This summarizes the major hospital and health system provisions included in the U.S. Senate’s health reform bill under consideration, the *Patient Protection and Affordable Care Act*, released on November 18.

**Coverage Expansion [Sections 1323, 1401, and 2001]**

The Senate bill would provide insurance coverage to 94% of all Americans; up to 31 million individuals would newly access coverage. Twenty-four million individuals would remain uncovered in 2019. Coverage expansion would be achieved by increasing federal support for Medicaid eligibility up to 133% of the federal poverty level (FPL) and by offering subsidies to moderate-income Americans to buy insurance either through private plans in new state-based health insurance exchanges, or through a new government-run public plan in which states would have the option to opt-out of allowing the public plan to operate in its state. The bill would also allow for the establishment of non-profit health insurance co-operatives, accessed through the exchange.

Expansion of Federal Support for Medicaid Eligibility: The bill would raise the threshold for mandatory Medicaid coverage to 133% of FPL. A federal matching rate of 100% would be provided to states for the cost of the expansion through 2016. The federal matching rate for 2017 and beyond would vary by state based on current levels of Medicaid coverage and would range from about 80%, limited to a maximum of 95%.

Subsidies for Health Insurance Coverage—Refundable Tax Credits: Premium assistance in the form of refundable tax credits would be provided on a sliding scale to individuals and families. The credits would start at 2.0% of income for those at 100% FPL and phase out at 9.8% of income for those at 400% of FPL. A cap on annual out-of-pocket costs is also provided to individuals and families that fall into these income categories.

Establishment of a Government-Run Public Insurance Plan and Non-Profit Health Insurance Co-operatives (Co-ops): The bill would require the Secretary of Health and Human Services (HHS) to develop a new government-operated public health insurance option to compete with private health insurance plans, and offer this option in the new state-based health insurance exchanges. Individual states may elect to opt-out of allowing the public plan to operate in the state if the state legislature enacts a law to prohibit the option. Also, federal funding for start-up loans and grants would be provided to qualified organizations to assist in the establishment of non-profit, member-run health insurance co-ops that would offer health insurance though the health insurance exchange.

Payment Rates to Providers under the Public Plan and By Co-ops: For the provision of services to individuals with coverage under the newly established public health insurance plan and co-ops, health care providers would either negotiate payment rates with the HHS Secretary (for public plan) or directly with the co-op.

Provider payment rates negotiated under the public plan would be limited, in aggregate, to average payment rates paid by health insurance plans operating in the state-based exchange. A newly established or designated State Advisory Council could develop or encourage the use of alternative payment methods to encourage quality improvement and cost control.
Medicare Marketbasket Reductions [Section 3401]

Productivity Offsets: Similar to the House-passed bill, the update factor for all Medicare Part A and B providers who are subject to a marketbasket or Consumer Price Index (CPI) update would be reduced to reflect estimated gains in productivity. Beginning in 2012, a full productivity adjustment of about 1.3% would be applied to inpatient and outpatient hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and nursing homes. Hospice providers would receive a productivity reduction beginning in 2013 and home health providers would begin in 2015. All other productivity reductions for Part B providers would begin in 2011. There is no floor for these marketbasket reductions.

Additional Marketbasket Reductions: In addition to the productivity offset, the annual marketbasket updates for inpatient and outpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, and inpatient psychiatric facilities would be reduced by 0.25% in 2010 and 2011. Updates would be reduced by 0.20% annually from 2012 through 2019. The update reductions from 2014 through 2019 could be restored if the previous year’s total percentage of insured population is more than five percentage points below projections. The provision would reduce updates for home health agencies by 1.0% in 2011 and 2012; and for hospice providers by 0.5% in 2013 through 2019.

Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment Reductions [Sections 2551 and 3133]

Medicare DSH: The bill would maintain current Medicare DSH payment levels through 2014. Beginning in 2015, hospitals’ Medicare DSH payments would be reduced to reflect lower uncompensated care costs relative to increases in the number of insured. Centers for Medicare and Medicaid Services (CMS) would determine payment based on two components. CMS would continue to make an “empirically justified” base disproportionate share payment that is equal to 25% of the DSH payments that would otherwise be made. The 75% of funds above this empirically justified base are considered to be tied to uncompensated care costs. For every percentage point reduction in the uninsured in each period evaluated, the percent of funding available for this amount would be proportionally reduced. Under this provision, Medicare DSH funding nationwide would be reduced by $20.6 billion over ten years.

Medicaid DSH: The bill would maintain current Medicaid DSH payment levels through 2014. A state’s DSH allotment would be reduced by 50% (25% for low DSH states) once the number of uninsured individuals in the state is reduced by 45% compared to an initial uninsured rate on the date of enactment. Thereafter, the state’s DSH allotment would be further reduced at a rate that corresponds with any further reduction in the rate of uninsured. A state’s DSH allotment could not fall below 35% of the total allotment in 2012, adjusted for inflation. Under this provision, Medicaid DSH funding nationwide would be reduced by $22.4 billion over ten years.

Establishment of a Medicare Readmissions Payment Policy [Sections 3025 and 3026]

Acute Care Hospitals Including Critical Access Hospitals (CAHs): Beginning in federal fiscal year (FFY) 2013, acute care hospitals and CAHs determined to have higher than expected readmission rates in any of three medical condition categories would receive reduced Medicare payments for every discharge. Medicare payments would be reduced by the lower of a hospital-specific readmissions adjustment factor or a pre-determined floor (1.0% in FFY 2013, increasing to 3.0% in FFY 2015 and thereafter). The policy would first apply to readmissions related to heart failure, heart attack, and pneumonia; in FFY 2015, the Secretary would be required to expand the list of applicable conditions to include chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), percutaneous transluminal coronary angioplasty (PTCA), and other vascular procedures—per the
Medicare Payment Advisory Commission’s (MedPAC) June 2007 recommendation to Congress. The Secretary also would have the authority to expand the policy to additional conditions in future years, including all-cause readmissions. The readmission rates derived under this provision would be made available to the public on the CMS Hospital Compare Web site.

This provision also requires the Secretary to calculate and publicly post (on Hospital Compare) all-payer readmission rates for identified conditions. This would require hospitals to submit their all-payer claims-level data to CMS, either independently or through their state data agency. This provision would apply to cancer, children’s, rehabilitation, long-term care, and psychiatric inpatient facilities as well.

Within two years of enactment, the Secretary is required to make a quality improvement program available to hospitals with high severity adjusted readmission rates through the Patient Safety Organizations. Beginning in FFY 2011, the legislation would provide $500 million over three years to fund a Community Care Transitions Program for hospitals with high readmission rates and partnership organizations to implement care transitions using evidence-based interventions for targeted high-risk beneficiaries.

Post-acute Care Providers: Reporting of all-patient claims data for posting of readmission rates on the Hospital Compare site (see above).

Physicians: No provision.

Establishment of a Medicare Value-Based Purchasing (VBP) Programs [Sections 3001, 3006, and 3007]

Inpatient Hospitals: The provision would establish a Medicare VBP program beginning in FFY 2013. Under this program, a percentage of hospital payments would be tied to a prior period’s performance (the higher of improvement or attainment) on quality measures from the following sources: the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and data from HHS on health care-associated infections. The HHS Secretary has the discretion/authority to select measures, determine the scoring methodology, and determine the payment methodology within the parameters of the bill. No earlier than FFY 2014, the Secretary would be required to include efficiency measures (including adjusted Medicare spending per beneficiary) as part of the VBP program.

The proposed VBP program would be funded by Medicare inpatient payment reductions to be phased in beginning with a 1% reduction in FFY 2013 and increased by 0.25% each year until the reduction reaches 2% for FFY 2017 and subsequent years. The program would be budget-neutral, meaning that each year’s funding pool must be returned to hospitals in that same year. The legislation provides an appeals process.

