicaid rebate program to drugs paid for by MCOs. A similar amendment to H.R. 3200, the House health care reform legislation, was scored as budget neutral by the Congressional Budget Office.

Bingaman Amendment # D-2 to America's Healthy Future Act of 2009

Ensuring GME Redistribution is Available to Rural and Other Underserved States

Summary: Ensures that 50% of the GME slot redistribution in the underlying Chairman's Mark is prioritized for rural and other underserved communities.

Offset: Budget Neutral

Description:

The Chairman's Mark currently provides a redistribution of unused Medicare Graduate Medical Education (GME) slots. These GME slots allow hospitals to receive additional GME payments to train physicians. Currently, the priority list within the Mark is ambiguous. The slots may be prioritized to states with the lowest ratio of residents to population. This criterion does not measure the need for physicians within a state but rather the level of training occurring within a state. For this reason, the redistribution would prioritize states with a low number of residents regardless of the fact that these states may have a high proportion of physicians per population. As a result, the slots may not be available to facilities in rural and other underserved states that have the highest level of population without access to physicians.

This amendment would reserve 50% of the slots provided in the redistribution for states meeting the second and third criteria with modification already established within the Chairman's mark:

1. Hospitals located in a state that is among the top 10 states in terms of the ratio of the total population living in a health professional shortage area (HPSA) determined by the U.S. Department of Health and Human Services as of the date of enactment compared to total population of the state based on the most recent state population projections by the U.S. Census Bureau; and

2. Hospitals located in rural areas.

Slots not re-assigned within one year after the Secretary allows for application under these criteria may be assigned using the other criteria established within the Mark.

This change would improve the ability of underserved and rural states to receive GME slots.

Bingaman Amendment # D-3 to America's Healthy Future Act of 2009

Improving Access to Rural Hospital Care by Modifying Criteria for Critical Access Hospitals

Summary:
Excludes Indian Health Services Hospitals for the purpose of mileage requirements for Medicare Critical Access Hospital designation.

Cost: $1 - $15 million

Offset: Commensurate acceleration in the reduction in MA IME payments provided for in the Medicare Improvements for Patients and Providers Act of 2008

Description:

Congress created the Medicare Critical Access Hospital (CAH) Program in 1997 to maintain and improve access to health care in rural communities. The principal benefit of designation as a CAH is cost reimbursement (plus 1%) for services furnished to Medicare patients. To qualify as a CAH, a facility must: be located in a rural area and a minimum distance from the next closest "hospital" (15 or 35 miles depending on roads and terrain); have an average length of stay of four days or less; offer emergency services twenty-four hours a day, seven days a week, and meet other standards established by CMS.

The proposed amendment would amend Section 1820 (c)(2)(B)(i)(I) of the Social Security Act to exclude Indian Health Service (IHS) operated hospitals from being considered in determining distance from the "next closest hospital."

IHS facilities are not routinely accessible to non-Indians; thus, a policy limiting access to the CAH designation when an IHS facility is within 15 or 35 miles (depending on roads and terrain) is contrary to the expressly stated intent of Congress in establishing the critical access designation, to maintain and improve access to health care in rural areas.

Bingaman Amendment # D-4 to America's Healthy Future Act of 2009

Protection for low-income Seniors and other Medicare beneficiaries

Summary:
Increases asset limits for Part D low-income subsidy and Medicare Savings Programs; extends Qualified Individual program; and makes other improvements to programs serving low-income seniors and other Medicare beneficiaries. These improvements were included in the America's Affordable Health Choice Act of 2009 as considered in the House. This amendment has been endorsed by: AARP, the Center for Medicare Advocacy, Inc., Families USA, and NCOA.

Score: Less than $12.7 billion

Offset: Proportionately increase the annual fees on health insurance providers; manufacturers and importers of branded drugs; manufacturers and importers of medical devices; and clinical laboratories in the Chairman's Mark by an amount commensurate with the cost associated with this amendment

Description:

The amendment would make the following changes:

1. *Increase in asset limits*: Increases asset limit for Part D low-income subsidy and Medicare Savings Program to $17,000 for an individual and $34,000 for a couple effective 2012 with annual indexing thereafter.

2. *Extension of QI program:* Extends QI through December 2012 and eliminates funding limitations on states by providing 100% Federal medical assistance percentage for all eligible beneficiaries.

3. *Part D cost-sharing for non-institutionalized full benefit dual eligibles:* Eliminates cost sharing for people receiving care under a home and community based waiver who would otherwise require institutional care.

4. *Eliminating barriers to enrollment:* Reduces barriers to the low-income subsidy by allowing self-certification and administrative verification of income and data sharing between IRS and SSA.

5. *Oversight on reimbursement for retroactive low-income subsidy enrollment:* Enhances oversight to make sure that low-income beneficiaries who are owed retroactive reimbursement payments from their drug plans receive them.

6. *Intelligent assignment in enrollment:* Gives HHS authority, for full benefit dual eligible individuals who have not chosen their own Part D plan, to use an enrollment process that accounts for the quality, cost and/or formulary of plans and that is designed to maximize the individual's access to necessary Part D drugs.

7. *Special enrollment period and automatic enrollment for all subsidy-eligible individuals:* Creates a permanent special enrollment period for all subsidy-eligible beneficiaries and extends intelligent assignment process to all subsidy-eligible individuals who have not enrolled in a plan of their choosing.

8. *Counting costs incurred by ADAPs and IHS towards Part D out-of-pocket threshold:* Allows drugs provided to patients by AIDS Drug Assistance Programs or the Indian Health Service to count toward out-of-pocket costs, allowing these individuals to qualify for Part D catastrophic benefits.

These improvements were included in the America's Affordable Health Choice Act of 2009 as considered in the House. This amendment has been endorsed by: AARP, the Center for Medicare Advocacy, Inc., Families USA, and NCOA.

Background:

Low-income Medicare beneficiaries – those who are eligible for the Medicare Savings Programs (MSPs) and the Part D low income subsidy (LIS) - are more likely to be old, female, black or Hispanic, and living alone than other Medicare beneficiaries. They are also more likely to be in fair or poor health. Thus, they have greater health care needs and fewer resources with which to pay for their health care. Subsidies to assist with premiums and cost-sharing required by Medicare are one way Congress has chosen to meet Medicare's goal of ensuring the health care security of those in greatest need.

This amendment proposes modest, long over due changes to the both the Medicare Savings Programs (paying some or all cost sharing for Medicare Parts A, B and C) and the Part D LIS (paying some or all of the cost-sharing for Medicare Part D) that would help to stabilize and update important protections for low-income Medicare beneficiaries that are intended to reduce financial barriers to care. It extends the Qualified Individual program that pays the Part B premium for more than a million beneficiaries, increases the amount of assets low-income beneficiaries can keep and still receive subsidy assistance, simplifies LIS enrollment, authorizes the Secretary to assign low income Medicare beneficiaries to the Part D plan most suited to their individual needs, and eliminates Part D cost-sharing for the lowest income and frailest beneficiaries. It also provides greater assurance that low-income beneficiaries who are due refunds from their plans will get them and allows beneficiaries getting assistance from AIDS drug programs or from the Indian Health Service to get catastrophic drug coverage.

Bingaman Amendment # D-6 to America's Health Future Act of 2009

Protection for Appropriate Medicare Payment Levels By Establishing a Prospective Payment System for Services Furnished By Federally Qualified Health Centers

Summary:

This amendment would establish a prospective payment system (PPS) for Medicare services furnished by Federally Qualified Health Centers (FQHCs) and would require the PPS to appropriately reimburse Medicare-covered preventive services when such services are provided in the FQHC setting.

Offset:

Eliminate provision in the Chairman's Mark that, beginning January 1, 2013, requires states to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored insurance if it is cost-effective.

Description:

This amendment directs the Secretary of Health and Human Services (Secretary) to establish a PPS for Medicare-covered services furnished by FQHCs in order to update the existing payment structure, which currently underpays for these services. Similar to the existing PPS for FQHCs in Medicaid and CHIP, this payment structure would set an initial payment based on a two year average of a health center's reasonable costs for providing care and include an appropriate annual update method developed by the Centers for Medicare and Medicaid Services (CMS). Additionally, the amendment would require the Medicare PPS to appropriately reimburse eligible preventive services when such services are provided to Medicare beneficiaries in the FQHC setting.

This amendment has been endorsed by the National Association of Community Health Centers

Background:

Community Health Centers play a critical role in the delivery of primary care to more than one million medically underserved Medicare beneficiaries. This rapidly growing population is well-served by America's health care homes, as these centers assist seniors and their families in managing chronic diseases and maintaining healthy lifestyles. Moreover, the community health center model has been proven to be a high-quality, cost-effective source of primary care in many communities.

The Federally Qualified Health Centers (FQHC) program was created in 1990 to ensure that America's medically underserved populations have access to a number of services including Medicare-covered preventive and primary health care benefits. To ensure that health centers were not forced to subsidize Medicare payments with federal grant dollars, Congress required centers to be paid at a rate that guaranteed they would not lose money serving Medicare patients. However, in 1992, federal regulations established a cap on Medicare FQHC payments. Neither Congress nor CMS have reviewed this cap since its implementation over 16 years ago, even though new costly services have been added to the Medicare program since that time.

Recent analysis indicates that the payment cap adversely affects nearly 75% of all FQHCs. The average health center loss due to the Medicare payment cap was $85,000 and total health center losses exceeded $51 million. In 2008, Congress recognized this issue and provided health centers with a much-needed increase in the payment cap in the Medicare Improvements for Patients and Providers Act (MIPPA). While MIPPA provided some temporary relief, this amendment would provide a permanent solution to an ongoing problem and improve payment accuracy by establishing a Medicare PPS for FQHCs that is modeled after the existing FQHC PPS in Medicaid and CHIP. The PPS rates established under this amendment would be effective for services furnished on or after January 1, 2012 and would be established on an average of health center's reasonable costs for providing services in 2010 and 2011.

This amendment would also ensure fair reimbursement for essential preventive and primary care services that have been added as Medicare-covered services over the past 16 years. Under the current Medicare payment regulations, these services are not appropriately reimbursed when administered at an FQHC. Congress took a first step in the Deficit Reduction Act of 2005 by adding Diabetes Self Management Therapy and Medical Nutrition Therapy to the list of FQHC services eligible for Medicare payment. This amendment would add remaining Medicare-covered preventive services to the list of services eligible for reimbursement when furnished by a FQHC.

Bingaman Amendment # D-7 to America's Healthy Future Act of 2009

National Health Care Workforce Commission

Summary:
Establishes a National Health Care Workforce Commission to determine current and projected workforce needs, and to advise Congress and the Administration how to align workforce resources with national needs.

Offset: Budget Neutral

Description:

This amendment creates a National Health Care Workforce Commission that will assess the needs of the health care workforce and, in doing so, evaluate Federal health professions programs. The Commission will be an independent entity that provides recommendations to Congress and the Administration on how to improve the delivery of health care services for all Americans by increasing the supply of a qualified health care workforce, enhancing workforce education and training, and providing support to the existing workforce. The creation of a National Workforce Commission was central to "Title IV. Building a health care workforce to meet the needs of the 21st century" of the *Affordable Health Choices Act* reported by the Senate HELP Committee.

This Amendment would strike the "Proposal on Development of a National Workforce Strategy" in the Chairman's Mark and replace with the following:

National Health Care Workforce Commission

Numerous studies and policy experts have called for a renewed effort to develop a comprehensive and coordinated national strategy to address workforce shortages and encourage training in key focus areas that support delivery system reform goals, such as improving care coordination, health provider use of information technology and increasing access to primary care services. To this end, an independent, permanent National Health Care Workforce Commission (referred to as the "Commission") will be established to provide comprehensive,

unbiased information to Congress, the Administration, States and localities on health care workforce policy; to develop and conduct evaluations of education and training activities to determine whether the demand for health care workers is being met; identify barriers to improved coordination at the Federal, state, and local levels and recommend ways to address such barriers; and encourage innovations to address population needs, constant changes in technology, and other environmental factors.

To avoid duplication of effort, the Commission will communicate and coordinate with existing federal resources including the expertise and work of the U.S. Department of Health and Human Service, the Health Resources and Services Administration, the Centers for Medicare & Medicaid Services, the U.S. Department of Education, and the U.S. Department of Labor. The Commission will also consult with relevant state and local entities.

The Commission will present annual reports to Congress, the Administration, relevant Federal agencies, and the public outlining its findings and policy recommendations. Specifically, the Commission will examine the current and projected health care workforce supply; the current and projected demand for health professionals; health care workforce education and training capacity; implications of new and existing Federal policies which affect the health care workforce; and the health care workforce needs of specific populations, including minorities, rural and urban populations, and medically underserved populations. In addition, the Commission will report on specific high-priority topics, including efforts to integrate the health care workforce into a reformed delivery system; the implications for the health care workforce as a result of greater utilization of health information technology; Medicare and Medicaid Graduate Medical Education policies; nursing, oral healthcare, and mental and behavioral healthcare workforce capacity; and the geographic distribution of health care providers.

The National Workforce Commission will be comprised of 15 members with expertise in health care labor market analysis, health care finance and economics, health care facility management, health care plans and integrated delivery systems, health care workforce education and training who represent broad geographic and professional perspectives with a balance between urban, suburban, and rural representatives. Membership shall include, at minimum, a health care workforce and health care professional; employer representative; third-party payers; individuals skilled in the conduct and interpretation of health care services and health economics research; representatives of consumers, labor unions, State or local workforce investment boards; and educational institutions. In addition, the Commission may include health professionals such as nurse practitioners; physician assistants; psychologists and other behavioral and mental health professionals; social workers; physical therapists; public health professionals; clinical

pharmacists; allied health professionals; chiropractors; community health workers; school nurses; certified nurse midwives; podiatrists; licensed complementary and alternative medicine providers; integrative health practitioners; national representatives of health professionals; representatives of health professional training programs, schools, public and private teaching hospitals, and ambulatory health facilities. Individuals who are directly involved in health professions education or practice will not constitute a majority of the membership.

Bingaman Amendment # D-8 to America's Healthy Future Act of 2009

Establishing "Teaching Health Centers" to Increase the Number of Primary Care Physicians

Summary:
This amendment will establish a grant program to provide community based training sites funding to establish and operate residency programs as "Teaching Health Centers" to improve access to primary care physicians throughout the nation.

Score: $250 million

Offset: Commensurate increase in annual insurance fee.

Description:

This Amendment would create a new Section 749, Teaching Health Centers Development Grants, would be included as part of the PHSA to establish newly accredited or to expand primary care medical residency programs. These grants would be awarded for up to 2 years and would not exceed more than $500,000. The funds would be used to cover the costs of establishing or expanding a medical residency training program and technical assistance provided by an eligible entity. The grants for medical residency training program costs would include the costs of curriculum development; recruitment, training and retention of residents and faculty; accreditation (by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Association); and faculty salaries during the development phase. The technical assistance grants would include the costs for materials development; staff salaries; travel; and administrative costs; entities eligible for these grants would be those capable of providing technical assistance including the AHEC program.

A teaching health center seeking a grant would submit an appropriate application to the Secretary. In awarding these grants, the Secretary would give priority to funding residency training programs in Federally qualified health centers, Community mental health centers, rural health centers, Indian Health Centers, newly established residency programs, integrated rural training tracks and rural training tracks, and residencies with a mission to train physicians for

rural and underserved practice. Further priority would be given to an application that documents an existing affiliation agreement with an AHEC program.

A teaching health center would be a facility which would be a community-based, ambulatory patient care center and is establishing a new or expanding an existing primary care residency program (under Medicare) in consultation with the National Health Workforce Commission that is determined to be high-need. This would include federally qualified health centers, community health centers, community mental health centers health care for the homeless centers, rural health centers, migrant health centers, Native American health centers operated by the Indian Health Service, Indian tribes, and tribal organizations, and other not-for-profit community based clinical entities.

A primary care residency program is an approved residency program under Medicare's direct medical education program in family medicine, general pediatrics, general internal medicine, or obstetrics and gynecology.

Certain amounts would be authorized to be appropriated: $25 million in FY2010; $50 million in FY2011; $50 million for FY2012 and such subsequent sums as may be necessary to carry out this section. No more than $5 million annually would be used for technical assistance program grants.

Except as provided in Section 338D of the PHSA, an individual who has entered into a written NHSC contract would provide services in the full-time clinical practice of such an individual's profession as a member of the Corps for the period of obligated service established by that contract. Up to 50% of that individual's time may be spent in teaching and count toward full-time clinical practice for the purpose of calculating any NHSC obligation.

In addition, this amendment would establish a program under which qualified teaching health centers would be eligible for two payments, one for direct graduate medical education expenses and the other for indirect expenses associated with operating approved graduate medical residency training programs. These programs will be in addition to existing Medicare-supported residency slots. The Secretary would determine the basis of payment and funding calculations for both the direct and indirect payments and would promulgate regulations under existing rulemaking requirements to establish this program.

Both ‘approved graduate medical residency training programs’ and ‘direct medical education costs’ would be defined according to the Medicare statute. A teaching health center would mean a facility which is community based, ambulatory patient care center and operates a primary care residency program. These would include Federally Qualified Health Centers, Community Mental Health Centers, community health centers, health care for the homeless centers, rural health centers, migrant health centers, Native American health centers operated by the Indian Health Service, Indian tribes and tribal organizations, and Title X clinics. A primary care residency program would mean a medical residency program in family medicine, internal medicine, pediatrics, medicine-pediatrics, obstetrics and gynecology, psychiatry and geriatrics.

A total of $250 million will transferred from the Medicare Part A trust fund for FY2011 to FY2015 using a formula for calculating the direct graduate medical education expenses and the indirect expenses associated with operating approved graduate medical residency training programs established by this Section.

A teaching health center would be required to submit an annual report with required data for full-time equivalent resident training positions in any training program sponsored by a teaching health center for the academic year completed immediately prior to such fiscal year. This report would include: the types of resident training programs; the number of residency training positions; the number recruited, and the number of FTEs filled; and the changes in residency training made during the academic year. These training program changes would include those made to the curricula, training experiences, and types of training programs as well as the resulting benefits; those made to train residents in the measurement and improvement of the patient care quality and safety. The required report would also include the number of residents who completed their training and care for vulnerable populations within the borders of the state where the center is located.

Payments to a teaching health center would be reduced by 25% for failure to report the required information. The Secretary would be required to provide notice to the teaching health center and provide an opportunity for the center to provide the required information by 30 days beginning on the date of such notice. If the teaching health center provides such information within such period, no payment reduction would occur. Funding for slots created in this section shall be offset by any funding received through Medicare GME funding for these slots.

Bingaman Amendment # D-9 to America's Healthy Future Act of 2009

Ensures Appropriate Consultation with Mental Health and Substance Abuse Experts and Better Coordination of Mental Illness and Substance Abuse treatment

Summary:
Ensures appropriate consolation with mental health and substance abuse experts and better coordination of mental illness and substance abuse treatment

Offset: Budget Neutral

Description:

This amendment will modify the Chairman's Mark such that:

1. SAMHSA will be consulted, when appropriate, in working groups, committees, task forces, etc. on issues pertaining to behavioral and mental health to address, specifically, prevention of mental illness and substance abuse;

2. The section on "Medicaid State Plan Option Promoting Health Homes and Integrated Care" (page 74) will include community mental health center in the list of provider teams.

Kerry Amendment D-1

Title III- Improving the Quality and Efficiency of Health Care
Subtitle A- Transforming the Health Care Delivery System

Section: National Strategy to Improve Health Care Quality
Short Title: Ensure Consumer and Patient Involvement in Decisions Affecting the Delivery of Health Care

Description of Amendment: All advisory panels, boards and committees charged with decision making on any aspects of the health care system shall whenever possible include a significant number of educated patients and consumer advocates as voting members. The term 'educated consumer or patient' means an individual who is accountable to, represents and reports back to organizations that represent consumers or individuals affected by a disease or health conditions, and is knowledgeable about the health care system and has received training to make informed decisions regarding relevant health, medical or scientific matters.

This amendment will not result in increased cost.

Kerry/Stabenow Amendment D-2

Title III- Improving the Quality and Efficiency of Health Care
Subtitle D-Improving Payment Accuracy

Section: Home Health Payment Changes
Short Title: Easing the Impact of Home Health Cuts

Description of Amendment: The amendment will rebase the home health prospective payment amount. In 2013, the Secretary shall initiate an adjustment to the home health services payment amount(s) based on an analysis of factors such as changes in the average number and types of visits in an episode, the change in the intensity of visits in an episode, and the growth in the costs per episode. The standards for setting the payment rates are as follows:

1. The rates are based on all usual and customary business costs consistent with standards under the Internal Revenue Code and usual business operations expenses.
2. The rates shall be set no lower than average cost plus 5 percent to reflect the needs of normal businesses for operating capital and operating margins.
3. During the rebasing period, the Secretary shall withhold any regulatory-based rate adjustments.
4. The rates shall reflect budget neutrality related to the estimate of expenditures by the Congressional Budget Office and in consideration of both any regulatory or legislative rate adjustments.

The amendment will also incorporate productivity adjustment into market basket update for home health services. A productivity adjustment shall not be applied any earlier than 2017, following the completion of the phase-in of rate rebasing.

Amendment will be offset by closing corporate tax loopholes.

Kerry Amendment D-3

Title III- Improving the Quality and Efficiency of Health Care
Subtitle D-Improving Payment Accuracy

Section: Accountable Care Organizations
Short Title: Enabling Physicians from Various Specialties to Participate in Accountable Care Organizations

Description of Amendment: Clarifies that physicians from various specialties can be the primary point of care for beneficiaries in accountable care organizations. Defines practitioners as physicians (regardless of specialty), nurse practitioners, physician assistants, clinical nurse specialists, and other practitioners or suppliers as the Secretary determines appropriate.

This amendment will not result in increased cost.

Kerry Amendment D-4

Title III- Improving the Quality and Efficiency of Health Care
Subtitle A- Transforming the Health Care Delivery System

Section: Accountable Care Organizations
Short Title: Pediatric Accountable Care Organization Demonstration Project under Medicaid and CHIP

Description of Amendment: To create a demonstration project which would allow pediatric medical providers who voluntarily meet certain statutory criteria, including quality measures, to be recognized as ACOs and be eligible to share in the cost savings they achieve for the Medicaid and CHIP programs. The Secretary shall develop guidelines in consultation with the states and pediatric providers, based on the experience with Medicare to the extent that it is applicable to children's health services.

This amendment should result in a reduced cost.

Kerry Amendment D-5

Title III- Improving the Quality and Efficiency of Health Care
Subtitle A- Transforming the Health Care Delivery System

Section: CMS Innovation Center
Short Title: Inclusion of Medicaid and CHIP in CMS Innovation Center

Description of Amendment: Include the Medicaid and CHIP programs in the CMS Innovation Center, with the same requirements for testing and evaluation of patient-centered delivery and payment models that have shown evidence of success in the Medicaid and CHIP population as proposed for Medicare. This is in addition to the Medicare and dual eligible populations.

This amendment will not result in increased cost.

Lincoln Amendment #D1 to The America's Healthy Future Act

Short Title: Improving access to primary and preventive care by adding a modified version of the Medicare Fracture Prevention and Osteoporosis Testing Act (**S.769).**

Description of Amendment: The Chairman's Mark includes a number of provisions aimed at improving access to primary and preventive care for Medicare beneficiaries, including Grade A and B recommendations from the U.S. Preventive Services Task Force (USPSTF). Consistent with these goals, this amendment would add a modified version of the Medicare Fracture Prevention and Osteoporosis Testing Act (**S.769)** to The America's Healthy Future Act.

This amendment would reinstate reimbursement for dual energy x-ray absorptiometry (DXA) and vertebral fracture assessment (VFA) services to 70% of the 2006 payment rates. It would also authorize the Institute of Medicine to study the effect of Medicare reimbursement reductions for DXA and VFA on beneficiary access to bone density tests.

Bone density measurements detect critical and treatable medical conditions, such as osteoporosis. Osteoporosis, characterized by low bone mass and structural deterioration, contributes to bones becoming thinner, brittle, and more likely to break. Osteoporosis and low bone mass affect an estimated 44 million Americans and are linked to falls among older adults.

The Agency for Healthcare Research and Quality's *News and Numbers* reported in July 2009 that fractures associated with osteoporosis:

- Accounted for one-fourth of the roughly 1 million hospitalizations in 2006 of patients with osteoporosis;
- Cost hospitals $2.4 billion in 2006;
- Caused women to be six times more likely to be hospitalized than men
- Involved mostly older patients: 90 percent of hospitalizations were for age 65 and older and 37 percent for patients age 85 and older; and
- Were highest in the Midwest (107 per 100,000 people) and lowest in the West (68 per 100,000 people).

About 20% of hip fracture patients die within a year of injury and one-quarter of adults living independently before the fracture require nursing home placement for at least a year post injury.

The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis (Grade B). The USPSTF found good evidence that the risk for osteoporosis and fracture increases with age and other factors, that bone density measurements accurately predict the risk for fractures in the short-term, and that treating asymptomatic women with osteoporosis reduces their risk for fracture.

The Deficit Reduction Act of 2005 limited reimbursement for imaging services performed in physician offices and non-facility settings. Two low-cost imaging services that test for osteoporosis affected by the DRA are DXA, the most widely accepted method of measuring bone mass to predict fracture risk, and VFA, a complimentary test that with DXA provides a complete assessment of osteoporosis risk.

DRA reduced DXA reimbursement over 60% from approximately $139 per scan in 2006 to an estimated $52 in 2010. VFA reimbursement will drop from $40 in 2006 to an estimated $28 in 2010, a 30% reduction. These cuts substantially threaten beneficiaries' access to a low cost evaluation that can lead to early detection and treatment of osteoporosis, especially for beneficiaries in rural and underserved areas.

CBO Preliminary Score: $1.6 billion over 10 years

Offset: Extend Medicare Secondary Payer (MSP) for privately-insured dialysis patients to Medicare after 30 months by amount necessary to offset the increase in spending.

Lincoln Amendment #D2 to The America's Healthy Future Act

Short Title: Improving access to primary and preventive care by adding a modified version of the Medicare Fracture Prevention and Osteoporosis Testing Act (**S.769).**

Description of Amendment: The Chairman's Mark includes a number of provisions aimed at improving access to primary and preventive care for Medicare beneficiaries, including Grade A and B recommendations from the U.S. Preventive Services Task Force (USPSTF). Consistent with these goals, this amendment would add a modified version of the Medicare Fracture Prevention and Osteoporosis Testing Act (**S.769)** to The America's Healthy Future Act.

This amendment would reinstate reimbursement for dual energy x-ray absorptiometry (DXA) and vertebral fracture assessment (VFA) services to 70% of the 2006 payment rates for two years (2010 and 2011). It would also authorize the Institute of Medicine to study the effect of Medicare reimbursement reductions for DXA and VFA on beneficiary access to bone density tests.

Bone density measurements detect critical and treatable medical conditions, such as osteoporosis. Osteoporosis, characterized by low bone mass and structural deterioration, contributes to bones becoming thinner, brittle, and more likely to break. Osteoporosis and low bone mass affect an estimated 44 million Americans and are linked to falls among older adults.

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- Involved mostly older patients: 90 percent of hospitalizations were for age 65 and older and 37 percent for patients age 85 and older; and
- Were highest in the Midwest (107 per 100,000 people) and lowest in the West (68 per 100,000 people).

About 20% of hip fracture patients die within a year of injury and one-quarter of adults living independently before the fracture require nursing home placement for at least a year post injury.

The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis (Grade B). The USPSTF found good evidence that the risk for osteoporosis and fracture increases with age and other factors, that bone density measurements accurately predict the risk for fractures in the short-term, and that treating asymptomatic women with osteoporosis reduces their risk for fracture.

The Deficit Reduction Act of 2005 limited reimbursement for imaging services performed in physician offices and non-facility settings. Two low-cost imaging services that test for osteoporosis affected by the DRA are DXA, the most widely accepted method of measuring bone mass to predict fracture risk, and VFA, a complimentary test that with DXA provides a complete assessment of osteoporosis risk.

DRA reduced DXA reimbursement over 60% from approximately $139 per scan in 2006 to an estimated $52 in 2010. VFA reimbursement will drop from $40 in 2006 to an estimated $28 in 2010, a 30% reduction. These cuts substantially threaten beneficiaries' access to a low cost evaluation that can lead to early detection and treatment of osteoporosis, especially for beneficiaries in rural and underserved areas.

CBO Preliminary Score: To be determined

Offset: Extend Medicare Secondary Payer (MSP) for privately-insured dialysis patients to Medicare after 30 months by amount necessary to offset the increase in spending.

Lincoln Amendment #D3 to The America's Healthy Future Act

Short Title: Increase health care workforce accessibility for Medicare beneficiaries with mental illness by adding the Seniors Mental Health Access Improvement Act (S.671) and the Clinical Social Work Medicare Equity Act (**S.687).**

Description of Amendment: The Chairman's Mark includes a number of provisions aimed at improving access to care for Medicare beneficiaries. Consistent with these goals, this amendment would add the Seniors Mental Health Access Improvement Act (S.671) and the Clinical Social Work Medicare Equity Act (**S.687)** to The America's Healthy Future Act.

The recent passage of mental health parity legislation in the Emergency Economic Stabilization Act of 2008 will decrease coverage barriers to mental health treatment, however access to and choice of mental health professionals remains problematic. This is especially true for older adults living in the over 3,000 Mental Health-Health Professional Shortage Areas (HPSAs) that contain 77 million residents. Over 50% of US rural counties have no practicing psychologists, psychiatrists, or social workers, and 2/3rds of rural residents with mental illness symptoms receive no treatment at all. These statistics demonstrate the serious challenge to currently delivering mental health treatment to older adults living in rural and frontier areas.

In an effort to provide for meaningful implementation of mental health parity legislation, this amendment would allow Medicare beneficiaries to receive mental health treatment services from licensed marriage and family therapists (MFT) and licensed professional mental health counselors (LPC) under Medicare Part B. This amendment would place special focus on mental health treatment services provided by MFTs and LPCs in rural health clinics, federally qualified health clinics, and hospice. It would excludes MFT and LPC services from skilled nursing facility (SNF) prospective payment system (PPS), permitting direct payment under Medicare for MFT and LPC services provided to SNF residents.

This amendment would also exclude clinical social worker services from coverage under the Medicare SNF PPS, permitting direct payment for clinical social work services provided to SNF residents. Prior to the Balanced Budget Amendment of 1997, clinical social workers were able to provide mental health treatment to Medicare beneficiaries in SNFs. This amendment would

reinstate parity across the mental health care workforce to provide psychotherapy to Medicare beneficiaries in SNFs. Per cost estimates created for HR 3200, CBO estimates that there is no cost to this provision.

CBO Preliminary Score: $500 million over 10 years

Offset: Health and Human Services/Office of Inspector General Redbook (May 2009): *Ensure Appropriateness of Medicare Payments for Mental Health Services* (pg. 26-27).

Lincoln Amendment #D4 to The America's Healthy Future Act

Short Title: To allow Medicare beneficiaries enrolled in MA or MA-PD plans to return to original Medicare in the first 45 days of the Calendar Year.

Description: The Chairman's Mark would eliminate the annual open enrollment period (January 1 through March 31) for Medicare Advantage (MA) plans effective in 2011.

This amendment would allow Medicare beneficiaries enrolled in a Medicare Advantage (MA) or Medicare Advantage-Prescription Drug (MA-PD) plan during the annual enrollment to return to original Medicare during the period of January 2 to February 15 with no reason required. Beneficiaries choosing to disenroll from MA or MA-PD and opt back into the original Medicare would be required to maintain comparable coverage. For example, beneficiaries who had a MA-only plan could return to original Medicare but would not be allowed to enroll in a stand-alone PDP. Beneficiaries in a MA-PD plan could return to original Medicare and would be required to enroll in a stand-alone PDP.

Beneficiaries who switched from a MA-PD plan to original Medicare with a stand-alone PDP before January 15 would begin prescription drug coverage on February 1. Beneficiaries who switched from a MA-PD plan to original Medicare with a stand-alone PDP between January 16 and February 15 would begin prescription drug coverage on March 1. If the insurer of the MA-PD plan that the beneficiary was disenrolling from also offered a stand-alone PDP product, the insurer would be allowed to inform the beneficiary its presence. The Secretary would be required to create a process that would expedite these requests in a streamlined manner to minimize beneficiary burden. The change would be effective beginning in 2011.

Two Senate Finance Committee hearings in February 2008 highlighted several problems with MA marketing practices to Medicare beneficiaries. These problems included door-to-door selling, entering homes and using high-pressure sales techniques, not taking "NO" for an answer on phone or in person; repeated visits to the same home, tricking seniors by asking them to sign forms "just in case," then enrolling them anyway; forging signatures and social security numbers, etc. Even when marketing behavior meets an appropriate legal and ethical standard, older and disabled adults may still have difficulty understanding the differences between MA and original Medicare until their first doctor's visit under an MA plan. This amendment allows beneficiaries a time-limited, quick release valve from MA or MA-PD plans in the beginning of the Calendar

Year to return to original Medicare with no questions asked.

Offset: To be determined

Lincoln-Hatch Amendment #D5 to The America's Healthy Future Act

Short Title: To create a comprehensive approach to ensuring adequate public-private infrastructure and resolving to prevent, detect, treat, understand, intervene in, and where appropriate, aid in the prosecution of, elder abuse, neglect, and exploitation - by adding the Elder Justice Act (S.795) to The America's Healthy Future Act.

Description of Amendment:

The Chairman's Mark includes a number of provisions aimed at improving quality of care and transparency in long-term care facilities and throughout health care. Consistent with these goals, this amendment would add the Elder Justice Act (S.795) to The America's Healthy Future Act.

Although the number of older Americans is growing fast, the problem of elder abuse, neglect and exploitation has long been invisible and is one of the gravest issues facing millions of American families. The Elder Justice Act would authorize federal resources for support State and community efforts on the front lines dedicated to fighting elder abuse with scarce resources and fragmented systems. From a social perspective, elder justice means assuring adequate public-private infrastructure and resources to prevent, detect, treat, understand, intervene in and, where appropriate, prosecute elder abuse, neglect and exploitation. From an individual perspective, elder justice is the right of every older person to be free of abuse, neglect and exploitation. The Elder Justice Act would promote both aspects of elder justice with the following provisions:

- **Elevating elder justice issues to national attention.** The bill will establish within the Department of Health and Human Services programmatic, grant-making, policy and technical assistance functions relating to elder justice, create of a public-private Advisory Board and a Coordinating Council to coordinate activities of all relevant federal agencies, States, communities and private and not-for-profit entities, and provide a consistent funding stream and national coordination for Adult Protective Services (APS).

- **Increasing knowledge and supporting promising projects.** Given the lack of research, the Elder Justice Act will enhance research, clinical practice, training and dissemination of information relating to elder justice. Priorities include jump-starting intervention research, developing community strategies to make elders safer, and enhancing multi-disciplinary efforts.

- **Developing forensic capacity.** There is scant data to assist in the detection of elder abuse, neglect and exploitation. Creating new forensic expertise (similar to that in child abuse) will promote detection and increase expertise.

- **Increasing prosecution.** New penalties for failure to promptly report crimes in facilities and to provide notice of nursing home closings will enhance prosecutions.

- **Training.** Training to combat elder abuse, neglect and exploitation is supported both within individual disciplines and in multi-disciplinary (such as public health-social service-law enforcement) settings.

- **Increasing Security, Collaboration, and Consumer Information in Long-Term Care**
    - Enhancing long-term care staffing settings
    - Improving prompt reporting of crimes in long-term care settings
    - Enhancing the long-term care ombudsman program
    - Requiring a study on establishment of a national nurse aide abuse registry
    - Requiring a report on findings of a criminal background check demonstration
    - Implementation of new reporting of crimes in nursing homes on the official federal website
    - Establishment of consumer information on nursing homes on the official federal website
    - Establishment of a National Training Institute for Surveyors of nursing homes

- **Evaluations/Accountability**. Provisions to determine what works and assure funds are properly spent.

Offset: To be provided

Lincoln Amendment #D6 to The America's Healthy Future Act

Short Title: To restore the ratios used in determining geographic hospital wage index reclassification to the pre-October 1, 2008 levels until the first fiscal year one year after the Secretary makes a proposal(s) that considers the nine points specified in the Tax Relief and Health Care Act of 2006 (Pub. L. 109–432, §106(b)(2)).

Description of Amendment:

Current Law

Section 106 of the Tax Relief and Health Care Act of 2006 (Public Law 109–432) directed the Secretary to propose revisions to the hospital wage index taking into account recommendations made by the Medicare Payment Advisory Commission and considering nine issues specified by Congress in the legislation. The legislation required that this proposal be included in the proposed update for the hospital inpatient prospective payment system for fiscal year 2009. The Secretary has not yet made a proposal considering the nine issues specified by Congress.

Effective October 1, 2008, the Secretary revised the criteria hospitals must meet to qualify for wage index geographic reclassification. Prior to October 1, 2008, a hospital seeking wage index geographic reclassification had to demonstrate, among other things, that its average hourly wage is above a specified ratio when compared to the average hourly wage of hospitals in the area to which the hospital seeks to be reclassified. For rural hospitals, the specified ratio was 82 percent; for urban hospitals, the specified ratio was 84 percent; and for urban hospitals applying as a group, the specified ratio was 85 percent. Effective October 1, 2008, the ratio for rural hospitals is 86 percent, and the ratio for urban hospitals applying individually and as a group is 88 percent, subject to a two-year transition.

Proposed Change

This amendment would restore the ratios to the pre-October 1, 2008 levels until the first fiscal year one year after the Secretary makes a proposal(s) that considers the nine points specified in the Tax Relief and Health Care Act of 2006 (Pub. L. 109–432, §106(b)(2)). It also would ensure that any applications for reclassification denied before the legislation is enacted on the basis of

the changed ratios would be reconsidered using the pre-existing ratios, and approved, if the applicant meets the pre-existing ratios. This amendment would be implemented in a budget neutral manner. These changes would be effective upon enactment.

Cost: Budget Neutral

Offset: N/A

Lincoln Amendment #D7 to The America's Healthy Future Act

Short Title: Provide access to home infusion therapy services for Medicare beneficiaries by adding the Home Infusion Therapy Coverage Act (S.254**).**

Description of Amendment: The Chairman's Mark includes a number of provisions aimed at improving access to care for Medicare beneficiaries. Consistent with these goals, this amendment would add the Home Infusion Therapy Coverage Act (S.254**)** to The America's Healthy Future Act.

This amendment would direct the Secretary to implement a home infusion therapy benefit in the Medicare program. The benefit would allow Medicare Part B payment for services, equipment, and supplies necessary to safely provide infusion therapy in the home, and coordinate services with drug coverage under Medicare Part D. The amendment also would require the Secretary to work with an Advisory Committee to develop quality standards to ensure the safe and effective provision of home infusion therapy.

Infusion therapy involves the administration of medication directly into the bloodstream via a needle or catheter. Providing infusion therapy in a patient's home involves not only the delivery of medication, but also requires specialized equipment, supplies, and professional services to ensure safe and effective administration of the therapy. While most infusion drugs are covered under the Medicare Part D drug benefit, CMS determined that it does not have the authority to cover infusion-related services, supplies, and equipment under Part D.

Currently, private insurance companies including many Medicare Advantage plans, TRICARE, the Veterans Administration, and most Medicaid programs reimburse for infusion therapy treatments provided in the home when prescribed by a physician and desired by the patient. Unfortunately traditional Medicare is the only national payer that does not reimburse for home infusion therapy, a setting that is far less expensive, more convenient for the patient, and less likely to result in secondary infections. As a result, Medicare beneficiaries are effectively denied access to home infusion therapy and forced to receive this treatment in hospitals and skilled nursing facilities at a significantly higher cost to Medicare and at great inconvenience to patients.

Offset: To be determined

Lincoln Amendment #D8 to The America's Healthy Future Act

Short Title: To Allow Critical Access Hospitals (CAHs) to access Medicare Disproportionate Share Hospital (DSH) funding proportionate to their level of uncompensated care.

Description of Amendment:

The Critical Access Hospitals (CAH) program was designed to improve rural health care access and reduce hospital closures. Critical Access Hospitals provide essential services to a community and are reimbursed by Medicare on a "reasonable cost basis" for services provided to Medicare patients. While they are reimbursed under Medicare at cost plus 1%, CAHs in many areas of the country often face high rates of uncompensated care due to uninsurance, underinsurance, and low reimbursement rates by Medicaid or even some private payors.