The VBP program would apply to all “subsection (d)” inpatient hospitals, which excludes psychiatric, rehabilitation, children’s, cancer, and long-term care hospitals. Small hospitals with low patient volume and/or a limited number of reported quality measures, Critical Access Hospitals (CAHs), hospitals cited for immediate jeopardy by CMS, and hospitals that receive the RHQDAPU payment reduction would be excluded from the VBP program initially. The proposal calls for the establishment of demonstration projects to test VBP models for CAHs and small hospitals and requires CMS to provide recommendations for a permanent VBP program for these inpatient facilities.

The VBP component measure scores, composite scores, and payment percentages would all be posted on the Hospital Compare Web site. The Secretary must improve the Hospital Compare Web site to make it more accessible and easy to navigate for consumers. The General Accountability Office (GAO) and HHS must each study the VBP program and report their findings to Congress.
**Post-acute Care Providers:** This provision would direct the HHS Secretary to submit plans to Congress for VBP programs for home health (HH) providers and skilled nursing facilities (SNFs) by October 1, 2011. These plans should be developed in consultation with the health care community.

**Physicians:** This provision would establish a value-based payment modifier that allows for differential payments to physicians based upon quality vs. cost indicators. The choice of indicators would be at the discretion of the Secretary. The selected quality and cost measures must be published by January 1, 2012. The payment modifier methodology would be determined during the 2013 rule-making process and implemented beginning on January 1, 2015 for specific physicians and groups; and by January 1, 2017 for all physicians and groups. The payment modifier must be implemented in a budget-neutral manner.

**Establishment of Medicare and Medicaid Health Care-Acquired (HAC) Conditions Payment Policies [Sections 2702 and 3008]**

**Medicare HAC Payment Policy:** This provision would reduce Medicare payments, starting in FFY 2015, for hospitals in the worst 25% of the nation for HACs (for certain high-cost and common conditions). The determination of hospitals’ HAC rates would be risk adjusted and would be based upon a prior period’s data (to be determined by the Secretary). The impacted hospitals would be subject to a 1% payment penalty on all discharges. This payment reduction would be in addition to the current CMS payment adjustments for HACs. The Secretary would be required to post all HAC information, by hospital, on the Hospital Compare Web site. The Secretary would be required to study alternatives for expanding the HAC policy to other care settings (including inpatient rehabilitation, long-term care, outpatient, skilled nursing, ambulatory surgery) and report her results to Congress by January 2012.

**Medicaid HAC Payment Policy:** The Secretary would be required to develop a list of HACs for Medicaid and promulgate regulations that prohibit Medicaid payments to states for any amounts expended for providing medical assistance for such conditions. Those regulations are to be effective as of July 1, 2011.

**Establishment of Delivery System Reform Pilot Programs and Demonstration Projects [Sections 2704, 2705, 2706, 2707, 3021, 3022, and 3023]**

**Medicare Payment Bundling:** This provision would direct the Secretary to implement a national, voluntary pilot program in 2013 to encourage hospitals, doctors, and post-acute care providers to test alternative means of improving collaboration and coordination of patient care. CMS would select eight conditions to be included in the pilot program. The bundled service would start three days prior to hospital admission and extend through 30 days following discharge; and would cover:

- acute care inpatient services including readmissions;
- outpatient hospital services including emergency room;
- physician including services both in and outside of the hospital; and
- post-acute care including home health services, skilled nursing facility, inpatient rehabilitation, and long-term care hospital services.

An entity comprised of providers including a hospital, a physician group, a skilled nursing facility, and a home health agency, could submit an application to join the pilot program. The Secretary is required to consult with representatives of small rural hospitals and CAHs regarding their participation in the pilot program.
A comprehensive bundled payment covering all services provided during an episode of care would be made to the entity. The Secretary would develop the bundled payment rates and could test payments based on bids submitted by the entities. Annual payments under the pilot to an entity could not exceed what would otherwise be paid for the same services by Medicare. An alternative payment methodology would be tested that includes payment for services such as care coordination, medication reconciliation, discharge planning, and transitional care services.