This amendment would allow Critical Access Hospitals (CAHs) to access Medicare Disproportionate Share Hospital (DSH) funding proportionate to their level of uncompensated care as applies to other hospitals under the Chairman's Mark.

Offset: To be determined

Lincoln Amendment #D9 to The America's Healthy Future Act

Short Title: To authorize qualified physical therapists in rural areas to provide services for Medicare beneficiaries without the requirement of a physician referral.

Description of Amendment:

Today, Medicare law requires a beneficiary who receives outpatient physical therapy services to be under the care of a physician. However, outside of Medicare, 44 states allow for direct access to the services of licensed physical therapists for evaluation and treatment. In rural communities with little or no access to a quick referral system from a primary care provider, timely access to a physical therapist can be delayed, adding cost to the overall recovery of a senior or individual with a disability.

This amendment would add to the Social Security Act (42 U.S.C. 1395x(p)) the following:

> "In the case of outpatient physical therapy services described in the second sentence of this subsection that are furnished in a primary care health professional shortage area that is located in a rural area (as defined for purposes of section 1886(d)(2)(D)), this subsection and section 1835(a)(2) shall be applied without regard to any requirement that an individual be under the care of (or referred by) a physician, or that services be provided under the supervision of a physician, and by allowing a physician or a qualified physical therapist to satisfy any requirement for certification and recertification and for establishment and periodic review of a plan of care. The preceding sentence shall not apply to outpatient occupational therapy services by operation of subsection (g)."

Offset: To be determined

Lincoln Amendment #D10 to The America's Healthy Future Act

Short Title: To revise Medicare coverage to permit respiratory therapists to work under the general supervision of the physician and to recognize respiratory therapists who work outside of the hospital.

Description of Amendment:

Current law (referred to as "incident to a physician's service") limits the areas in which a respiratory therapist can work because the physician has to provide direct supervision when the respiratory therapist furnishes a service the physician would otherwise personally perform. Direct supervision means the physician has to be present in the office suite. The distinction between this amendment and current law is the physician would not be required to be in the office, although he or she would have to be available by phone for consultation if needed.

The proposed changes to Medicare law will substantially improve patient's access to care because the respiratory therapist could furnish a service to a Medicare beneficiary in the physician's office without the physician being present. This change would allow respiratory therapists the flexibility to provide office-based spirometry or smoking cessation counseling; to perform certain home visits for ventilator and oxygen use; and to contract their services to a number of physicians for disease management programs or lung testing.

Disease management programs, specifically those dealing with asthma and COPD, have a real chance for helping patients help themselves. Other kinds of patient education, such as smoking cessation or better education on aerosol devices and delivery are needed. Ventilator patients at home need management and assessment. The Medicare Respiratory Therapy Initiative will address these inadequate services and improve opportunities for better patient care.

A number of advanced-level allied health care providers, such as physician assistants, nurse practitioners, and clinical nurse specialists, currently furnish services without direct physician supervision. This amendment requires that a respiratory therapist would need to be a "registered" RT and have a bachelor's degree to be eligible to participate under the new initiative. The amendment would not change the status or impact the employment of respiratory therapists who do not meet these qualifications. About 33% of RTs in the country would qualify under the

RRT/Bachelor's guidelines; this amendment will create an incentive for respiratory therapists to achieve higher education and more advanced credentials ultimately benefiting the profession.

Physicians who are currently providing these services are paid an amount based on 100% of the Medicare fee schedule. If respiratory therapists were permitted to provide these services without the physician having to be physically present, Medicare would pay the physician a reduced amount based on 85% of the physician fee schedule. And, the physician practice would have more flexibility in utilization of the physician's time.

Offset: To be determined

Lincoln Amendment #D11 to The America's Healthy Future Act

Short Title: To overturn the Centers for Medicare and Medicaid Services' (CMS') CY 2010 Physician Fee Schedule Proposed Rule's application of equipment utilization policy to radiation therapy. The amendment would be exempt from budget neutrality requirements under the statute.

Description of Amendment:

Background

Payments for radiation oncology services are projected to be reduced by 19 percent in 2010 based in large part on a change in equipment utilization policy and the use of new survey data on physicians' practice expenses. The change in equipment utilization policy and new survey data were used by the Centers for Medicare and Medicaid Services (CMS) to calculate practice expense relative value units (RVUs) for 2010 that were dramatically and unexpectedly reduced below their 2009 levels. Studies conducted by radiation oncology specialty societies have found that data manipulation by the CMS contractor resulted in freestanding radiation oncology practice expense values that are understated by almost half. Practice expense RVUs are an important component of the statutory formula used to determine payments under the Medicare fee schedule for physicians' services.

CMS has proposed changing the utilization rate from 50 percent to 90 percent for all equipment costing over $1 million. This stems from a misreading of a proposal by the Medicare Payment Advisory Commission (MedPAC) regarding diagnostic imaging services, but there is a clear distinction between radiation therapy and diagnostic imaging. In fact, in its comment letter to CMS on the Proposed Rule, MedPAC states, "MedPAC did not contemplate applying this [equipment utilization] policy to radiation therapy machines."

This amendment would overturn the application of equipment utilization policy to radiation therapy and would be exempt from budget neutrality requirements under the statute.

Offset: To be provided

Wyden Amendment #D1 to the Chairman's Mark of America's Healthy Future Act of 2009
Title III Subtitle B Part I

Short Title: Ensuring People in Hospice Do Not Have to Give Up the Prospect of a Cure

Description:

This amendment adds the following to the Chairman's Mark.

Creates a Medicare Hospice Concurrent Care (HCC) three-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time. To examine the effectiveness this delivery model, the Secretary would establish 26 sites across the country in both urban and rural areas to examine improvement in patient care, quality of life, and cost-effectiveness that results from the concurrent care model. An independent evaluation of this delivery model would be conducted with reports submitted to the Secretary and Congress. This demonstration would be required to be budget neutral.

The Secretary shall ensure that the aggregate expenditures under title XVIII of the Social Security Act do not exceed the amount of expenditures that the Secretary estimates would have been made under such title if the demonstration program had not been implemented.

Offset: This amendment will not result in increased cost.

Wyden Amendment #D2 to the Chairman's Mark of America's Healthy Future Act of 2009
Title III Subtitle B Part I

Short Title: The Independence at Home (IAH) Act, S.1131, seeks to provide high cost Medicare beneficiaries suffering from multiple chronic conditions with coordinated, primary care services in their homes or residences from a team of qualified health care professionals.

Cosponsors: Carper

Description: Medicare beneficiaries with multiple chronic conditions account for a disproportionate amount of Medicare spending, receive poor care, and account for a majority of hospital admissions, prescriptions, and physician visits. Interdisciplinary teams of health care professionals caring for patients with multiple chronic conditions in their residences can reduce hospital and emergency room visits and achieve significant savings.

This amendment adds the following to the Chairman's Mark.

The IAH program:

- Creates a chronic care coordination pilot project to bring primary care services to the highest cost Medicare beneficiaries with multiple chronic conditions in their home.
- Generates savings by providing better, more coordinated care to beneficiaries with multiple chronic conditions, reducing duplicative and unnecessary services, and avoiding unnecessary hospitalizations and emergency room visits.
- Holds providers accountable for quality outcomes, patient satisfaction and achieving cost savings to Medicare.
- Creates incentives for providers to develop better and lower cost health care for the highest cost beneficiaries.
- Is based on successful house calls programs operating by the Veteran's Administration and other providers across the country.

Offset: This amendment will not result in increased cost.

Wyden Amendment #D3 to the Chairman's Mark of America's Healthy Future Act of 2009
Title III Subtitle B Part I

Short Title: Empowering Medicare Patient Choices

Description:

This amendment is to add the bipartisan Wyden-Gregg bill, the Empowering Medicare Patient Choices Act of 2009 (S. 1133) to the Chairman's Mark. This legislation empowers and educates patients using patient decision aids to help them find the best treatment for conditions like chronic back pain.

Offset: Reduce market baskets uniformly across Medicare Part B as needed to offset the increases.

Wyden Amendment #D4 to the Chairman's Mark of America's Healthy Future Act of 2009
Title III Subtitle B Part I

Short Title: Medicare Efficiency and Fairness Amendment

Description of Amendment: The amendment would limit the application of any payment reductions, reimbursement rate changes or other reductions in spending in Medicare to states where the average Medicare spending per enrollee over the past 5 years has been above the median Medicare spending per enrollee. No reduction should drop a state below the median Medicare spending per enrollee amount for 2009.

Offset: This amendment will not result in increased cost.

Wyden Amendment #D5 to the Chairman's Mark of America's Healthy Future Act of 2009

Short Title: Health Homes

Description: To ensure the participation of nurses, physicians, and other providers can lead the coordination of patient care as "health homes."

Strike every reference to "medical home" in the Mark and replace with "health home."

Offset: This amendment will not result in increased cost.

Wyden Amendment #D6 to the Chairman's Mark of America's Healthy Future Act of 2009
Title III, Subtitle B, Part II

Short Title: Rural Health Clinic Patient Access and Improvement Act

Description: This amendment adds the following to the Chairman's Mark.

The amendment is based on the bipartisan Rural Health Clinic Improvements Act (S. 1355) sponsored by Senators Barrasso and Wyden, would increase the rural health clinic cap from $75 per visit to $92 per visit in 2010. Each subsequent year the cap would increase based on MEI. It would also give incentive payments for Rural Health Clinic Quality Reporting. Incentive payments in the amount of $2 per visit shall be made to rural health clinics with respect to eligible professionals who furnish rural health clinic services during the period beginning on January 1, 2010, and ending on December 31, 2013.The Secretary shall conduct a study on the quality reporting initiative.

Also, this amendment would also allow rural health clinics to contract with Community Health Centers, providing that they set policies to ensure nondiscrimination based upon the ability of a patient to pay and the establishment of a sliding fee scale for low-income patients.

Requires a GAO report on diabetes education and medical nutrition therapy services.

Establishes a rural health provider demonstration project.

Defines a rural health clinic as "A facility that is in operation, that qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement in clause (i) that the clinic is not located in an urbanized area, shall, with respect to services furnished on or after the date of enactment of the Rural Health Clinic Patient Access and Improvement Act of 2009, be considered, for purposes of this title and title XIX, as still satisfying such requirement if it is determined that the clinic is located in an area defined by the State and certified by the Secretary as rural."

The amendment sets a minimum standard for Medicare Advantage payments.

Includes a Sense of the Senate regarding the adequacy of network based health plans.

Offsets: Create a specific exemption to allow health plan sponsors to encourage beneficiaries to utilize lower-cost generic drugs by allowing them to waive copays as an incentive to get the beneficiaries to try a generic drug. This practice is commonly known as the "Free Generic Fill." In the commercial sector, plan sponsors routinely waive from one to three months worth of copays in order to encourage patients to try generics. They do this because the amount the plan saves overall substantially outweighs the forgone copays as generics typically cost between 60-90% less than a branded pharmaceutical.

In the commercial market, plan sponsors that have offered Free Generic Fill can expect a conservative 5% uptake (beneficiaries taking advantage of the program), and correspondingly increasing their generic fill rate (GFR) by 2%. The Congressional Budget Office has scored every 1% increase in GFR as saving the government $1 billion, therefore the potential to save money in Medicare is real.

Wyden Amendment #D7 to the Chairman's Mark of America's Healthy Future Act of 2009
Title III, Subtitle B, Part 2

Short Title: Amends Title XVIII of the Social Security Act to provide flexibility in the manner in which beds are counted for purposes of determining whether a hospital may be designated as a critical access hospital under the Medicare program and to exempt from the critical access hospital inpatient bed limitation the number of beds provided for certain veterans.

Description:

This amendment adds the following to the Chairman's Mark. The amendment is based on the bipartisan Critical Access Hospital Flex Act (S. 307) cosponsored by Senators Crapo and Wyden. It amends title XVIII (Medicare) of the Social Security Act with respect to state Medicare rural hospital flexibility programs, in particular the criteria for designation of critical access hospitals.

Revises requirements for the counting of beds for purposes of determining whether a hospital may be designated as a critical access hospital. Allows a facility to provide a maximum of 20 (currently 25) acute care inpatient beds, as determined on an annual, average basis. Declares that only occupied beds shall be counted.

Exempts from the critical access hospital inpatient bed limitation beds provided to certain veterans.

Offset: Create a specific exemption to allow health plan sponsors to encourage beneficiaries to utilize lower-cost generic drugs by allowing them to waive copays as an incentive to get the beneficiaries to try a generic drug. This practice is commonly known as the "Free Generic Fill." In the commercial sector, plan sponsors routinely waive from one to three months worth of copays in order to encourage patients to try generics. They do this because the amount the plan saves overall substantially outweighs the forgone copays as generics typically cost between 60-90% less than a branded pharmaceutical.

In the commercial market, plan sponsors that have offered Free Generic Fill can expect a conservative 5% uptake (beneficiaries taking advantage of the program), and correspondingly increasing their generic fill rate (GFR) by 2%. The Congressional Budget Office has scored every 1% increase in GFR as saving the government $1 billion, therefore the potential to save money in Medicare is real.

Wyden Amendment #D8 to the Chairman's Mark of America's Healthy Future Act of 2009
Title III, Subtitle B, Part 2

Short Title: Rural Health Clinic Patient Access and Improvement and Critical Access Hospital Flexibility Act.

Description:

This amendment adds the following two pieces of legislation to the Chairman's Mark.

Rural Health Clinic Improvements Act (S. 1355) sponsored by Senators Barrasso and Wyden, would increase the rural health clinic cap from $75 per visit to $92 per visit in 2010. Each subsequent year the cap would increase based on MEI. It would also give incentive payments for Rural Health Clinic Quality Reporting. Incentive payments in the amount of $2 per visit shall be made to rural health clinics with respect to eligible professionals who furnish rural health clinic services during the period beginning on January 1, 2010, and ending on December 31, 2013.The Secretary shall conduct a study on the quality reporting initiative.

Also, this amendment would also allow rural health clinics to contract with Community Health Centers, providing that they set policies to ensure nondiscrimination based upon the ability of a patient to pay and the establishment of a sliding fee scale for low-income patients.

Requires a GAO report on diabetes education and medical nutrition therapy services.

Establishes a rural health provider demonstration project.

Defines a rural health clinic as "A facility that is in operation, that qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement in clause (i) that the clinic is not located in an urbanized area, shall, with respect to services furnished on or after the date of enactment of the Rural Health Clinic Patient Access and Improvement Act of 2009, be considered, for purposes of this title and title XIX, as still satisfying such requirement if it is determined that the clinic is located in an area defined by the State and certified by the Secretary as rural."

The amendment sets a minimum standard for Medicare Advantage payments.

Includes a Sense of the Senate regarding the adequacy of network based health plans.

Critical Access Hospital Flex Act (S. 307) sponsored by Senators Crapo and Wyden amends title XVIII (Medicare) of the Social Security Act with respect to state Medicare rural hospital flexibility programs, in particular the criteria for designation of critical access hospitals.

Revises requirements for the counting of beds for purposes of determining whether a hospital may be designated as a critical access hospital. Allows a facility to provide a maximum of 20

(currently 25) acute care inpatient beds, as determined on an annual, average basis. Declares that only occupied beds shall be counted.

Exempts from the critical access hospital inpatient bed limitation beds provided to certain veterans.

Offset: Create a specific exemption to allow health plan sponsors to encourage beneficiaries to utilize lower-cost generic drugs by allowing them to waive copays as an incentive to get the beneficiaries to try a generic drug. This practice is commonly known as the "Free Generic Fill." In the commercial sector, plan sponsors routinely waive from one to three months worth of copays in order to encourage patients to try generics. They do this because the amount the plan saves overall substantially outweighs the forgone copays as generics typically cost between 60-90% less than a branded pharmaceutical.

In the commercial market, plan sponsors that have offered Free Generic Fill can expect a conservative 5% uptake (beneficiaries taking advantage of the program), and correspondingly increasing their generic fill rate (GFR) by 2%. The Congressional Budget Office has scored every 1% increase in GFR as saving the government $1 billion, therefore the potential to save money in Medicare is real.

Wyden Amendment #D9 to the Chairman's Mark of America's Healthy Future Act of 2009
Title I, Subtitle A

Short Title: The Confidence in Long-Term Care Insurance Act (S. 1177) proposes greater consumer protection, increased consumer information and choice, and increased competition among private insurers.

Brief Description:

The amendment adds the following to the Chairman's Mark.

Directs the Secretary of HHS to request the National Association of Insurance Commissioners (NAIC), which represents all state insurance commissioners (NAIC) to conduct national surveys of LTCI markets every five years to generate needed data on lapse rates, numbers of policyholders exhausting benefits, and other key market parameters. Amends the Health Information Portability and Accountability Act (HIPAA) and the Deficit Reduction Act (DRA) to require compliance with all minimum NAIC 2000 and 2006 standards in order to reduce state-to-state variability, including procedures that are designed to keep premium rates stable over time. The amendment proposes to make a series of commonsense improvements to current law, such as requiring NAIC to form a working group that would develop model disclosures and definitions of key benefits offered in LTCI policies, and requiring the Secretary to set up a website known as "Long-Term Care Insurance Compare" to allow consumers to easily and accurately compare benefits, premiums, and other important features of policies and companies much more readily than they can today. LTCI Compare would also provide links to state websites for information on services offered under state Medicaid programs for individuals with Partnership policies. Importantly, the amendment improves consumer protections for Medicaid Partnership Policies and tax-qualified policies by streamlining the process for applying new/updated consumer protection model provisions as they are developed by NAIC.

Offset: This amendment will not result in increased cost.

Wyden Amendment #D10 to the Chairman's Mark of America's Healthy Future Act of 2009 Title III, Subtitle B, Part I

Short Title: Personalized Medicine and Access to Critical Lab Tests

Cosponsors: Carper

Description:

Present Law

In cases when a laboratory test is ordered less than 14 days after a beneficiary leaves a hospital, the hospital collecting the sample must bill for the laboratory services.

This amendment adds the following Proposed Change to the Chairman's Mark.

This amendment would provide that for the two-year period beginning on the date of enactment, the laboratory furnishing the test could bill for the test provided the test meets the following criteria:

- The test is an analysis of DNA, RNA, chromosomes, proteins, or metabolites that detects, identifies, or quantitates genotypes, mutations, chromosomal changes, biochemical changes, cell response, protein expression, or gene expression or similar method or is a cancer chemotherapy sensitivity assay or similar method, but does not include methods principally comprising routine chemistry or routine immunology;
- The test is developed and performed by a laboratory that is independent of the hospital where the sample was collected;
- The test is not furnished by the hospital where the sample was collected directly or under arrangements; and
- The sample was collected during a hospital encounter or stay, and is performed after the beneficiary leaves a hospital.

Offset:
Short Summary

This offset reduces Medicare spending and improves quality of care for amputees and persons with limb impairments by:

1) requiring Medicare to make payment only for those orthotic and prosthetic services provided by licensed providers in States that require State licensure;

2) requiring providers meet accreditation/credentialing already articulated in federal statute in order to receive Medicare payment; and

3) re-aligning the Medicare Orthotic and Prosthetic fee schedule so that Medicare payment is linked to the complexity of the device the patient needs and the qualifications of the provider of the orthotic and prosthetic services.

This amendment exempts physicians, physical therapists and occupational therapists who are already licensed or otherwise certified by Medicare and are currently being paid by Medicare to provide these services.

Wyden Amendment #D11 to the Chairman's Mark of America's Healthy Future Act of 2009 Title III, Subtitle B, Part I

Short Title: Take Back Your Health Amendment

Description:

This amendment adds the following to the Chairman's Mark.

With revolutions in wellness, prevention, and treatment, physicians and patients could enter the "Take Back Your Health" program which helps patients fight chronic disease and stipulates that providers won't get paid unless they keep their patients out of the hospital for their chronic illness.

This amendment is based on the bipartisan legislation, the Take Back Your Health Act (S. 1640) sponsored by Senators Wyden, Harkin, and Cornyn, which amends H.R. 6331, the "Medicare Improvements for Patients and Providers Act of 2008" in order to reimburse treatment programs of intensive lifestyle changes that have been scientifically proven to stop or reverse the progression of chronic diseases such as coronary heart disease, diabetes, prostate cancer/breast cancer, and obesity. This amendment reframes a common misconception about lifestyle changes, which are often incompletely viewed as providing only risk factor reduction or prevention.

Intensive lifestyle treatment programs as an intensive non-surgical, non-pharmacologic intervention have been shown in randomized controlled trials to be highly effective not only at *preventing* chronic diseases but also at *reversing* the progression of these illnesses. Several demonstration projects have shown that using intensive lifestyle treatment programs to treat chronic diseases causes substantial reductions in costs during the first year. Thus, treatment programs of intensive lifestyle changes are not only medically effective but also cost effective.

Health teams, consisting of physicians, nurses, nutritionists, mental health workers and other health professionals would provide the Intensive Lifestyle Treatment Plan

This proposed legislation will reimburse physicians and other health professionals who train patients to make and maintain intensive lifestyle changes that are proven to be safe and effective in beneficially treating and reversing chronic diseases.

Offset: To be determined when offered if needed.

Wyden Amendment #D12 to the Chairman's Mark of America's Healthy Future Act of 2009 Title III, Subtitle A, Part III

Short Title: Authorizing the Use of New Technologies that Empower Patients and Their Providers to Get More Value in Accountable Care Organizations

Description: This amendment adds the following to the Chairman's Mark.

Allow Accountable Care organizations to use telehealth, remote patient monitoring, and other such enabling technologies to help achieve savings.

Offset: This amendment will not result in increased cost.

Wyden Amendment #D13 to the Chairman's Mark of America's Healthy Future Act of 2009 Title III, Subtitle A, Part 2

Short Title: To Encourage Integrated Care Delivery Across All Care Settings through Integrated Health Clinics

Description:

This amendment adds the following to the Chairman's Mark.

The provision allows for the organization of providers or groups of health care professionals in a separate entity established to provide integrated inpatient and ambulatory care services solely through contract with or employment of medical and professional personnel. Federal and state laws and regulations which would prevent or inhibit the separate corporation from carrying out such required integrated care activities and objectives would not apply.

Offset: This amendment will not result in increased cost.

Wyden Amendment #D14 to the Chairman's Mark of America's Healthy Future Act of 2009 Title III, Subtitle A, Part IV

Short Title: Getting the Best Possible Training for Home Health and Other Workers Who Provide Hands-On Care

Description:

Meeting the health needs of baby boomers will create new jobs for individuals trained in geriatric care, in addition to meeting the current high demand for such individuals. Direct care workers, nurse aides, home health aides, and personal and home care aides are the primary providers of paid hands-on care, supervision, and emotional support for older adults in the United States. The Institute of Medicine report, entitled ''Retooling for an Aging America'' described direct care workers, nurse aides, home health aides, and personal and home care aides as the linchpin of the formal health care delivery system for older adults.

This amendment adds the following to the Chairman's Mark.

The Secretary shall develop additional training content for nurse aides and home health aides to supplement training for nurse aides and home health aides that is required under Federal law or regulation. The Secretary shall, in consultation with an expert panel, implement the program with respect to additional training content activities not later than 18 months after such date of enactment. Not later than 120 days after the date of enactment of this Act, the Secretary shall establish a panel of long-term care workforce experts. For purposes of the program, the additional and revised training content developed shall only apply with respect to newly hired home health aides and nurse aides.

The expert panel shall be composed of 11 members appointed by the Secretary from among leading experts in the long-term care field, including representatives of personal or home care agencies; home health care agencies; nursing homes and residential care facilities; the disability community (including the mental retardation and developmental disability communities); the nursing community; national advocacy organizations and unions that represent direct care workers; older individuals and family caregivers; State Medicaid waiver program officials; curriculum developers with expertise in adult learning; researchers on direct care workers and the long-term care workforce; and geriatric pharmacists. Not less than 2 of the 11 members appointed by the Secretary shall represent the interests of individuals who rely on long-term care services. Not later than 1 year after the date of enactment of this Act, the expert panel shall submit a report to the Secretary.

Offset: To be determined when offered if needed.

Wyden Amendment #D15 to the Chairman's Mark of America's Healthy Future Act of 2009

Short Title: Requiring the Medicare Payment Advisory Commission to Consider Medicaid Payments When Making Recommendations to Congress on Medicare Reimbursement for Skilled Nursing Facilities

Description:

This amendment adds the following to the Chairman's Mark.

The Medicare Payment Advisory Commission shall review, and take into account, the interaction of Medicaid payment policies with Medicare payment policies for services provided in skilled nursing facilities when making Medicare payment recommendations for skilled nursing facilities. In doing such a review, the commission shall review Medicaid trends, spending and margins for skilled nursing facilities, and look at net margins for nursing homes from all payment sources.

Offset: This amendment will not result in increased cost.

Wyden Amendment #D16 to the Chairman's Mark of America's Healthy Future Act

Short Title: Ensuring Quality Hospice Care

Description of Amendment: To ensure the quality of hospice care is not reduced

Offset: To be determined

Wyden Amendment #D17 to the Chairman's Mark of America's Healthy Future Act

Short Title: Ensuring Continuation of Benefits for Seniors Covered Under Medicare Advantage

Description of Amendment: To ensure that seniors participating in Medicare Advantage continue to receive good quality, affordable benefits

Offset: To be determined

SCHUMER #D1

Schumer Amendment #D1 to Title III, Subtitle B

Short Title: Affordable Biosimilars Reimbursement Equity Amendment

Description of Amendment:

The Medicare Modernization Act established that every biologic drug be assigned its own billing code. For Part B drugs this means each brand name biologic drug has its own Average Sales Price (ASP). To ensure that patients and the Medicare program utilize biosimilars appropriately, this amendment will create parity between brand name biologics and biosimilars and save patients and Medicare money. The amendment allows a Part B biosimilar product approved by the Food and Drug Administration and assigned a separate billing code to be reimbursed at the ASP of the biosimilar plus six percent of the ASP of the reference product.

Offset:

Savings to be applied towards improving affordability in the Exchange.

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SCHUMER # D2

Schumer #D2 to Title III, Subtitle A, Part II-

Short Title: HHS Study regarding payment systems for new clinical laboratory diagnostic tests

Description of Amendment:

This amendment would direct the Secretary of Health and Human Services to convene a public meeting on payment systems for new clinical laboratory diagnostic tests and to submit a report to Congress, summarizing the meeting and providing recommendations for legislative and administrative actions to reform the reimbursement mechanisms for new clinical laboratory diagnostics.

SCHUMER # D3

Schumer Amendment #D3 to Extend Section 508 Reclassifications-

Short Title: Hospital Reclassifications

Description of Amendment:

This amendment provides for the wage index reclassification for hospitals in certain counties.

No cost anticipated.

SCHUMER # D4

Schumer Amendment #D4 to Title III, Subtitle D-

Short Title: Changes to Medicare DSH Reductions and Addition of Medicare DSH Report

Description of Amendment:

This amendment would replace the existing Medicare DSH language with the following. Not later than January 1, 2016, the Secretary of Health and Human Services must submit to Congress a report on Medicare DSH taking into account the impact of the health care reforms carried out under Title I in reducing the number of uninsured individuals. The report must include recommendations relating to: the appropriate amount, targeting, and distribution of Medicare DSH to compensate for higher Medicare costs associated with serving low-income beneficiaries (taking into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size), consistent with the original intent of Medicare DSH; and, the appropriate amount, targeting, and distribution of Medicare DSH to hospitals given their continued uncompensated care costs, to the extent such costs remain. The Secretary must coordinate this report with the report on Medicaid DSH under Title I, Subtitle G, Part VI.

Beginning in 2017, the Secretary must implement adjustments to Medicare DSH if a trigger is met. The trigger is met if there is a significant decrease in the national rate of uninsurance, defined as a decrease in the national rate of uninsurance from 2012 to 2014 that exceeds 8 percentage points. The term ‘‘national rate of uninsurance’’ means, for a year, such rate for the under-65 population for the year as determined and published by the Bureau of the Census in its Current Population Survey in or about September of the succeeding year.

If the trigger is met, then the Secretary of Health and Human Services must, beginning in fiscal year 2017, implement the following adjustments to Medicare DSH.

The Secretary must adjust the amount of Medicare DSH based on the recommendations of the Medicare DSH report and shall take into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size. For each fiscal year (beginning with fiscal year 2017), the Secretary must estimate the aggregate reduction in Medicare DSH that will result from this adjustment.

The Secretary must increase Medicare DSH for a hospital by an additional amount that is based on the amount of uncompensated care provided by the hospital based on criteria for uncompensated care as determined by the Secretary, which shall exclude bad debt. The Secretary shall compute this increase in Medicare DSH for a fiscal year in accordance with a formula established by the Secretary that provides that: the aggregate amount of such increase for the fiscal year does not exceed 50 percent of the aggregate reduction in Medicare DSH estimated by the Secretary for such fiscal year; and, hospitals with higher levels of uncompensated care receive a greater increase.

SCHUMER-MENENDEZ # D5

Schumer - Menendez Amendment #D5 to Title III, Subtitle A, Part IV

Short Title: Extending and Expanding Medicare Demonstration Projects to Permit Gainsharing Arrangements

Description of Amendment:

This amendment permits projects already authorized under current law to continue through September 30, 2011. To enhance the success of this demonstration project and provide more experience with gainsharing arrangements for the Medicare program, this amendment also increases the number of projects authorized, with all of the same quality and efficiency requirements and protections as under current law. Specifically, the amendment requires the Secretary, subject to the availability of sufficient qualifying proposals, to award 50 demonstration projects by July 1, 2011. Preference is given to applicants in states where current demonstration projects have already been approved. Authorization for these additional or renewed demonstration projects would continue through 2015, at which point the Secretary may, through formal rulemaking, allow the participating hospitals to permanently participate in qualified gainsharing arrangements. In addition, if the Secretary concludes in the Final Report to Congress required by law that the demonstrations have been broadly successful in both quality improvement and cost reduction, she shall, through formal rulemaking, permit other hospitals to undertake such programs through an election process. This amendment provides $1.6 million for FY 2010; however, because the amendment extends the program through 2015, the amendment provides for $2 million annually for FY 2011 through FY 2015. To defray these costs, demonstration projects initially approved or renewed after October 1, 2011, shall be required to return 5% of the savings attributable to their projects, net of payments made to physicians under the projects, as identified by the Secretary in the Quality Improvement and Savings Report to Congress required by law. The amendment also changes the dates for required reports, including the project update, the quality improvement and savings report, and the final report, consistent with the extension required by this amendment.

Stabenow Amendment D-1 to the Chairman's Mark

Short title/purpose: To provide technical guidance for the reimbursement of school-based health centers under Medicaid and the Children's Health Insurance Program

Description of Amendment: The Children's Health Insurance Program Reauthorization Act of 2009 (Public Law No: 111-3) included a definition of school-based health centers (SBHCs) and created a state option for state Medicaid and CHIP programs to reimburse such entities.

This amendment would continue to build off of that language by ensuring that sufficient technical and regulatory guidance is available for state Medicaid programs, insurance programs in the exchanges, and for school-based health centers' sponsoring organizations. Under this amendment, the Secretary must issue regulations regarding the reimbursement for health services provided by SBHCs to individuals eligible to receive such services through the program under this section, including reimbursement under any insurance policy or any Federal or State health benefits program (including titles XIX and XXI of the Social Security Act).

The Stabenow amendment would also authorize an Urban Indian program under title V of the Indian Health Care Improvement Act to be a sponsoring facility.

This language ensures that a process will take place upon enactment of this bill that will require the Secretary to analyze, develop and issue regulations regarding the reimbursement of covered services delivered to covered children in SBHCs.

Offset: Similar language was debated in the House Energy and Commerce Committee and did not score.

Contact: Oliver Kim

Stabenow Amendment D-2 to the Chairman's Mark

Short title/purpose: To authorize community mental health centers to obtain health information technology grants

Description of Amendment: This amendment would allocate $50 million in funding for community mental health centers (CMHCs) to purchase information technology, with $25 million allocated in FY10 and $25 million in FY11. CMHCs that obtain such a grant must follow "meaningful use" criteria as established by the HHS Secretary for the incentives in the American Recovery and Reinvestment Act.

Offset: To the extent necessary, the fee on brand-name drug companies would be increased by $50 million across 5 years.

Contact: Oliver Kim

Stabenow Amendment D-3 to the Chairman's Mark

Short title/purpose: To authorize community mental health centers to obtain health information technology grants

Description of Amendment: The American Recovery and Reinvestment Act (ARRA) allocated $40 million for each of fiscal years 2009 through 2015 and $20 million for each succeeding fiscal year through 2019 for enhanced Medicaid payments to encourage the adoption of electronic medical records. Rural health clinics and Federally-Qualified Health Centers that have at least 30 percent of their patient volume attributable to Medicaid patients would also be eligible for a payment equal to not less than 85 percent of their net allowable technology costs.

This amendment would add community mental health centers (CMHC) to the list of eligible providers in ARRA that may receive Medicaid incentives. To be eligible, a community mental health center (CMHC) would need to follow the same requirements for meaningful use and for the percentage of Medicaid patients served as a community health center or a rural health clinic.

Additionally, HHS may subject eligible CMHCs to aggregate or annual limitations for these payments.

Offset: No additional funding would be allocated to this program.

Contact: Oliver Kim

Stabenow Amendment D-4 to the Chairman's Mark

Short title/purpose: To provide training for advance practice nurses

Description of Amendment: This amendment would authorize Medicare reimbursement for FY11 through FY15 to hospitals for the educational costs (including faculty salaries, student stipends (if any), clinical instruction costs, and other direct and indirect costs) of an eligible hospital attributable to the training of advanced practice nurses with the skills necessary to provide primary and preventive care, transitional care, chronic care management, and other nursing services appropriate for the Medicare-eligible population.

To be eligible, a hospital must have an affiliation with one or more accredited schools of nursing (as defined in section 801 of the Public Health Service Act) and partner with two or more non-hospital community-based care settings where at least half of all clinical training occurs. Such an affiliation must include an agreement with the schools of nursing and non-hospital community-based settings to pay them for their share of the costs of educational activities. However, the Secretary may waive the community-based setting requirement under clause (ii) for clinical training of advanced practice registered nurses, such as certified registered nurse anesthetists and certified nurse-midwives, in rural and medically underserved areas.

Costs under this paragraph are limited to costs attributable to an increase in the enrollment and the number of advanced practice nurse graduates in each education or training program over the comparable average number from 2006 to 2010 (as determined by the Secretary) but shall not be offset or take into account tuition, fees, or State or local government appropriations. The proportion of such costs paid under this paragraph shall be determined based on the proportion of the total inpatient days of the hospital attributable to this title. No more than $1 billion over five years could be spent in implementing this provision.

For purposes of this amendment, the term "advanced practice nurse" shall include a clinical nurse specialist, nurse practitioner, certified registered nurse anesthetist, and certified nurse midwife.

In 2014, MedPAC is required to report to Congress on the effectiveness of this program in training advanced practice nurses and in reducing the nurse shortage, particularly in rural or medical undeserved areas.

Offset: The brand-name pharmaceutical fee would be increased by $1 billion over ten years.

Contact: Oliver Kim

Stabenow Amendment D-5 to the Chairman's Mark

Short title/purpose: To better integrate primary care and behavioral health services for our most vulnerable populations

Description of the Amendment: The Chairman's mark authorizes a new State Medicaid option promoting health homes and integrated care. Further the proposal states that only Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition would be eligible to receive coordinated services under the optional program. Finally, the Chairman's mark lists examples of eligible designated providers. This would amendment would clarify that persons with severe mental illnesses would qualify to receive integrated care under the option, and that Community Mental Health Centers (CMHCs) could participate as designated providers.

This amendment has two parts. First, it would clarify that Medicaid eligible persons with serious and persistent mental illnesses would be eligible to receive integrated care under this new Medicaid optional program. Second, the amendment would add Community Mental Health Centers (CMHCs) to the list of examples of designated providers eligible to participate in the program.

Offset: Neither component of the amendment would increase the cost of Medicaid State Option Promoting Health Homes and Integrated Care, so no offset is needed.

Contact: Oliver Kim: (4-4822)

Stabenow Amendment D-6 to the Chairman's Mark

Short title/purpose: To establish guidelines to ensure patient access for our nation's emergency rooms

Description of Amendment: This amendment first establishes the United States Bipartisan Commission on Access to Emergency Medical Services to: (1) identify and examine factors in the health care delivery, financing, and legal systems that affect the effective delivery of screening and stabilization services furnished in hospitals that have emergency departments pursuant to the Emergency Medical Treatment and Labor Act; and (2) make specific recommendations to Congress within eighteen months of enactment with respect to federal programs, policies, and financing needed to assure the availability of such screening and stabilization services and the coordination of state, local, and federal programs for responding to disasters and emergencies.

The Commission shall be composed of 24 members with 8 appointed by the President, 8 appointed by the Speaker of the House of Representatives, and 8 appointed by the majority leader of the Senate. The membership of the Commission must include two individuals who represent emergency physicians, emergency nurses, and other health care professionals who provide emergency medical services; two individuals who are elected or appointed Federal, State, or local officials and who are involved in issues and programs related to the provision of emergency medical services; two health care consumer advocates; and two individuals who represent hospitals and health systems that provide emergency medical services. Members must be appointed within six months of enactment, and the Commission shall dissolve 30 days following the release of its recommendations.

Second, this amendment directs CMS to convene a working group that includes experts in emergency care, inpatient critical care, hospital operations management, nursing, and other relevant disciplines to develop boarding and diversion standards for hospitals and guidelines, measures, and incentives for implementation, monitoring, and enforcement of such standards. This CMS working group shall: (1) identify barriers contributing to delays in timely processing of patients requiring admission as inpatients who initially sought care through the hospital's emergency department; (2) identify best practices to improve patient flow within hospitals; and (3) report within a year of convening to Congress and the Secretary a detailed description of the standards, guidelines, measures, and incentives developed, as well as identified barriers and best practices. The working group must be convened within six months of the date of enactment and shall dissolve 30 days following the release of the report.

Offset: None

Contact: Oliver Kim

Stabenow Amendment D-7 to the Chairman's Mark

Short title/purpose: To ensure access to our nation's emergency rooms and to encourage on-call specialists to serve our nation's emergency rooms

Description of Amendment: This amendment would provide a 5% Medicare reimbursement bonus for services provided by an emergency room physician or by an on-call specialist for services performed in an emergency room in FY10 through FY15.

Offset: This amendment would be offset by an increase in the pharmaceutical fee on brand name drugs.

Contact: Oliver Kim

Stabenow Amendment D-8 to the Chairman's Mark

Short title/purpose: To ensure access to our nation's emergency rooms and to encourage on-call specialists to serve our nation's emergency rooms

Description of Amendment: This amendment would eliminate the payment reduction for emergency room physicians and for services provided by on-call specialists in an emergency room that the Chairman's Mark identifies as an offset for the primary care/general surgery bonus.

Offset: This amendment would be offset by an increase in the pharmaceutical fee on brand name drugs.

Contact: Oliver Kim

Stabenow Amendment D-9 to the Chairman's Mark

Short title/purpose: To establish a National Center on Hospital Quality

Description of Amendment: The Chairman's Mark would direct the Secretary to establish a national quality improvement strategy.

This amendment would modify the strategic plan to also include strategies to align incentives among public and private payers with regard to quality and patient safety efforts; strategies to implement best practices to improve patient safety, eliminate health care-associated infections, and prevent unnecessary hospital readmissions and improve the culture of safety in health care.

As part of implementing these additional elements of the plan, the Secretary may contract with a non-profit organization or organizations that have at least five years of experience in developing and implementing the new strategies; have operated such programs on a statewide or multi-state basis to improve patient safety and the quality of health care delivered in hospitals, including at a minimum such programs in hospital intensive care units, hospital-associated infections, hospital perioperative patient safety, and hospital emergency rooms; and working with a variety of institutional health care providers, physicians and other health care practitioners.

In carrying out this section, there will be a mandatory appropriation of $25 million per year for FY10, FY11, and FY12.

Offset: This amendment would be offset by an increase in the pharmaceutical fee on brand name drugs.

Contact: Oliver Kim

Stabenow Amendment D-10 to the Chairman's Mark

Short title/purpose: To study barriers to appropriate utilization of generic medicine in our nation's Medicaid program

Description of Amendment: This amendment would require the Government Accountability Office to review state laws that have a negative impact on generic drug utilization in federal programs due to restrictions such as but not limited to limits on pharmacists' ability to substitute a generic drug or carve-outs of certain classes of drugs. This amendment would also require the review to consider the

The review should also include recommendations on how to ensure appropriate utilization in all federal health programs. Additionally, the review should make recommendations on any potential barriers in state law for increasing generic utilization in the insurance exchanges and CO-OPs in the Chairman's Mark.