CMS would develop quality measures for episodes of care and for post-acute care. The measures would include functional status improvement, readmission rates, emergency room utilization after hospitalization, efficiency measures, and patient perception of care.

The pilot program would last five years and the Secretary could extend the program for those hospitals that are participating at the end of the five-year period. In 2016, CMS would report on the results of the pilot program and make recommendations to Congress on expansion.

Medicare Accountable Care Organizations (ACOs): This provision would establish a voluntary program, beginning in 2012, that would allow groups of providers to be recognized as ACOs and be eligible to share in the cost savings they achieve for the Medicare program. ACOs could include:

- group practice arrangements;
- networks of individual physician practices;
- partnerships or joint-venture arrangements between hospitals and practitioners; and
- hospitals employing practitioners.

To qualify, the organization must act as the primary care provider for at least 5,000 Medicare fee-for-service beneficiaries. ACO providers would agree to participate for at least three years.

The ACO would be accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it. Payments to providers participating in an ACO would continue to be made using existing Medicare fee-for-service methodologies. In addition, the ACO would be eligible to receive a shared savings payment if the ACO’s average per capita Medicare expenditures are below a benchmark based on the claim history and characteristics of the patients assigned to the ACO.

Medicaid Payment Demonstrations: The Secretary would be authorized to conduct the following Medicaid demonstration projects:

- Medicaid bundled payment demonstrations to evaluate integrated care around a hospitalization in up to eight states;
- Medicaid global payment demonstrations for safety net hospitals in up to five states;
- Pediatric Accountable Care Organization demonstrations; and
- Medicaid emergency psychiatric demonstration projects.

CMS Center for Medicare and Medicaid Innovation (CMI): This provision would establish an Innovation Center at CMS to test and evaluate payment structures and methodologies that improve coordination, quality, and efficiency of services. The Secretary is directed to test payment models where there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The legislation lists several models that should be tested including patient-centered medical home models, risk-based comprehensive payments, care coordination for chronically-ill Medicare beneficiaries at high risk of hospitalization, and other models. CMI’s funding would be set at $5
million in 2010, $10 billion for the period 2011 through 2019 and an additional $10 billion for each subsequent ten-year period.

**Expansion of Medicare Pay-for-Reporting and Quality Reporting Programs [Sections 3004 and 3005]**

This provision would implement pay-for-reporting programs for long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), and hospice providers in either rate year or FFY 2014. Providers that do not successfully participate in the program would be subject to a two percentage point reduction in their annual marketbasket update. In addition, the Secretary would be required to select quality and efficiency measures for Inpatient Prospective Payment System (IPPS)-exempt cancer hospitals by FFY 2013, with mandatory quality reporting for these providers to begin FFY 2014.

**Addressing the Geographic Variation in Medicare Spending [Section 3001]**

The bill would require the Secretary to include efficiency measures in an inpatient hospital VBP program by FFY 2014. The measures must include measures of Medicare spending per beneficiary and be adjusted for age, sex, race, severity of illness, and other factors that the Secretary determines to be appropriate.

**Medicare Hospital Wage Index Reform [Section 3137]**

The bill would require the Secretary to report to Congress by December 31, 2011 with recommendations for comprehensive reform of the Medicare wage index system. The plan would be required to take into account the 2001 MedPAC wage index report, including proposed use of Bureau of Labor Statistics data and recommended redefinition of wage areas.

**340B Drug Discount Program Expansion [Section 7101]**

The bill would expand, beginning January 1, 2010, the 340B drug discount program to include inpatient drugs and would extend access to 340B program to children’s, CAHs, Medicare-dependent Hospitals, Sole Community Hospitals (SCHs), and Rural Referral Centers. Hospitals would be required to issue credit to the State Medicaid program, as determined by the Secretary, for inpatient covered drugs provided to Medicaid recipients, no later than 90 days after the date of filing of the hospital’s most recently filed Medicare cost report.