This review shall be completed and delivered to Congress before January 1, 2012.

Offset: None

Contact: Oliver Kim

Stabenow Amendment D-11 to the Chairman's Mark

Short title/purpose: To give seniors enrolled in Medicare Part D plans more opportunities to sample affordable generic medicines

Description of Amendment: Under section 1128A(a)(5) of the Social Security Act (the Act), enacted as part of HIPAA, a person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties (CMPs) of up to $10,000 for each wrongful act. For purposes of section 1128A(a)(5) of the Act, the statute defines "remuneration" to include, without limitation, waivers of copayments and deductible amounts (or any part thereof) and transfers of items or services for free or for other than fair market value.

This amendment would create a specific exemption to allow health plan sponsors to encourage beneficiaries to utilize lower-cost generic drugs by allowing them to waive copays as an incentive to get the beneficiaries to try a generic drug.

This practice is commonly known as the "Free Generic Fill." In the commercial sector, plan sponsors routinely waive from one to three months worth of copays in order to encourage patients to try generics. They do this because the amount the plan saves overall substantially outweighs the forgone copays as generics typically cost between 60-90% less than a branded pharmaceutical.

Any savings achieved from this option shall be deposited in a fund to be established by the Secretary for grants to be used for the operating expenses for school-based health centers as defined in the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law No: 111-3). A school-based health center may not use the funding to provide for any service that is not authorized or allowed by state or local law.

Offset: This amendment is not expected to score.

Contact: Oliver Kim

Stabenow Amendment D-12 to the Chairman's Mark

Short title/purpose: To ensure congressional intent is followed when the Centers for Medicare and Medicaid Services implement Section 508

Description of Amendment: This amendment would ensure that all hospitals reclassified by Section 508 of MMA realized the full benefit of the extension provided by the Chairman's Mark. The Secretary would exclude the wage and hour data of a Section 508 hospital if doing so would result in a lower wage index value for all hospitals reclassified to that market.

Offset: This amendment would simply ensure that the existing block grant for Section 508 hospitals was being appropriately spent per congressional intent.

Contact: Oliver Kim

Stabenow Amendment D-13 to the Chairman's Mark

Short title/purpose: To ensure congressional intent is followed when the Centers for Medicare and Medicaid Services implement Section 508

Description of Amendment: This amendment would state that it is the Sense of the Senate that the Secretary should exclude the wage and hour data of a Section 508 hospital if doing so would result in a lower wage index value for all hospitals reclassified to that market to ensure appropriate implementation of Section 508 of the MMA.

Offset: None

Contact: Oliver Kim

Stabenow Amendment D-14 to the Chairman's Mark

Short title/purpose: To ensure patient access in Michigan's rural communities

Description of Amendment: This amendment would waive certain statutory requirements for some Michigan hospitals to receive Medicare rural health designations.

Offset: None

Contact: Oliver Kim

Stabenow-Menendez Amendment D-15 to the Chairman's Mark

Short title/purpose: To ensure communities were receiving access to high quality cancer care

Description of Amendment: Congress has recognized on numerous occasions (Social Security Amendments Act of 1983, the Omnibus Budget Reconciliation Act of 1989, the Balanced Budget Act of 1997, and the Fiscal Year 2001 Omnibus Appropriations Act) that the Medicare prospective payment system does not work for certain providers such as cancer hospitals. This amendment would establish a system for granting PPS exemptions to certain qualified cancer hospitals.

This amendment would exempt certain hospitals involved extensively in the treatment for or research on cancer, provided that their current or predecessor entities received NCI comprehensive cancer center designation on July 27, 1978, February 17, 1998, June 13, 2000, or which was designated on June 10, 2003 as the official cancer institute of its State.

Offset: This amendment is unlikely to affect a large number of hospitals and therefore trigger a CBO score. However, to the extent necessary to offset the amendment, the insurers' fee would be increased an appropriate amount.

Contact: Oliver Kim

Stabenow Amendment D-16 to the Chairman's Mark

Short title/purpose: To correct a flaw in the Medicare Disproportionate Share formula that impacts the appropriate utilization of ventilation-dependent units

Description of Amendment: Because the nature of their disability can require long-term hospitalization, ventilator-dependent patients are likely to exhaust their Medicare coverage and qualify for Medicaid due to the costs of their care. Under the Secretary's interpretation of the Medicare DSH regulations, days of care provided to an individual who is eligible for both Medicare Part A and Medicaid cannot be included in the Medicaid fraction, even if the patient has exhausted his or her Medicare coverage. While the Secretary amended the regulation in 2004 to permit some exhausted days to be counted in the Medicare fraction, that calculation is limited to Medicare patients who qualify for SSI. This results in many Medicaid patient days not being included anywhere in the Medicare DSH calculation. The effect of the Secretary's interpretation is particularly harmful to hospitals serving ventilator-dependent patients because these patients tend to have lengthy hospital stays. The amendment makes clear that the dually eligible ventilator patient days must be included in either the Medicaid fraction or the Medicare fraction and cannot be excluded simply because the patient is eligible for both programs.

This amendment would clarify that, when Medicaid pays for days of care provided by a hospital to ventilator-dependent patients who are dually eligible for Medicare and Medicaid, the Secretary may not exclude those days from the numerator of the Medicaid fraction simply because the patient is also enrolled in Medicare (unless the day was already counted in the numerator of the Medicare fraction). This would ensure that all days of care a hospital provides to dually eligible ventilator-dependent patients are accounted for in either the Medicare fraction or the Medicaid fraction of the DSH calculation, consistent with Congressional intent to provide increased reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients" (Social Security Act § 1986(d)(5)(F)(i)(I)).

Offset: This amendment is unlikely to affect a large number of hospitals and therefore trigger a CBO score. However, to the extent necessary to offset the amendment, the brand-name pharmaceutical fee would be increased an appropriate amount.

Contact: Oliver Kim

Stabenow Amendment D-17 to the Chairman's Mark

Short title/purpose: To reclassify certain hospitals within Michigan

Description of Amendment: This amendment would reclassify certain hospitals within Michigan to a different core statistical-based area to adjust their Average Wage Index

Offset: To the extent necessary, the brand-name pharmaceutical fee would be increased an appropriate amount.

Contact: Oliver Kim

Stabenow-Snowe Amendment D-18 to the Chairman's Mark

Short title/purpose: To help solve our nation's physician workforce shortage

Description of Amendment: Medical residency training programs receiving initial accreditation by American College of Graduate Medical Education or a new program number issued by the American Osteopathic Association on or after January 1, 1995, and prior to December 31, 2006, shall be treated as new programs for which an adjustment to a hospital's otherwise applicable resident limit shall be made without regard to whether there are other indicia that the program was newly commenced. The amount of such adjustment shall be the product of the highest number of residents in any program year during the third year of the program's existence and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program.

Offset: Given the small number of hospitals potentially affected by this amendment, it is unlikely to score. However, if this amendment does score, the annual fee on manufacturers and importers of branded drugs would be increased an equivalent amount.

Contact: Oliver Kim

Stabenow Amendment D-19 to the Chairman's Mark

Short title/purpose: To protect our nation's seniors from abuse and assist nursing homes

Description of Amendment: The amendment is the same as S.631, the Patient Safety and Abuse Prevention Act, and was passed by the Finance Committee in the last Congress.

This amendment would require the Secretary to 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. Except for certain modifications described below, the Secretary would be required to carry out the nationwide program under similar terms and conditions as the Background Check Pilot program ("pilot program") under Section 307 of the MMA, as specified. The Committee intends that the Secretary make relevant changes to the provisions based upon lessons learned from the MMA pilot program and that are reflected in the legislative language. Under the nationwide program, the Secretary would be required to enter into agreements with newly participating States, as specified, and certain previously participating States, as specified.

According to the procedures established under the pilot program, certain LTC providers 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. States would also be required to describe and test methods that reduce duplicative fingerprinting, including the development of a "rap back" capability, as specified. The Committee intends that the Secretary implement this provision in a fashion that does not result in application fees for potential long term care workers.

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 procedures in place, including procedures to: (1) conduct screening and criminal history background checks; (2) monitor compliance by LTC facilities and providers; (3) provide for a provisional period of employment of a direct patient access employee, as specified; (4) provide procedures for an independent process by which a provisional employee or an employee may request an appeal, or dispute the accuracy of, the information obtained in a background check, as specified; (5) provide for the designation of a single State agency with specified responsibilities; (6) determine which individuals are direct patient access employees; (7) as appropriate, specify disqualifying offenses, including convictions for violent crimes; and (8) describe and test methods that reduce duplicative fingerprinting, as specified.

States would be required to guarantee (directly or through donations from public or private entities) a designated amount of non-Federal contributions to the program. The Federal government would provide a match equal to three times the amount a State guarantees; except that Federal funds would not exceed $3 million for newly participating States and $1.5 million for previously participating States.

The term "LTC facility or provider" would be defined to mean the following types of facilities or providers which receive payment for services under Medicare or Medicaid: skilled nursing facilities; nursing facilities; home health agencies; hospice providers; LTC hospitals; providers of personal care services; providers of adult day care; residential care providers that arrange for, or directly provide, LTC services, including certain assisted living facilities that provide a nursing home level of care established by the Secretary; intermediate care facilities for the mentally retarded (ICF/MRs); and other LTC facilities or providers of services under Medicare and/or Medicaid that the participating State determines appropriate. The term "direct patient access employee" would be defined to mean any individual who has access to a patient or resident of a LTC facility through employment or contract and who has duties that involve (or may involve) one-on-one contact with a patient or resident of a facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include volunteers unless they have equivalent duties that involve (or may involve) one-on-one contact with a patient or resident of a LTC facility or provider.

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. The Secretary of the Treasury would be required to transfer to HHS an amount specified by the HHS Secretary as necessary (not to exceed $160 million) to carry out the nationwide program for fiscal years 2010 through 2012. Such amounts would be required to remain available until expended.

Offset: This amendment would be fully offset by mandating state use of the National Correct Coding Initiative (NCCI) in Medicaid. The Mark would amend Section 1903(r) of the Social Security Act to require states to have an MMIS that, effective for claims filed on or after October 1, 2010, incorporates compatible elements of the NCCI (or any successor initiative) and such other elements of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with specified requirements. Not later than September 1, 2010, the Secretary would be required to:

- identify those methodologies of the NCCI (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under Medicaid;
- identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under Medicaid with respect to items and services for which no national correct coding methodologies have been established under such Initiative with respect to Medicare;
- notify states of the elements identified (and of any other national correct coding methodologies identified) and how states are to incorporate such elements (and methodologies) into claims filed under Medicaid; and
- submit a report to Congress that includes the notice to states and an analysis supporting the identification of the elements (or methodologies).
-

If the Secretary determines that state legislation is required in order for a Medicaid state plan to meet the additional requirements imposed by the provision, the state plan would not be regarded

as failing to comply before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment. In the case of a state that has a 2-year legislative session, each year of the session would be considered a separate regular session of the state legislature.

Contact: Oliver Kim

Stabenow Amendment D-20 to the Chairman's Mark

Short title/purpose: To ensure the viability of certain hospitals

Description of Amendment: The proposed amendment would modify the Chairman's Mark to provide that general acute care hospitals with physician ownership would be exempt from the new requirements applicable to hospitals with physician ownership. Under the amendment, general acute care hospital is defined in a way to preclude a "specialty" hospital from subverting the general ban on physician ownership created in the Mark by re-characterizing itself as a general acute care hospital. This is accomplished by requiring any hospital seeking to qualify as a general acute care hospital to provide a broad array of services of the sort community, secondary and tertiary care hospitals generally provide. In addition, in order to qualify as a general acute care hospital, any hospital would be required to demonstrate a history of service to substantial Medicare and Medicaid patient populations.

Offset: The annual fee on manufacturers and importers of branded drugs would be increased an equivalent amount.

Contact: Oliver Kim

Cantwell Amendment #D-1 to America's Healthy Future Act of 2009

Short Title: Incentivize Value in the Medicare Fee-For-Service Physician Payment Formula

Description of Amendment: The Secretary of Health and Human Services shall apply a separate payment modifier to the physician payment formula, independent of the Geographic Adjustment Factor. This separate payment modifier will, in a budget neutral manner, pay physicians or groups of physicians differentially based upon the relative quality of care they achieve for Medicare beneficiaries relative to cost. Quality shall be based upon a composite of appropriate measures of quality that reflect the health outcomes and health status of Medicare beneficiaries served by physicians or groups of physicians. Costs shall be based upon a composite of appropriate measures of cost that take into account justifiable differences in input practice costs, as well as the demographic characteristics and baseline health status of the Medicare beneficiaries served by physicians or groups of physicians.

The Secretary would be required to specify, during fee schedule rulemaking applicable for 2011, how the measurement of quality and cost would be structured, as well as specifying the prospective performance period. During the performance period, which will begin in 2012, the Secretary will provide information to physicians about the value of care they provide. Performance would be assessed and the Secretary will implement payment consequences beginning in 2013.

The payment modifier shall be applied in a way that promotes systems-based care. The Secretary shall coordinate these value-based purchasing reforms with other HHS initiatives that are intended to incentivize more integrated and coordinated delivery of efficient and high-quality care.

The Secretary would be required to ensure that: (1) the VBP report to Congress includes a plan for moving the physician payment system to a value-driven model; (2) the plan is phased-in, in accordance with the schedule described in the plan, ensuring implementation as quickly as practicable, but no later than within five years of the initial implementation of this section. By this time, all physicians or groups of physicians must be participating in a payment system that holds them accountable for the value of care they deliver to Medicare beneficiaries.

Offset: This amendment is budget neutral.

Cantwell Amendment #D-2 to America's Healthy Future Act of 2009

Short Title: Physician Workforce Enhancement

Description of Amendment: Directs the Secretary of the Department of Health and Human Services to establish the loan program through the Administrator of the Centers for Medicare & Medicaid Services. Hospitals committed to starting new osteopathic or allopathic residency training programs in one of eight medical specialties or a combination of specialties (family medicine, internal medicine, emergency medicine, obstetrics/gynecology, general surgery, preventive medicine, pediatrics, or behavioral and mental health) could secure start-up funding to offset the initial costs of starting such programs.

Provides financial incentives to facilitate the creation of new residency training programs in geographic areas that lack an adequate supply of physicians. Acquired funding could be used to offset the costs of residency salaries and benefits, faculty salaries, and other costs directly attributable to the residency program.

Directs the Secretary to establish the program no later than January 1, 2010. Requires hospitals securing a loan under the program to repay the total sum, without interest, to the Treasury within 24 months. The program would be terminated December 31, 2019.

This amendment reflects Title I, Physician Workforce Enhancement, of the S.1262, the Medical Efficiency and Delivery Improvement of Care Act (MEDIC) of 2009.

Offset: The amendment specifies loan re-payment schedule making it budget neutral.

Nelson-Rockefeller Amendment #D-1 to the America's Healthy Future Act of 2009

Short Title: Eliminate the Part D Coverage Gap and Require Drug Maker Rebates for Full-Benefit Dual Eligible Individuals

Description of Amendment: Amends Section 1860D-2 of the Social Security Act by phasing-out the Medicare Part D coverage gap and requiring drug manufacturers to provide rebates for full benefit dual eligible beneficiaries that match Medicaid rebates.

Every year, beginning in 2011, the initial coverage limit will be increased and the out-of-pocket threshold will be decreased until the coverage gap is closed. The initial coverage limit, otherwise computed without regard to the phaseout, will be increased by half the cumulative phase-in percentage times the out-of pocket gap amount for the year. The annual out-of-pocket threshold, otherwise computed without regard to the phaseout, will be decreased each year by half the cumulative phase-in percentage of the out-of-pocket gap amount for the year multiplied by 1.75. The cumulative phase-in percentage will be calculated by adding the annual phase-in percentage for the year and all previous years beginning in 2011, but cannot exceed 100 percent. The annual phase-in percentages are: for 2011, 13 percent; for 2012 through 2015, 5 percent; for 2016 through 2018, 7.5 percent, and for 2019 and each subsequent year, 10 percent. The out-of-pocket gap amount is defined as the amount by which the annual out of pocket threshold (as determined without regard to the phaseout) exceeds the sum of the annual deductible plus ¼ of the amount by which the initial coverage limit (as determined without regard to the phaseout) for the year exceeds the annual deductible.

Offset: Require Part D Drug Rebates for Dual Eligible Individuals. Drug manufacturers, as a condition of having any of their drugs covered under Part D, are required to provide the Secretary of Health and Human Services with a rebate for any drug covered under Medicare Part D dispensed to any full-benefit dual eligible after December 31, 2010. This provision applies to drugs used by dual eligible individuals enrolled in Prescription Drug Plans run by Part D sponsors and MA-PD plans administered by MA organizations. The size of the rebates is defined as the amount (if any), by which the average Medicaid drug rebate (as modified by this statute, and including both the basic and inflation rebates) for each unit of the drug exceeds the average per-unit rebate, discount, or price concession provided to Part D sponsors and MA-PD plans administered by MA organizations drugs used by dual eligibles, multiplied by the number of units of the drug provided to dual-eligibles by Part D or MA-PD plans. Part D prescription drug plans (PDPs) and Medicare Advantage plans must make confidential reports to the Secretary on the drugs dispensed, the price rebates given, the extent to which rebates are available to dual eligible and non-dual eligible Medicare beneficiaries, and any other information needed by the Secretary to calculate the rebate amount needed. Confidentiality provisions

similar to those that already apply to the Medicaid drug rebate will apply to the data provided under the Part D rebate program. The Inspector General of the Department of Health and Human Services may use this information to conduct audits, investigations and evaluations. The plans are subject to a $10,000 per day civil money penalty for failing to provide these information reports and a $100,000 civil money penalty for providing false information in their reports. The rebates are to be deposited into the Medicare Prescription Drug Account and used to pay for all or part of the gradual elimination of the Part D coverage gap.

The Chairman's Mark provision on improving coverage in the Part D coverage gap is modified so that pharmaceutical manufacturers are required to give discounts on drugs used in the donut hole as if it existed without regard to the phaseout. Discounts provided in the portion of the donut hole that has been closed by the phaseout will be used to reduce the cost of the phaseout.

Nelson Amendment #D-2 to the America's Healthy Future Act of 2009

Short Title: Prescription Drug Price Competition

Description of Amendment: The amendment would impose an excise tax on settlements between generic and brand drug companies that delay availability of quality, affordable generic drugs at an enormous cost to the American health care system. Specifically, the tax would be imposed on settlements of Hatch-Waxman patent challenges between generic drug companies eligible for the Hatch-Waxman 180 day exclusivity period and their brand counterparts.

Each party of such settlements would be required to pay a tax to the federal government equal to 50 percent of the value of the settlement. The IRS would be charged with determining the value of the settlements and amount due by each of the settling parties. The settling parties would be required to report to the IRS the full terms of the settlement under which they are currently required to report such settlements to the Federal Trade Commission under the Medicare Modernization Act.

Any revenue that accrues from the above provision would be used to reduce the size of the coverage gap under Medicare Part D. Revenues accrued in a given year would be used to reduce the size of the coverage gap in the subsequent year. The Secretaries of the Treasury and Health and Human Services shall prescribe such regulations as are necessary to carry out the purposes of this proposal.

Offset: Amendment is expected to be budget neutral.

Nelson Amendment #D-3 to the America's Healthy Future Act of 2009

Short Title: Inspector General Report Comparing Prices Paid for Prescription Drugs under Medicare Part D and Medicaid

Description of Amendment: The Inspector General of the Department of Health and Human Services shall conduct a study comparing prescription drug prices paid by Medicare Part D insurers to those negotiated by state Medicaid plans for the top 200 drugs determined by both volume and expenditures. The prices should include all rebates and discounts the Medicaid and Part D plans receive. In conducting the study, the Inspector General is given the authority to collect all necessary information related to pricing necessary to produce comparisons of the Medicare and Medicaid drug benefits. The Inspector General shall assess--

(A) the financial impact of any price discrepancies on the federal government; and

(B) the financial impact of any price discrepancies on beneficiaries.

The report shall not disclose information that is deemed proprietary or likely to negatively impact a Medicaid program or Part D plan's ability to negotiate drug prices. The report shall be submitted to Congress no later than October 1, 2011.

Offset: Amendment is expected to be budget neutral.

Nelson Amendment #D-4 to the America's Healthy Future Act of 2009

Short Title: Medicare Part D Copayment Equity

Description of Amendment: Under Medicare Part D, full-benefit dual eligible individuals in institutional settings are exempted from prescription drug cost sharing, but dual eligible beneficiaries with similar financial constraints and medication needs in other settings are not. This amendment would eliminate any beneficiary cost sharing described in section 1860D-2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D-2(b)(4)) for full-benefit dual eligible individuals who are either (1) recipients of home and community based services under a section 1915 or 1115 waiver, or (2) residents of facilities including assisted living facilities or resident care program facilities (as such terms are defined by the Secretary); board and care facilities (as defined in section 1903(q)(4)(B)); or any other facility that is licensed or certified by the State and is determined appropriate by the Secretary, such as a community mental health center that meets the requirements of section 1913(c) of the Public Health Service Act, a psychiatric health facility, a mental health rehabilitation center, and a mental retardation developmental disability facility.

Offset: Increase Medicaid drug rebate by amount necessary to offset the increase in spending.

Nelson Amendment #D-5 to the America's Healthy Future Act of 2009

Short Title: Medicare Part D Copayment Equity (2)

Description of Amendment: Under Medicare Part D, full-benefit dual eligible individuals in institutional settings are exempted from prescription drug cost sharing, but similar dual eligible beneficiaries in home and community based settings are not. This amendment would eliminate beneficiary cost sharing for Medicare Part D full-benefit dual eligible individuals receiving home and community based services under section 1915 or 1932 or under a section 1115 waiver.

Offset: Increase Medicaid drug rebate by amount necessary to offset the increase in spending.

Nelson-Schumer-Cantwell-Kerry Amendment #D-6 to the Senate Finance Health Reform Bill

Short Title: Resident Physician Shortage Reduction

Description of Amendment: The current cap on Medicare-funded graduate medical education training slots is to be increased by an aggregate of an additional 10,000 slots.

One third of the new residency positions will be distributed to hospitals training more residents than their resident limit using the following criteria: (1) the number of new residency positions for each hospital over its limit will be determined by multiplying the total number of new resident positions available for hospitals exceeding their limits by that hospital's proportionate share of total full-time equivalent residents exceeding the residency cap for all hospitals; (2) to be eligible, the hospitals must be training at least 10 more positions or 10 percent more, whichever is less, than their eligible resident limit for the past year; and (3) hospitals must train at least 25 percent of their full-time equivalent residents in primary care and general surgery, and continue to train at least 25 percent of their full-time equivalent residents in those fields for the next 10 years or the Secretary may reduce their resident limit.

Two-thirds of the new residency positions will be distributed to hospitals using the following criteria: (1) the Secretary will take into account the demonstrated likelihood of filling the positions within three years; (2) preference will be given to hospitals submitting applications for new primary care and general surgery residency positions so long as those residency positions remain in those fields for 10 years and so long as the total number of primary care and general surgery residency positions at that hospital does not decrease for 10 years or the hospital's limit may be reduced; (3) preference will be given to hospitals that emphasize training in community health centers and other community-based clinical settings; (4) preference will be given to hospitals in states with more medical students in accredited medical schools (including those with provisional accreditation by the Liaison Committee on Medical Education or the American Osteopathic Association) than residency positions, and greater preference to those in states with smaller resident-to-medical-student ratios; (5) preference will be given to hospitals in states with low resident-to-population ratios, and greater preference for those in states with lower resident-population ratios; (6) hospitals cannot apply for more than 50 full-time equivalent additional residency positions unless there are more positions available for distribution than there are applications for new positions.

The cap slots for the additional residency positions will go to hospitals within two years of the bill's enactment, and the per-resident amount will be equal to the per resident amounts for primary care and non-primary care. The indirect medical education (IME) adjustment for the

residency positions redistributed under this provision would be the full IME adjustment available under Medicare.

Offset: Offset to be provided when amendment is offered.

Nelson Amendment #D-7 to the America's Healthy Future Act of 2009

Short Title: Medicare Graduate Medical Education Slots

Description of Amendment: To the section Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians, add an additional number of new residency training slots equivalent to $250 million in federal spending. Slots allocated under this amendment will be available to hospitals located in the ten states with the lowest resident-to-population ratios. The indirect medical education adjustment for these resident positions distributed under this provision would be reimbursed at the full IME adjustment factor.

Offset: Offset to be provided when amendment is offered.

Nelson Amendment #D-8 to the Senate Finance Health Reform Bill

Short Title: Group Purchasing Organization Sunshine Provision

Description of Amendment: Clarifies reporting requirements for hospitals and adds group purchasing organization to payment sunshine requirements in the Chairman's mark.

Requires distributions and similar payments from group purchasing organizations to provider members to be separately reported on provider cost reports.

Requires transparency in the relationship between group purchasing organizations, hospitals and medical suppliers with respect to payments and other transfers of value. The amendment would require annual transparency reports, penalties for noncompliance, procedures for the submission of information and public availability of this information.

Medical suppliers must report any rebates, payments or transfers of value made to group purchasing organizations.

These reports must be made annually and in electronic form to the Secretary of HHS, and include specified information on such transactions. The report would include the transfer recipient's name, business address, amount of the payment, date of the payment, a description of the form of the payment, a description of the nature of the payment, if the payment is related to marketing, education, or research specific to a covered drug, device, biological or medical supply the name of that product, and any other category of information that the Secretary determines appropriate. If the recipient requests a transfer of payment to another entity or individual at the request of the recipient the supplier should disclose that information. Delayed reporting requirements would apply for payments made pursuant to a product development agreement or clinical trial. Some information would be excluded from these reporting requirements, including payments or transfers of $10 or less, unless the aggregate annual payments or transfers to a recipient exceeds $100, in which case all payments or transfers shall be reported, samples intended for patient use, patient educational materials, loan of a covered device for a short-term time period, payments made to a hospital for the provision of health care to employees. This reporting requirement would begin on March 31, 2012 and continue on the 90th day of each subsequent calendar year.

Medical suppliers and group purchasing organizations would be subject to a civil money penalty (CMP) of not less than $1,000 but not more than $10,000 for each payment or transfer not reported. The total amount of the penalties for any annual submission shall not exceed $150,000. Any manufacturer or group purchasing organization that knowingly fails to submit information

would be subject to a CMP of not less than $10,000 but not more than $100,000 for each payment or transfer not reported. The total amount of the penalties for this failure to report category of submissions shall not exceed $1,000,000 annually.

The amendment would require the Secretary to establish procedures no later than October 1, 2010 to ensure public availability of this information. Beginning September 30, 2012 and on June 30 of subsequent years, submitted information should be available on an Internet website that meets formatting, search, and usability requirements. In addition to the transfer information, the website should include information on enforcement actions during the preceding year, background information on relationships between group purchasing organizations, medical suppliers and hospitals, a separate listing for payments related to clinical research, and other information that the Secretary deems appropriate. The Secretary should also allow recipients an opportunity to submit corrections to their information. This reporting procedure should be established after consulting the Office of the Inspector General (HHS OIG), affected industry, consumers and other parties in order to ensure that the information is presented in an appropriate context. The Secretary would be required to submit an annual report to Congress and the states beginning April 1, 2012.

Effective January 1, 2011 the amendment would preempt any state (or political subdivision of a state) law or regulation that requires manufacturers to disclose the type of information required under this provision regarding payments or transfers to covered recipients. The Mark would not preempt any state (or political subdivision of a state) law or regulation that requires the disclosure or reporting of (1) any information not required under this provision; (2) the types of information excluded from reporting requirements under this provision, with the exception of the $10 de minimis/$100 aggregate reporting requirement; (3) information by any person or entity other than an applicable manufacturer or covered recipient described above; and (4) information reported to a Federal, state, or local government for public health purposes.

The Secretary would be required to consult with the HHS OIG on the implementation of this section.

Offset: This amendment is expected to be budget neutral.

Nelson Amendment #D-9 to the America's Healthy Future Act of 2009

Short Title: Medicare Physician Concierge Care Transparency

Description of Amendment: This amendment would require physicians who participate in Medicare and who provide concierge care services to disclose information about their concierge care practice on their Medicare cost reports. The information disclosed should include (1) the number of Medicare patients who receive concierge services; (2) the number of total patients who receive concierge services through the physician and (3) if the physician requires participation in the concierge care program of all patients.

Offset: This amendment is expected to be budget neutral.

Nelson Amendment #D-10 to the America's Healthy Future Act of 2009

Short Title: Medicare Advantage Enrollee Benefit Stability

Description of Amendment: Medicare Advantage (MA) plans in targeted areas are permitted to grandfather existing enrollees. Targeted areas are defined as metropolitan statistical areas (MSAs) where the weighted average of current MA bids is less than the average per capita fee-for-service expenditure in that MSA. Organizations are required to participate in competitive bidding within an MSA in order to offer a grandfathered plan in that same MSA.

Grandfathered plans will receive a base payment to cover A and B benefits and a benefit stabilization payment. The base payment will be equal to the plan's competitive bid for non-grandfathered beneficiaries in the same MSA. The base payment for each plan would be modified by two factors: 1) it would be risk adjusted to reflect different population characteristics in the grandfathered plan; and 2) it would be adjusted by a utilization factor to account for differences in utilization between the grandfathered and competitively-bid plans. The benefit stabilization payment will be equal to the amount of the 2011 average rebate and will be updated by medical inflation annually.

Offset: This amendment would be offset by the creation of a Commission similar to the Medicare Commission included in the Chairman's Mark to reduce costs and improve quality throughout the private health system. This multi-stakeholder system-wide approach would 1) speed and ease adoption of reforms, reduce transition costs, and increase the effectiveness of reforms; 2) avoid the "balloon" squeezing problem where reforms in one part of the system result in cost shifting to the other – as opposed to gaining efficiencies; and, 3) create for consumers a more affordable, higher quality, and easily navigated health care system.

Menendez/Kerry Amendment D# 1 to Chairman's Mark of America's Healthy Future Act

Short Title: Application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor for each all-urban and rural state.

Description of Amendment:

In the case of discharges occurring on or after 30 days from the date of enactment, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

Offset: No cost anticipated

Menendez Amendment D# 2 to Chairman's Mark of America's Healthy Future Act

Short Title: Designation of Urban Medicare-Dependent Hospitals (UMDH)

Description of Amendment:

Provide a special Medicare add-on payment for hospitals receiving the designation of urban Medicare-dependent hospitals. To qualify as an UMDH, a hospital would have to: (1) be located in an urban area; (2) have over 60 percent of its inpatient days or discharges covered by Medicare; and (3) not receive another type of mitigating payment, such as IME, DSH, RRC, CAH, SCH, and MDH payments.

The payment would be similar to the existing payment for rural MDHs – i.e., PPS payments plus 75 percent of the difference between those payments and a hospital-specific rate based on each hospital's costs in a previous year, trended forward for inflation. The methodology would use the higher of 2002 or 2006 costs as the base year costs for those hospitals. In addition, this amendment would be budget neutral because it would require the Secretary to ensure that aggregate payments to PPS hospitals are not, as a result of this provision, greater than would have otherwise been paid.

Offset: No cost anticipated

Menendez Amendment D# 3 to Chairman's Mark of America's Healthy Future Act

Title III, Subtitle A

Short Title: Including Healthcare-Associated Infections in Value-Based Purchasing Authorization

Description of Amendment:

Measures for the hospital VBP program would be selected from the measures used in the RHQDAPU program. The measures would focus on the same areas that are the focus of the RHQDAPU program: heart attack (AMI); heart failure; pneumonia; surgical care activities; and patient perception of care; and in addition would include healthcare-associated infections, as measured by the prevention metrics and targets established in the Department of Health and Human Services' HHS Action Plan to Prevent Healthcare-Associated Infections or any successor plan.

Offset: No cost anticipated

Menendez Amendment D#4 to Chairman's Mark of America's Healthy Future Act

Title III

Short Title: Puerto Rico Medicare Fairness

Description of Amendment:

The amendment would adjust the Puerto Rico Medicare inpatient hospital rate to 100% of the national payment rate.

The amendment would provide that Puerto Rican Medicare enrollees are automatically enrolled in Part B.

Offset: Increase annual fee on health insurance providers by amount necessary to offset the increase in spending

Carper Amendment #D1 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To require CMS Innovation Center to evaluate models for paying physicians in group practices and in hospitals through salary-based payments.

Description of Amendment: Under the Chairman's Mark, a new Innovation Center will be established in the Centers for Medicare and Medicaid Services to test and evaluate new health care delivery and payment systems. The new program will be required to review models that meet at least one of thirteen criteria.

This amendment would ensure that the list of criteria for new models that will be tested in the Innovation Center includes a salary-based reimbursement model for doctors in group practices and in hospitals. Paying physicians with an annual salary has been an effective strategy employed by some of the most successful health care providers in the country. Highly regarded institutions, including the Cleveland Clinic, Geisinger Health System, the Mayo Clinic, and Kaiser Permanente in Northern California have all moved to the salary payment model for their doctors, often combining annual salaries with additional compensation based on performance.

The amendment would read as follows –

After "1. Promote broad payment and practice reform in primary care, including patient-centered medical home models for high-need beneficiaries, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment," **insert** "or salary-based payment."

After "2. Contract directly with groups of providers and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payments," **insert** "or through salary-based models."

After "2. Contract directly with groups of providers and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payments or through salary-based models," **insert the following**:

"3. Promote care coordination between health care providers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payments."

Offset: No offset is required.

Carper Amendment #D2 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To revise the criteria used by the HHS Secretary in selecting new models for the CMS Innovation Center.

Description of Amendment: The current Chairman's Mark requires the new Innovation Center in the Centers for Medicare and Medicaid Services (CMS) to select, evaluate, and put into practice new payment models based on several additional criteria, including the promotion of close relationships between care coordinators and primary care practitioners. This condition should be expanded to ensure that specialists and other health care providers are included. Strong relationships between primary care doctors, specialist physicians, and other health care providers are a critical component of successful health care delivery systems, leading to better health outcomes for patients through increased communication and coordination.

This amendment revises the list of criteria used to select new payment models to ensure that the pilot programs both promote and maintain close relationships between care coordinators, primary care doctors, specialist physicians, and other health care providers.

Specifically, in Title III Subtitle A Part III, the additional criteria used to evaluate new payment models should be changed from "Maintain a close relationship between care coordinators and primary care practitioners," should be changed to **"Maintain a close relationship between care coordinators, primary care practitioners, specialist physicians, and other health care providers."**

Offset: No offset is required.

Carper Amendment #D3 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To extend the length of time states have to repay the federal share of a Medicaid overpayment.

Description of Amendment:

Under current law, states have to repay the federal share of any overpayments within 60 days of discovery; however, collections of overpayments—especially in fraud cases—seldom occur that fast.

This amendment would extend the 60 days states have to repay the federal share of a Medicaid overpayment to 180 days for fraud and abuse cases. In any case due to fraud, where the State is unable to recover within the 180 days because the amount has not been finally determined through the judicial process or the final judgment is under appeal, the state must repay the federal share within 30 days after the final judgment is made.

Offset: No offset is required.

Carper Amendment #D4 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To express the Sense of the Senate that Congress should address medical malpractice in an effort to reduce defensive medicine, reduce litigation, and improve patient outcomes.

Description of Amendment: The amendment expresses the Sense of the Senate that health care reform is an opportunity to address medical malpractice. States should be encouraged to develop and test alternatives to the current civil litigation system in an effort to improve patient outcomes and reduce medical errors, reduce defensive medicine, and limit the amount of medical malpractice litigation. Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system that meets these objectives.

Offset: No offset is required.

Carper Amendment #D5 to Chairman's Mark of the America's Healthy Future Act of 2009

Short Title: To establish a state demonstration program to develop, test, and evaluate the "Safe Harbor" model as an alternative to the current civil litigation system.

Description of Amendment:

The amendment authorizes the Secretary of Health and Human Services to award demonstration grants to states for the development, implementation, and evaluation of a "Safe Harbor" model as an alternative to the current civil litigation system. Each state desiring a grant must develop a model that meets the definition below, and should demonstrate in its application how the model would:

(i) Improve patient outcomes and reduce medical errors;
(ii) Reduce the practice of defensive medicine; and
(iii)Reduce medical malpractice litigation.

To qualify as a "Safe Harbor" model, the state shall develop, for certification by the Secretary, a set of accepted clinical practice guidelines listed in the National Guideline Clearinghouse. In developing the set of guidelines, the state shall consult with health care providers and organization, patient advocacy groups, and attorneys in relevant practice areas.

The state shall provide that, in any claim or action brought in a State court or other State forum arising from the provision of a health care service to an individual, if the service was provided to the individual in accordance with the guidelines developed by the State and certified by the Secretary, the guidelines—

(i) may be introduced by a provider who is a party to the claim or action; and

(ii) if introduced, shall establish a rebuttable presumption that the service prescribed by the guidelines is the appropriate standard of medical care.

Nothing in this amendment establishes or creates a basis for a federal court jurisdiction in any medical malpractice action or defense.

The Secretary is required to conduct an overall evaluation of the effectiveness of the grants awarded and to annually submit a report to the appropriate committees of Congress. The report should examine how effective the grants were in achieving the three goals outlined in the grant application. The report should also examine the effect of the grants on patient safety, provider

and patient satisfaction with the reform, and the volume of medical malpractice litigation, in comparison to data from states that did not receive grants.

Offset: No offset is required.

Grassley Amendment #D 1

Short Title:
To allow Medicare beneficiaries to keep what they have

Purpose:
To increase Medicare Advantage plan utilization of care coordination and management techniques and promote efficiency in plan bids

Background:
The Chairman's Mark establishes a new system of competitive bidding in the Medicare Advantage program. Instead of the administratively set benchmarks that exist under current law, competitive bidding would set benchmarks at the enrollment weighted average of plan bids in each payment area. In addition to these competitively established benchmarks, plans may also receive bonus payments for practicing certain care coordination techniques and/or bidding a certain percentage below the average per capita fee-for-service (FFS) Medicare cost in each payment area.

The Chairman's Mark provides .5 percent of the U.S. Per Capita Cost for plans that conduct 4 of 8 qualified care coordination and management techniques. This means plans may earn up to 2 percent in bonus payments for care coordination and management. This amendment would allow plans to earn .5 percent for each of the 8 specified care coordination and management techniques, thus raising the bonus to a maximum of 4 percent for plans that use all 8 techniques.

The Chairman's Mark also provides an efficiency bonus to plans that bid more than 85 percent below the average per capita FFS Medicare cost in a payment area. Under this bonus, plans would receive 10 percent of the difference between their bid and 85 percent of the average FFS amount. This amendment would increase the bonus to 25 percent of the difference between the plan's bid and 90 percent of the average FFS amount.

Description:
This proposal would be fully offset by setting the federal matching rate for all Medicaid administrative costs at 50 percent – except those administrative costs for state efforts directed at fraud, waste and abuse prevention. Enhanced matching rates were designed to encourage states to develop and support particular administrative activities that the federal government considers important for the Medicaid program. Once those administrative systems are operational, however, there is less reason to continue the higher subsidy. Moreover, because states pay, on average, about 43 percent of the cost of health care for Medicaid beneficiaries, they have a substantial incentive to maintain efficient information systems and employ skilled professionals.

Grassley Amendment #D 2

Short Title:

Medicare Physician Payment Equity

Description:

Amend Title III, Subtitle B of the Chairman's Mark, "Providing Equitable and Accurate Geographic Adjustments for Medicare Physician Payment."

The proposal would direct the Secretary to adjust the practice expense GPCI for 2010 to reflect 1/4 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages (instead of the full difference under current law). For 2011, the adjustment would reflect 1/2 of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national averages. These adjustments are based on the recognition of limitations on the available data used in calculating the index and are to be done on a budget-neutral basis for both years.

The proposal would direct the Secretary no later than January 1, 2012 to gather and utilize physician office rent, wage, and practice expense data that fairly and reliably establishes distinctions in actual costs of operating a medical practice in the different Medicare payment localities, and ensure that office expenses that do not vary from region to region be included in the "other" office expense category. In determining the "wage" category, CMS shall include the range of professional and non-professional personnel employed in a medical office and utilize related survey data developed by recognized medical organizations such as the American Medical Association and the Medical Group Management Association unless more reliable survey data is available. CMS is prohibited from relying upon proxy data unless the Secretary establishes that such proxy data fairly and accurately reflect distinctions in actual costs borne by physicians in the different Medicare payment localities.