**Independent Medicare Payment Board [Section 3403]**

This provision would establish an independent Medicare Commission that would submit proposals to Congress that would, beginning 2015, reduce Medicare spending by targeted amounts (0.5 percentage point reduction in 2015 increasing to a 1.5 percentage point reduction in 2018), if it is determined that there is excess cost growth in the Medicare program. A process would be established for Congress to review, modify, and pass an alternative to the proposals, but Congress would be required to maintain the targeted level of Medicare savings for a particular year. The Commission’s original proposal would be implemented if Congress does not consider the Commission’s proposal. Prior to 2020, any proposed reductions from the Commission would not affect providers, such as hospitals and hospice, that are scheduled to receive a reduction to their marketbasket update in excess of a reduction due to productivity.
Medicare Graduate Medical Education (GME) Provisions [Sections 5503, 5504, 5506, 5507, and 5508]

Protection of GME Payments to Hospitals: No reductions to GME payments to hospitals, maintaining current levels of funding for Indirect Medical Education (IME) and Direct Medical Education in perpetuity.

Redistribution of Unused Resident Slots: GME training positions for primary care would be increased through a slot re-distribution program. The provision would redistribute 65% of currently unused training slots. Rural hospitals with less than 250 beds and hospitals that participated in voluntary reduction programs are exempt from reductions. Hospitals could apply to receive up to 75 additional residency positions and would be required to use at least 75% of the increase for primary care or general surgery residency and to maintain their number of primary care residents. Priority would be given to hospitals located in states with low resident-to-population ratios; to hospitals located in a state that is among the top ten states in the ratio of the total population living in a Health Professional Shortage Area (HPSA); and to hospitals located in rural areas.

Resident Training in Non-Provider Settings: Allows hospitals to be paid for residents training in non-hospital settings if the hospital incurs the costs of the stipends and fringe benefits of the resident. This eliminates current requirements for compensating supervising physicians in non-hospital settings.

Counting of Resident Didactic Time: Allows hospitals to count time spent by a resident in non-patient care activities such as didactic conferences and seminars.

Preservation of Resident Slots from Closed Hospitals: Resident slots from a closed hospital will be redistributed using a process to be determined by the Secretary. Priority would be given to other hospitals within the same Core-Based Statistical Area (CBSA), followed by hospitals within the same state.

Establishment of Workforce Advisory Committee: Would establish a National Health Care Workforce Commission made up of external stakeholders tasked with working with HHS and other relevant federal agencies to develop and implement a national workforce strategy.

Medicare Rural Provisions [Sections 3122, 3123, 3124, 3126, 3127, 3129, and 3131]

Extension of outpatient hold-harmless payments: Same as House, but would extend the hold-harmless payments for one year rather than two.

Rural Home Health Add-on: The provision would provide a 3.0% add-on payment for home health service provided to Medicare beneficiaries in rural areas from April 1, 2010 through December 31, 2015.

Clinical Diagnostic Laboratory Services: This provision would reinstate reasonable cost payment for clinical diagnostic laboratory services to rural hospitals with less than 50 beds from July 1, 2010 through June 30, 2011.

Rural Community Hospital Demonstration Program: This provision would extend, for one additional year, through December 31, 2010, the rural community hospital demonstration project and increase the number of participating hospitals from 15 to 30. In addition, this provision would expand the eligible sites to rural areas in all states.

Medicare Dependant Hospitals (MDHs): The special rural MDH classification, which is set to expire on September 30, 2011, would be extended for one additional year, through September 30, 2012.

Expansion of Community Health Integration Models in Rural Areas: This provision would strike the limitation on the number of eligible counties that may participate in the demonstration project on community health
integration models in certain rural counties within the qualifying states. In addition, it would delete references
to rural health clinic services and replaces it with the requirement that physician services may also be included
within the scope of the demonstration project.

**MedPAC Review of Medicare Payments for Rural Areas:** This provision would require MedPAC to review
payment adequacy for rural health care providers serving the Medicare program and to provide a report to
Congress by January 1, 2011.