Grassley Amendment #D 3

Short Title: Eliminate new trust fund taxes to fund comparative effectiveness research

Purpose:
To strike the funding of the Patient-Centered Outcomes Research Trust Fund through the creation of a new excise tax and correlated trust fund

Description:
The Chairman's Mark adds Internal Revenue Code sections 4375-4377 which create a new excise tax to fund the PCORTF. Current IRC trust funds include:

Airport and Airway Trust Fund
Alternative Minimum Tax
Aquatic Resources
Black Lung Disability
Boat Safety Account
Harbor Maintenance
Hazardous Substance Superfund
Hazardous Waste Cleanup, excise taxes for
Highway Trust Funds
Inland Waterways
Leaking Underground Storage Tank Trust Fund
Sport Fish Restoration Account
Trans-Alaska Pipeline Liability Trust Fund
Vaccine Injury Compensation Trust Fund

Under the Chairman's Mark, the PCOR Institute would apparently be an independent non-profit organization with limited government oversight.

The amendment would strike the creation of new IRC sections 4375-4377.

Offset will be provided at the Markup.

Grassley Amendment #D 4

Short Title:

Improve Governance of Patient-Centered Outcomes Research Institute

Purpose:

To remove cabinet secretaries and other high-ranking government officials from the PCORI's board

Background:

The Chairman's Mark creates the PCORI to conduct comparative effectiveness research. Oversight and reforms of the American Red Cross and the Smithsonian Institution have proven that cabinet secretaries and other high-ranking government officials frequently are not able to properly fulfill their roles and responsibilities as board members.

Description:

This amendment would strike the provisions requiring the Secretary of Health and Human Services, the Director of NIH and other high-ranking government officials, including elected officials and appointees, to be members of the board of the PCORI.

Hatch Amendment #D1 to America's Healthy Future Act of 2009

Short Title: Full Federal Preemption for Physician Payment Disclosure

Description: This amendment would preempt any state (or political subdivision of a state) physician payment disclosure law or regulation to prevent the unnecessary need to potentially comply with potentially 51 different disclosure requirements.

Offset: Not applicable.

Hatch Amendment #D2 to America's Healthy Future Act of 2009

Short Title: Small Business Exemption under the Physician Payment Sunshine Disclosure

Description: This amendment would provide for a small business exemption for those companies with $30 million in annual sales or less to preserve and encourage the innovation pipeline that predominately comes from small businesses.

Offset: Not applicable.

Hatch Amendment #D3 to America's Healthy Future Act of 2009

Short Title: Strike Medicare Disproportionate Share (DSH) Provisions

Description: This amendment would strike the provisions on page 149 making changes to Medicare DSH payments.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark.

Hatch Amendment #D4 to America's Healthy Future Act of 2009

Short Title: Strike Medicaid Disproportionate Share (DSH) Provisions

Description: This amendment would strike the provisions on page 56 phasing out Medicaid DSH payments if a state trigger is met based on the state's uninsured rate measured by the Census Bureau's American Community Survey.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark.

Hatch Amendment #D5 to America's Healthy Future Act of 2009

Short Title: Preventing Unnecessary Hospital Readmissions

Description: This amendment would strike the provisions that would reduce avoidable hospital readmissions on page 156 of the mark and replace it with a IOM study that would make recommendations to Congress on how reduce avoidable hospital readmissions. One year after enactment of this legislation, the Institute of Medicine is required to submit a report to Congress on recommendations on how to reduce unnecessary hospital readmissions. In addition, the report would include recommendations on how to develop a coordinated care plan for patients being discharged from the hospital.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark.

Hatch Amendment #D6 to America's Healthy Future Act of 2009

Short Title: Strike Medicare Commission

Description: This amendment would strike the Medicare Commission created on page 156 of the mark.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark.

Hatch Amendment #D7 to America's Healthy Future Act of 2009

Short Title: Medicare Advantage Restoration Act

Description: This amendment would strike the Medicare Advantage provisions of the Chairman's mark if CBO certifies that beneficiaries currently participating in the Medicare Advantage program will lose plan benefits when the Medicare Part C reductions are implemented by the Centers of Medicare and Medicaid Services. CBO is required to make this certification 3 months after the enactment of the health reform bill.

Offset: A proportionate reduction as needed in spending in the Chairman's Mark.

Hatch Amendment #D8 to America's Healthy Future Act of 2009

Short Title: Provide a uniform system of awarding noneconomic damages in health care lawsuits.

Description: Strike Subtitle H from Title III

Limits noneconomic damages in federal and state health care liability lawsuits to $250,000. No limit on economic damages.

Exception: Damages may exceed the cap if it is proven by clear and convincing evidence that defendant acted with malicious intent to injure the plaintiff of that they deliberately failed to avoid an unnecessary injury that they knew or should have known the plaintiff was substantially certain to suffer.

Express non-preemption of state laws that specify a particular monetary amount for compensatory or punitive damages, regardless of whether such amount is greater or less than the amount stated in this amendment.

Rationale: Excessive jury awards in health care lawsuits result both in unnecessary procedures and higher malpractice insurance premiums for health care providers, the costs of which are passed along to patients, resulting in higher overall health care costs. A cap on noneconomic damages will encourage more settlements and make liability system less unpredictable.

Offset: Not applicable.

Hatch Amendment #D9 to America's Healthy Future Act of 2009

Short Title: Provide a uniform system of awarding noneconomic damages in health care lawsuits.

Description: Strike Subtitle H from Title III

Limits noneconomic damages in federal and state health care liability lawsuits to $500,000. No limit on economic damages.

Exception: Damages may exceed the cap if it is proven by clear and convincing evidence that defendant acted with malicious intent to injure the plaintiff of that they deliberately failed to avoid an unnecessary injury that they knew or should have known the plaintiff was substantially certain to suffer.

Express non-preemption of state laws that specify a particular monetary amount for compensatory or punitive damages, regardless of whether such amount is greater or less than the amount stated in this amendment.

Rationale: Excessive jury awards in health care lawsuits result both in unnecessary procedures and higher malpractice insurance premiums for health care providers, the costs of which are passed along to patients, resulting in higher overall health care costs. A cap on noneconomic damages will encourage more settlements and make liability system less unpredictable.

Offset: Not applicable.

Hatch Amendment #D10 to America's Healthy Future Act of 2009

Short Title: Provide a uniform system of awarding noneconomic damages in health care lawsuits.

Description: Strike Subtitle H from Title III

Limits noneconomic damages in federal and state health care liability lawsuits to $1,000,000. No limit on economic damages.

Exception: Damages may exceed the cap if it is proven by clear and convincing evidence that defendant acted with malicious intent to injure the plaintiff of that they deliberately failed to avoid an unnecessary injury that they knew or should have known the plaintiff was substantially certain to suffer.

Express non-preemption of state laws that specify a particular monetary amount for compensatory or punitive damages, regardless of whether such amount is greater or less than the amount stated in this amendment.

Rationale: Excessive jury awards in health care lawsuits result both in unnecessary procedures and higher malpractice insurance premiums for health care providers, the costs of which are passed along to patients, resulting in higher overall health care costs. A cap on noneconomic damages will encourage more settlements and make liability system less unpredictable.

Offset: Not applicable.

Hatch Amendment #D11 to America's Healthy Future Act of 2009

Short Title: Healthcare Innovation Zone Summary

Description: This amendment, based on H.R. 3134, would establish the Healthcare Innovation Zone (HIZ) pilot program to increase integration and align healthcare provider incentives to reduce the rate of healthcare costs while improving quality of care for Medicare, Medicaid and privately insured patients. The HIZ is a geographic region that contains a teaching hospital, physicians, and other clinical entities that would provide a full spectrum of health care and could provide for the incorporation of new and innovative clinical initiatives for training the next generation of health care providers. New innovations in clinical care would be developed and implemented by physicians and other clinicians in an innovation zone that helps facilitate coordination of care, quality improvement, and cost reduction.

The program would consist of two phases. The first phase would distribute planning grants to entities, comprising a teaching hospital and others, that would develop and submit HIZ design plans tailored to their own geographic region, and address issues including, but not limited to, how providers would reduce the rate of increase in spending, how physicians, hospitals and other providers would collaborate and align to provide the full spectrum of care as well as collect, analyze and share data among the clinical partners. The proposals could include necessary exemptions from regulations and other barriers that impede integration and alignment. The second phase would be the implementation of a pilot program that would be based on the approved proposals but would also require that the participants provide care to at least 50 percent of the population within the HIZ and accept Medicare payments that are equal to a base level increased by a rate of growth that is 1.5 percentage points less than the project rate of growth for the HIZ.

Offset: Not applicable.

Snowe Amendment # 1 -- Delivery System

Short Title: IMD Demonstration Project

Description of Amendment: This amendment establishes a three-year, $75 million demonstration project that would allow Medicaid funding to be directed to non-publicly owned and operated psychiatric hospitals for Medicaid beneficiaries between the ages of 21-64 who require stabilization in these settings as required by the ***Emergency Medical Treatment and Active Labor Act*** (EMTALA). Today, these hospitals are denied payment for care that is required under the EMTALA rules. A similar demonstration project was included in H.R. 3200.

Snowe Amendment # 2 - Delivery System

Short Title: Air Ambulance Standards

Description of Amendment: Consistent with and building upon the recommendations just issued by the National Transportation Safety Board, the amendment directs CMS to develop national standards regarding air ambulances to ensure quality patient care delivery and safety of the aircraft. Air ambulances that don't meet those standards wouldn't be eligible to participate in Medicare or Medicaid. The amendment also requires air ambulances to be licensed in the state in which they are based, and clarifies the role of states in overseeing appropriate utilization and medical oversight in the operations of medical helicopters and incorporating air ambulances into state EMS systems and assuring cross border operations between states.

KYL AMENDMENT #D1
America's Healthy Future Act of 2009

Short Title: Protecting Seniors' Access to Medicare Benefits and Health Care Providers

Description: Strike Title III.

Offset: None.

KYL AMENDMENT #D2
America's Healthy Future Act of 2009

Short Title: Ensuring Seniors' Care Will Not Be Rationed through the Physician Feedback Program

Description: In Subtitle A of Title III, the amendment would strike the following provision related to the Physician Feedback Program:

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

Offset: Strike federal funding for the CO-OP program.

KYL AMENDMENT #D3
America's Healthy Future Act of 2009

Short Title: Limiting the Number of New Federal Health Care Bureaucrats & Preventing the Rationing of Seniors' Care

Description: The amendment would strike the CMS Innovation Center.

Offset: Strike federal funding for the CO-OP program.

KYL AMENDMENT #D4
America's Healthy Future Act of 2009

Short Title: Preserving Seniors' Access to Specialty Care

Description: In Subtitle A of Title III, the amendment would strike the following provision related to the Primary Care/General Surgery Bonus:

"Half (50 percent) of the cost of the bonuses would be offset through an across-the-board reduction to all other codes, except for physicians who primarily provide services in a HPSA zip code."

Offset: Strike federal funding for the CO-OP program.

KYL AMENDMENT #D5
America's Healthy Future Act of 2009

Short Title: Strengthening the Health Care Safety Net

Description: In Subtitle D of Title III, the amendment would strike the Medicare DSH provision and replace it with the following language:

"The Government Accountability Office shall submit a report to Congress on the insurance coverage levels in each state, including the projected impact of the coverage provisions in this Act by the end of fiscal year 2018."

Offset: The amendment would tie the premium tax credit to the lowest cost bronze plan.

KYL-CRAPO AMENDMENT #D6
America's Healthy Future Act of 2009

Short Title: Ensuring Seniors Can Keep Their Coverage if They Like It

Description: The amendment would strike the MA payment cuts under subtitle C of Title III.

Offset: None

KYL AMENDMENT #D7
America's Healthy Future Act of 2009

Short Title: Prohibiting a Federal Rationing Board

Description: The amendment would strike the following language from the Medicare Commission in subtitle E of Title III:

"By April 1, 2014, the Senate Finance Committee, along with the relevant House committees, would be required to report out either the Commission's (or Secretary's) proposal or an amended proposal that achieves the same level of reductions in excess cost growth."

"If a committee fails to report a legislative package achieving the targeted level of Medicare savings by April 1st, the Commission's (or Secretary's) package would be automatically discharged from that committee."

"If a package that meets the level of the Medicare savings described above is not enacted into law by August 15, 2014, the Chairman's Mark would require the Commission's (or Secretary's) original proposal to go into effect automatically."

Offset: None

KYL-ROBERTS-CRAPO-CORNYN AMENDMENT #D8
America's Healthy Future Act of 2009

Short Title: The PATIENTS Act

Description: The amendment would add the "Preserving Access to Targeted, Individualized, and Effective New Treatments and Services (PATIENTS) Act of 2009" (S.1259).

SECTION 1. SHORT TITLE.

This Act may be cited as the `Preserving Access to Targeted, Individualized, and Effective New Treatments and Services (PATIENTS) Act of 2009' or the `PATIENTS Act of 2009'.

SEC. 2. PROHIBITION ON CERTAIN USES OF DATA OBTAINED FROM COMPARATIVE EFFECTIVENESS RESEARCH; ACCOUNTING FOR PERSONALIZED MEDICINE AND DIFFERENCES IN PATIENT TREATMENT RESPONSE.

(a) In General- Notwithstanding any other provision of law, the Secretary of Health and Human Services--

(1) shall not use data obtained from the conduct of comparative effectiveness research, including such research that is conducted or supported using funds appropriated under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), to deny coverage of an item or service under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f))); and

(2) shall ensure that comparative effectiveness research conducted or supported by the Federal Government accounts for factors contributing to differences in the treatment response and treatment preferences of patients, including patient-reported outcomes, genomics and personalized medicine, the unique needs of health disparity populations, and indirect patient benefits.

(b) Rule of Construction- Nothing in this section shall be construed as affecting the authority of the Commissioner of Food and Drugs under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act.

Offset: None

KYL AMENDMENT #D9
America's Healthy Future Act of 2009

Short Title: Prohibiting the Use of Taxpayer Dollars to Conduct Cost-Based Health Care Research and Ration Care

Description: The amendment would prohibit any federal funding, including all funds appropriated under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) from being used to conduct or support cost-effectiveness research.

Offset: None

Bunning Delivery System Reform Amendment

Bunning Amendment #D1 to America's Healthy Future Act of 2009

Short Title: Equity and Access for Podiatric Physicians under Medicaid Amendment

Description of Amendment: Amends Title XIX of the Social Security Act to cover physician services delivered by podiatric physicians to ensure access by Medicaid beneficiaries to appropriate quality foot and ankle care.

Offset: To be determined when offered.

Bunning Delivery System Reform Amendment

Bunning Amendment #D2 to America's Healthy Future Act of 2009

Short Title: Moratorium on Medicare Reductions in Payment Rates for Certain Interventional Pain Management Procedures

Description of Amendment: The amendment inserts into the Chairman's mark at the appropriate place a requirement that the payment rate for the interventional pain management procedures listed below and furnished between January 1, 2010 and January 1, 2012 shall not be less than the payment rate that was in effect on January 1, 2007.

The interventional pain management procedures are:

- Epidural injections (CPT 62310, 62311, 64483, 64484)
- Facet joint injections (CPT 64470, 64472, 64475, 64476)
- Sacroiliac joint injection (CPT 27096)

Offset: To be determined when offered.

Bunning Amendment #D3 to Subtitle E to Title III to America's Healthy Future Act of 2009

Short Title: Congressional Responsibility Amendment

Description of Amendment: This amendment deletes the provision in the Chairman's mark that requires the Medicare Commission's (or Secretary's) original proposal to go into effect automatically if Congress has not passed legislation based on the Commission's (or Secretary's) proposal by a certain date.

Offset: Paid for by reducing the federal poverty level threshold for premium credits in the bill by the amount necessary, starting with the premium credit for individuals between 300% and 400% of poverty.

Crapo-Kyl-Roberts Amendment D-1 to Chairman's Mark, America's Healthy Future Act of 2009

Short Title: To preserve choice of plans for seniors under Medicare Advantage

Description of Amendment:

The amendment would amend the proposed Medicare Advantage cuts in the Title III, Subtitle D of the Chairman's Mark. The amendment would prohibit the implementation of the competitive bidding changes to the Medicare Advantage program in any bidding area where the proposed changes would result in decreased choice and competition for seniors in the Medicare program.

Offset:

To be provided.

Roberts Amendment # D1 to Title III, Subtitle A, Part I, Physician Value-Based Purchasing

Short Title: To prevent Medicare payment policies which discourage physicians from fulfilling their Hippocratic Oath to maintain the good of their patients as their highest priority, and instead encourage the rationing of health care.

Description of Amendment: Amend Title III, Subtitle A, Part I, Physician Value-Based Purchasing to strike the five percent payment penalty for physicians whose resource use is at or above the 90th percentile of national utilization (or any other threshold to which it is converted after 2020).

COST: $1 billion

OFFSET: To be provided.

Roberts Amendment # D2 to Title III, Subtitle B, Part I, Misvalued Relative Value Units (RVUs)

Short Title: To ensure that adjustments to Medicare payment policies are transparent, accountable, and patient-centered.

Description of Amendment: Strike Title III, Subtitle B, Part I, Misvalued Relative Value Units

COST: $0

OFFSET: n/a

Roberts Amendment # D3 to Title III, Subtitle E, Medicare Commission

Short Title: To ensure that adjustments to Medicare payment policies are transparent, accountable, and patient-centered.

Description of Amendment: Strike Title III, Subtitle E, Medicare Commission

COST: $22.6 billion

OFFSET: To be provided

Roberts Amendment # D4 to Title III, Subtitle F, Patient-Centered Outcomes Research Act of 2009

Short Title: To protect patients and doctors

Description of Amendment: Strike Title III, Subtitle F, Patient-Centered Outcomes Research Act of 2009

COST: $0

OFFSET: n/a

Roberts Amendment # D5 to Title III, Subtitle F, Patient-Centered Outcomes Research Act of 2009

Short Title: To protect patients and doctors

Description of Amendment: Amend Title III, Subtitle F, Patient-Centered Outcomes Research Act of 2009 to prohibit cost from being a factor in any comparative clinical effectiveness research conducted using federal funds, including funds under this Subtitle and those appropriated through the American Recovery and Reinvestment Act of 2009.

COST: $0

OFFSET: n/a

Roberts Amendment #D6 to Title III, Subtitle D, Home Health Payment Changes and Title III, Subtitle E, Market Basket Cuts

Short Title: To prevent seniors requiring in-home health care from being forced out of their homes and into institutional care.

Description of Amendment: Amend Title III, Subtitle D, Home Health Payment Changes to strike the home health provider payment rebasing beginning in 2013 and continuing thereafter; and to strike the provider-specific cap on home health outlier payments beginning in 2011. Additionally, amend Title III, Subtitle E, Market Basket Cuts to strike the one percent home health provider market basket reduction for 2011 and 2012 and the productivity payment cuts beginning in 2015.

Cost: $43.7 billion

Offset: To be provided.

Roberts Amendment #D7 to Title III, Subtitle E, Market Basket Cuts

Short Title: To prevent health care reform from being paid for on the backs of our most vulnerable and frail seniors in nursing homes.

Description of Amendment: Amend Title III, Subtitle E, to strike the productivity payment cuts for skilled nursing facilities beginning in 2012.

Cost: $14.6 billion

Offset: To be determined.

Roberts Amendment #D8 to Title III, Subtitle E, Market Basket Cuts

Short Title: To ensure that if people like the hometown hospital they have, they can keep it.

Description of Amendment: Amend Title III, Subtitle E, to strike the market basket minus 0.25 percent reduction in 2010 and 2011 and the 0.2 percent market basket reduction from 2012-2019, and strike the productivity adjustments, for hospitals paid under the inpatient prospective payment system.

Cost: $75.8 billion

Offset: To be determined.

Roberts Amendment #D9 to Title III

Short Title: To prevent health care reform from being paid for on the backs of our seniors.

Description of Amendment: Amend Title III to strike all provisions that reduce or have the effect of reducing financing for Medicare.

Cost: $409 billion.

Offset: To be determined.

Ensign Amendment # D1 to America's Healthy Future Act of 2009

Short Title: Health Care Safety Net Enhancement Amendment

Description of Amendment: The amendment will insert language in Title III, Subtitle H of the Chairman's Mark to improve access to pro bono care for medically underserved or indigent individuals by providing limited medical liability protections.

Under the amendment, no health care professional shall be liable for the performance of, or the failure to perform, any duty in providing pro bono medical services to a medically underserved or indigent individual. This would not limit the liability of a health care professional or a health care provider for:

- an act or omission that is outside the scope of the services the health care professional or health care provider is deemed to be licensed or certified to perform, unless such services can reasonably be determined necessary to prevent serious bodily harm or preserve the life of the individual being treated;
- the services on which the claim is based did not arise out of the rendering of pro bono care for medically underserved or indigent individuals;
- or an act of omission constituting willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by the pro bono health care professional or pro bono health care provider.

A medically underserved individual means an individual that does not have health care coverage under a group health plan, health insurance coverage, or any other health care coverage program, or who is unable to pay for the health care services that are provided to the individual.

Ensign Amendment # D2 to America's Healthy Future Act of 2009

Short Title: Disaster Volunteer Health Care Professional Protection Amendment

Description of Amendment: The amendment will insert language in Title III, Subtitle H of the Chairman's Mark to facilitate the rapid development of private volunteer health care professionals across state lines and increase surge capacity in times of disaster.

Upon a declaration of disaster, a volunteer health care professional or health care provider who provides health or dental services in the disaster area or to a non-resident disaster victim shall not be liable for damages for an act or omission of the professional in providing those services. This would not limit the liability of a health care professional or health care provider for:

- an act or omission that is outside the scope of the services the health care professional or health care provider is deemed to be licensed or certified to perform, unless such services can be reasonably be determined necessary to prevent serious bodily harm or preserve the life of the individual being treated;
- the services on which the claim is based did not arise out of the rendering of pro bono care for medically underserved or indigent individuals;
- or an act of omission constituting willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by the pro bono health care professional or health care provider.

No person or health institution deploying or using such a volunteer is vicarious liable unless the volunteer health care professional or health care provider is liable.

In a declared disaster, the certification of the volunteer health care professional or the volunteer health care provider will be recognized by the state in which the services are rendered to a disaster victim, subject to conditions, limitations, or expansions set by the Governor of that state.

Ensign Amendment # D3 to America's Healthy Future Act of 2009

Short Title: Medical Care Access Protection Act

Description of Amendment: The amendment will insert language in Title III, Subtitle H of the Chairman's Mark to improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.

The amendment applies to all health care providers and health care institutions.

The amendment ensures timely resolution of claims by providing a general statute of limitations on filing health care lawsuits. Under the statute of limitations an action must be filed within 3 years of the date of manifestation of injury or within 1 year after the claimant discovers the injury. Certain exceptions apply, including expanded time to file for minors, or in cases fraud or intentional concealment.

The amendment provides fair and just compensation for patient injury. It allows for unlimited economic damages.

The amendment uses the Texas stacked-cap model for non-economic damages. Where a final judgment is rendered against a health care provider, non-economic damages shall be limited to an amount not to exceed $250,000 for each claimant. Where a final judgment is rendered against a single health care institution, non-economic damages shall be limited to an amount not to exceed $250,000 for each claimant. Where a final judgment is rendered against more than one health care institution, non-economic damages shall be limited to an amount not to exceed $250,000 for each institution or $500,000 for all institutions. Thus, non-economical damages can total up to $750,000.

The amendment preserves states' rights by keeping medical liability statutes in place and by allowing future state laws to supersede federal limits on damages.

The amendment permits punitive damages to be the greater of 2x the amount of economic damages awarded or $250,000. It raises the burden of proof for the award of punitive damages. In addition, it protects providers who prescribe an FDA approved product for an indicated use. Such providers may not be party to a product liability suit involving that product.

Where an attorney is paid on a contingency basis, the attorney is limited to 40% of the first $50,000; 33.3% of the next $50,000; 25% of the next $500,000; and 15% of any amount exceeding $600,000. For personal injury awards exceeding $50,000, future costs would be paid over time.

The amendment also establishes standards for expert witnesses. Experts must be licensed to practice in one or more states and be substantially familiar with the applicable standards of care and practice as they relate to the act or omission that is the subject of the claim. Furthermore, an expert in one medical specialty or subspecialty may not testify against a physician in another

medical specialty or subspecialty unless the expert demonstrates substantial familiarity between the two and demonstrates that the standards of care are similar.

The amendment promotes fairness in recovering health benefits and preventing double recovery. The amount of damages received shall be reduced by the amount of any other benefits (collateral sources) to which the claimant is entitled, less any amounts spent to obtain or secure such benefits. Where benefits have been provided by a collateral source that has a right of recovery by reimbursement or subrogation and such right is permitted under state law, the award shall not be reduced.

Finally, the amendment keeps the focus on the patient. Under a "fair share" model, each defendant would only be liable for those damages attributable to their fault, thus eliminating the incentive for attorneys to pursue "deep pocket" parties. Attorneys who file frivolous lawsuits will be subject to Rule 11 sanctions with imposed fines.

Ensign Amendment # D4 to America's Healthy Future Act of 2009

Short Title: Increased FMAP for Medical Liability Reform

Description of Amendment: The amendment will insert language in Title III, Subtitle H of the Chairman's Mark to provide any state that enacts the medical liability limits reforms consistent with the provisions described below shall be eligible for a Federal Medical Assistance Percentage (FMAP) increase for two years for children. The FMAP increase would be paid for by reducing the federal poverty level threshold for tax credits in the bill by the amount necessary.

The amendment applies to all health care providers and health care institutions.

The amendment ensures timely resolution of claims by providing a general statute of limitations on filing health care lawsuits. Under the statute of limitations an action must be filed within 3 years of the date of manifestation of injury or within 1 year after the claimant discovers the injury. Certain exceptions apply, including expanded time to file for minors, or in cases fraud or intentional concealment.

The amendment provides fair and just compensation for patient injury. It allows for unlimited economic damages.

The amendment uses the Texas stacked-cap model for non-economic damages. Where a final judgment is rendered against a health care provider, non-economic damages shall be limited to an amount not to exceed $250,000 for each claimant. Where a final judgment is rendered against a single health care institution, non-economic damages shall be limited to an amount not to exceed $250,000 for each claimant. Where a final judgment is rendered against more than one health care institution, non-economic damages shall be limited to an amount not to exceed $250,000 for each institution or $500,000 for all institutions. Thus, non-economical damages can total up to $750,000.

The amendment preserves states' rights by keeping medical liability statutes in place and by allowing future state laws to supersede federal limits on damages.

The amendment permits punitive damages to be the greater of 2x the amount of economic damages awarded or $250,000. It raises the burden of proof for the award of punitive damages. In addition, it protects providers who prescribe an FDA approved product for an indicated use. Such providers may not be party to a product liability suit involving that product.

Where an attorney is paid on a contingency basis, the attorney is limited to 40% of the first $50,000; 33.3% of the next $50,000; 25% of the next $500,000; and 15% of any amount exceeding $600,000. For personal injury awards exceeding $50,000, future costs would be paid over time.

The amendment also establishes standards for expert witnesses. Experts must be licensed to practice in one or more states and be substantially familiar with the applicable standards of care and practice as they relate to the act or omission that is the subject of the claim. Furthermore, an

expert in one medical specialty or subspecialty may not testify against a physician in another medical specialty or subspecialty unless the expert demonstrates substantial familiarity between the two and demonstrates that the standards of care are similar.

The amendment promotes fairness in recovering health benefits and preventing double recovery. The amount of damages received shall be reduced by the amount of any other benefits (collateral sources) to which the claimant is entitled, less any amounts spent to obtain or secure such benefits. Where benefits have been provided by a collateral source that has a right of recovery by reimbursement or subrogation and such right is permitted under state law, the award shall not be reduced.

Finally, the amendment keeps the focus on the patient. Under a "fair share" model, each defendant would only be liable for those damages attributable to their fault, thus eliminating the incentive for attorneys to pursue "deep pocket" parties. Attorneys who file frivolous lawsuits will be subject to Rule 11 sanctions with imposed fines.

Ensign Amendment # D5 to America's Healthy Future Act of 2009

Short Title: Protecting Current MA Plan Coverage of Seniors

Description of Amendment: The Secretary of Health and Human Services shall not implement the provisions relating to Medicare Advantage in Title III, Subtitle C of the Chairman's Mark for any year unless the Secretary certifies for such year that none of the provisions of such part would result in any senior who would otherwise be enrolled in a Medicare Advantage plan from being forced away from or losing that senior's enrollment in such Medicare Advantage plan, as such enrollment was in effect as of the day before the date of enactment of this Act.

This amendment has not been scored yet; offset to be derived from a proportionate decrease in certain spending provisions in the Chairman's bill.

Ensign Amendment # D6 to America's Healthy Future Act of 2009

Short Title: Medicare Savings Should be Kept within Medicare

Description of Amendment: The Amendment would require all of the Medicare savings achieved under the Chairman's Mark to be used to restore the solvency of the Medicare program.

Ensign Amendment # D7 to America's Healthy Future Act of 2009

Short Title: Private Options for Seniors Amendment

Description of Amendment: This amendment would allow an individual who elects to opt-out of the Medicare Part A benefit to do so without being required to opt-out of Social Security benefits. In addition, the amendment would ensure that an individual would not be required to refund any amount paid under Medicare Part A for items and services furnished prior to making such election.

This amendment has not been scored yet; if required, offset to be derived from a proportionate decrease in certain spending provisions in the Chairman's bill, excluding Medicare spending.

Ensign Amendment #D8 to America's Healthy Future Act of 2009

Short Title: GAO Study on impact of new employer responsibility provision.

Description of Amendment: : No later than 18 months after the date of enactment, the Government Accountability Office shall submit a report on the provision called the "Required Payments for Employers Receiving Premium Credits" found in Title I, Subtitle D of the Chairman's Mark. The report will provide a detailed analysis of the impact of this provision on: employer profits and federal tax revenues from any changes in those profits; level of wages and benefits; employee hours (i.e., full-time employment versus part-time employment); layoffs; etc.

Ensign Amendment #D9 to America's Healthy Future Act of 2009

Short Title: Employer Flexibility Amendment

Description of Amendment: Nothing in this act shall interfere with the authority of an employer to have flexibility in designing health benefits, copayments, and premium structures for their employees.

Ensign Amendment #D10 to America's Healthy Future Act of 2009

Short Title: An amendment to prohibit funding under this bill for ACORN.

Description of Amendment: The amendment would provide that no funds made available under the bill may be distributed to the Association of Community Organizations for Reform Now (ACORN) or its subsidiaries.

This amendment has no cost.

Ensign Amendment #D11 to America's Healthy Future Act of 2009

Short Title: To ensure that the financial well-being of future generations is not compromised by the activities of the current generation.

Explanation: Not later than 18 months after the date of the enactment, the Congressional Budget Office shall submit to the Congress a detailed report describing the generational impact of the Act on current and future birth cohorts. The report shall include, but not be limited to, an analysis on the different impact on cohorts born in 1920, 1940, 1960, 1980, 2000, and 2020. In addition, the report shall include detailed information on the effects of the Act on lifetime earnings; overall tax burden assuming deficits no greater than 3% of GDP; anticipated levels of economic growth; access to medical care; and length of life expectancy.

Ensign/Bunning Amendment # D12 to America's Healthy Future Act of 2009

Short Title: Ensuring Medicare Beneficiary Access to Health Care Professionals

Description of Amendment:

The amendment would eliminate the sustainable growth rate formula and provide an update to physicians and other health care providers covered by the Medicare physician fee schedule equal to or based on the Medicare Economic Index (MEI). This would be paid for by eliminating the hundreds of billions of dollars in waste and fraud identified by President Obama in his most recent address to Congress.

Enzi Amendment #D1

Enzi Amendment #D1 to the America's Healthy Future Act of 2009

Short Title: Fair and Reliable Medical Justice Reform

Description of Amendment: Authorize grants to states under the Social Security Act for the development, implementation, and evaluation of alternatives to resolve medical disputes. The alternatives must make the medical liability system more reliable and accessible, promote a reduction in health care errors and encourage early disclosure of errors, allow for collection and analysis of patient safety data related to disputes, and provide for an appeals process and access to civil litigation system. Every state would be eligible for grants to implement new alternatives.

Alternatives may include: Certificate of merit, early disclosure and compensation, administrative determination of compensation, health courts, physician safe harbors for following guidelines, or other options states develop and the Secretary approves as consistent with goals of the demonstration program.

Each State receiving a grant under this subsection shall submit to the Secretary an annual report evaluating the effectiveness of activities funded with grants awarded under such subsection. Such report shall, at a minimum, include the impact of the activities funded on patient safety and on the availability and price of medical liability insurance.

Grants under this amendment shall equal $1,000,000,000 in mandatory spending.

OFFSET: Reduce startup funding for health care cooperatives by $1,000,000,000.

Enzi Amendment #D2

Enzi Amendment #D2 to the America's Healthy Future Act of 2009

Short Title: Incentives for states to enact medical justice reform

Description of Amendment: Provide incentives through temporary increases in federal Medicaid match rates to states that adopt caps on non-economic damages for medical malpractice cases. The amount for incentives is $10,000,000,000.

OFFSET: Reduce the subsidies as much as necessary to make this amendment budget neutral starting with subsidies awarded to individuals earning 400% of poverty.

Cornyn Amendment #D1 to America's Healthy Future Act of 2009

Short Title: Increasing access to innovative plans for Medicaid beneficiaries.

Description of Amendment: States would be given the flexibility to offer value-based insurance design (VBID) benefits to certain Medicaid populations.

Offset: Do not expect to need an offset.

Cornyn Amendment #D2 to America's Healthy Future Act of 2009

Short Title: Ensuring Medicaid beneficiaries have access to a doctor.

Description of Amendment: Prior to implementing the mandatory Medicaid program expansions in the Chairman's Mark, the Secretary of Health and Human Services must certify that at least 75 percent of physicians in the country accept Medicaid patients.

Offset: Do not expect to need an offset.

Cornyn Amendment #D3 to America's Healthy Future Act of 2009

Short Title: Ensuring that seniors can keep the health care benefits they have.

Description of Amendment: The amendment would amend the proposed changes to the Medicare Advantage program in Title III, Subtitle D of the Chairman's Mark. The amendment would prohibit the implementation of the competitive bidding changes to the Medicare Advantage program in any bidding area where the proposed changes would result in reduced benefits for seniors.

Offset: Reduction in spending under the Mark.

Cornyn Amendment #D4 to America's Healthy Future Act of 2009

Short Title: Ensuring seniors have access to physicians beyond 2010.

Description of Amendment: Provide a positive update for physicians reimbursed under the Medicare fee schedule beyond 2011.

Offset: Strike the premium tax credit for individuals between 300-400 percent of FPL under Title I, Subtitle C of the Chairman's Mark.

Cornyn Amendment #D5 to America's Healthy Future Act of 2009

Short Title: The Patient's Right to Information on Quality.

Description of Amendment: Require Medicare to release patient de-identified claims data to independent entities to generate "Consumer Reports-like" information for patients on the quality of their health care providers. (S. 1544)

Offset: If an offset is needed, it will be provided at the markup.

Cornyn Amendment #D6 to America's Healthy Future Act of 2009

Short Title: Ensuring Spending Accuracy.

Description of Amendment: Strike the Medicare Commission in Title II, Subtitle D of the Chairman's Mark.

Offset: Reduction in spending under the Mark.

Cornyn Amendment #D7 to America's Healthy Future Act of 2009

Short Title: Protecting Seniors' Access to Care.

Description of Amendment: The amendment would prohibit the Medicare Commission in Title II, Subtitle D of the Chairman's Mark from presenting proposals that would result in reduced payments to primary care practitioners.

Offset: Reduction in spending under the Mark.

Cornyn Amendment #D8 to America's Healthy Future Act of 2009

Short Title: Protecting the health care workforce.

Description of Amendment: The amendment would prohibit the Medicare Commission in Title II, Subtitle D of the Chairman's Mark from presenting proposals that would result in reduced payments for graduate medical education.

Offset: Reduction in spending under the Mark.

Cornyn Amendment #D9 to America's Healthy Future Act of 2009

Short Title: Protecting Seniors' Access to Care.

Description of Amendment: The amendment would prohibit the Medicare Commission in Title II, Subtitle D of the Chairman's Mark from presenting proposals that would result in reduced payments to home health providers.

Offset: Reduction in spending under the Mark.

Cornyn Amendment #D10 to America's Healthy Future Act of 2009

Short Title: Protecting Seniors' Access to Care.

Description of Amendment: The amendment would prohibit the Medicare Commission in Title II, Subtitle D of the Chairman's Mark from presenting proposals that would result in reduced payments to hospice care providers.

Offset: Reduction in spending under the Mark

Cornyn Amendment #D11 to America's Healthy Future Act of 2009

Short Title: Promoting Choice and Competition in Health Care Facilities.

Description of Amendment: The amendment would strike the limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals in Title IV of the Chairman's Mark.

Offset: To be provided at the markup.

Cornyn Amendment #D12 to America's Healthy Future Act of 2009

Short Title: Promoting Choice and Competition in Health Care Facilities.

Description of Amendment: The amendment would change the date from November 1, 2009 to November 1, 2012 for the exemption from the self-referral ban in the limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals in Title IV of the Chairman's Mark.

Offset: Offset will be provided at the markup.

Cornyn Amendment #D13 to America's Healthy Future Act of 2009

Short Title: Limiting Non-Economic Damages in Medical Liability Lawsuits

Description of Amendment: Any state receiving funding under Medicaid shall enact a limit on total noneconomic damages against doctors and health care facilities of one million dollars or less.

Cornyn Amendment #D14 to America's Healthy Future Act of 2009

Short Title: Eliminating Junk Science in Medical Liability Lawsuits.

Description of Amendment: States must raise statutory qualification standards for medical liability expert witnesses to require that medical liability experts:

- Be credentialed or licensed in 1 or more States to deliver health care services;
- Typically treat the diagnosis or condition at issue in the case or provide the type of treatment under review; and
- Demonstrate that they are substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit.

Cornyn Amendment #D15 to America's Healthy Future Act of 2009

Short Title: Protecting Generic Drug Manufacturers from Liability for Label Language That They Did Not Write.

Description of Amendment: Generic drug manufacturers cannot be held liable in a state tort suit because the label failed to adequately warn of the risks of the drug, so long as the generic drug manufacturer's label complied with the language required by the FDA and the generic was in compliance with relevant reporting requirements.

Cornyn Amendment #D16 to America's Healthy Future Act of 2009

Short Title: Encouraging Amicable Settlement of Medical Liability Lawsuits.

Description of Amendment: Any state receiving funds under Medicaid shall enact rules that encourage parties to accept reasonable settlement offers by requiring a party that turns down a settlement offer that is significantly better than their verdict at trial to pay for the costs of trial and attorneys' fees.

Cornyn Amendment #D17 to America's Healthy Future Act of 2009

Short Title: Encouraging Compliance with the Institute's Recommendations

Description of Amendment: Doctor's health care decisions that follow the Institute's recommendations cannot be the basis of a tort claim of negligence or failure to comply with the standard of care.

Cornyn Amendment #D18 to America's Healthy Future Act of 2009

Short Title: Limiting Punitive Damages

Description of Amendment: Any state receiving funds under Medicaid shall enact legislation that requires:

- That punitive damages in medical malpractice cases may only be awarded by a unanimous verdict of the jury as to both liability and amount.
- That plaintiffs may only recover punitive damages if they show by "clear and convincing evidence" that a defendant acted with malice or gross negligence.

Cornyn Amendment #D19 to America's Healthy Future Act of 2009

Short Title: Protecting Doctors from Frivolous Lawsuits.

Description of Amendment: Any state receiving funds under Medicaid shall enact legislation that requires a plaintiff in a medical malpractice suit to accompany the filing of the complaint with a certificate or affidavit of merit signed by a qualified healthcare provider.

Cornyn Amendment #D20 to America's Healthy Future Act of 2009

Short Title: Protecting Doctors from Excessive Damage Awards.

Description of Amendment: Any state receiving funds under Medicaid shall enact legislation providing for the periodic payment of medical liability awards.

Cornyn Amendment #D21 to America's Healthy Future Act of 2009

Short Title: Ensuring that seniors can keep the health care benefits they have.

Description of Amendment: The amendment would amend the proposed changes to the Medicare Advantage program in Title III, Subtitle D of the Chairman's Mark. The amendment would prohibit the implementation of the competitive bidding changes to the Medicare Advantage program in any bidding area where the proposed changes would result in reduced benefits for low-income seniors.

Offset: Reduction in spending under the Mark.