**Medicare Rural Hospital Flexibility Program:** This provision would extend the “FLEX” program for an
additional two years through 2012. This would allow Small Rural Hospital Improvement (SHIP) grant program
funding to be used to support small rural hospitals’ participation in the delivery system reform programs
outlined in this legislation (such as VBP, bundling, and accountable care organizations).

**Medicare Home Health Agency Payment Reductions [Section 3131]**

The Secretary would be directed to reduce payments through rebasing the home health payment rates. Reduced
payments would be phased in over four years beginning in 2013 and the reductions could not exceed 3.5% each
year. Beginning in 2011, the Secretary would establish a 10.0% outlier cap on the amount of reimbursement a
home health provider can receive from outlier payments. Also, the Secretary would be required to report to
Congress by March 1, 2011 on home health payment reforms related to serving patients with varying severity of
illness or to improve beneficiary access to care.

**New Requirements Applicable to Tax-Exempt Status [Section 9002]**

The bill would not establish thresholds hospitals and health systems must meet to attain or maintain their tax-
exempt status. Instead, the proposal establishes new requirements applicable to Section 501(c)(3) hospitals
including the required implementation of strategies to meet the community needs based on the findings of
periodic health needs assessments, and the adoption of financial assistance, billing, and debt collection policies.
Other disclosure and reporting requirements would apply.

**Medical Liability Reform [Section 6801]**

The proposal would express a “sense of the Senate” encouraging states to develop and test alternatives to the
existing civil litigation system and encourage Congress to consider establishing state demonstration projects to
test alternatives to the current civil litigation system as a means to reduce providers’ medical liability insurance
burdens.

**Physician Payment Reform [Section 3101]**

This provision would replace the 21% cut to physician Medicare payment rates scheduled for 2010 with a
0.5% update.

**Other Hospital and Health System Provisions [Sections 3137, 3141, 3138, and 6411]**

**Restoration of Medicare Hospital Wage Index Reclassification Thresholds:** This provision would direct the
Secretary to restore for FFY 2011 the FFY 2008 Medicare hospital wage index reclassification thresholds used
for comparing hospitals average hourly wages (AHWs) for the purpose of determining wage index
reclassifications. The average hourly wage comparison criterion, which requires hospitals to show their AHWs are comparable to hospitals in the area to which it seeks reclassification, was made stricter over the past two years. Restoration of the FFY 2008 criteria would require that hospitals meet an 84% (for urban hospitals) or 82% (for rural hospitals) threshold rather than the current, more strict 88% (for urban hospitals) and 84% (for rural hospitals) thresholds. The restoration of the Medicare hospital wage index reclassification thresholds would continue until the first year that is on or after the date the Secretary submits the report to Congress on reforming the wage index system. Reclassifications would be budget-neutral.

**Extension of Section 508 Legislative Medicare Wage Index Reclassifications:** Would extend for one year, through FFY 2010, special Section 508 Medicare hospital wage index reclassifications.

**Application of Budget Neutrality for the Medicare Hospital Wage Index:** The provision would, beginning on October 1, 2010, require that the application of budget neutrality associated with the effect of the Medicare wage index rural floor and imputed rural floor be applied on a national, rather than state-specific basis through a uniform, national adjustment to the area wage index. The current methodology that applies the wage index floor budget neutrality adjustment at the state level was adopted by CMS in FFY 2009.

**Updating Outpatient Payments for PPS-Exempt Cancer Hospitals:** The Secretary would be required to conduct a study to determine if the outpatient costs incurred by PPS-exempt cancer hospitals exceed the costs incurred by other hospitals reimbursed under outpatient PPS. If appropriate, CMS would provide an adjustment for services furnished starting January 1, 2011.

**Expansion of the Recovery Audit Contractor (RAC) program:** The RAC program, which currently audits Medicare Part A and Part B claims, would be expanded no later than December 31, 2010, to include audits of the Medicaid program and Medicare Parts C and D.