



### ***OUR SIX PUBLIC POLICY ADVOCACY OBJECTIVES***

- Address the acute and growing nationwide shortage of geriatricians and all geriatrics healthcare professionals; and ensure that other healthcare providers have training that prepares them to meet the unique healthcare needs of older people
- Strengthen primary and preventive care and care coordination
- Effect healthcare financing reform that ensures all older adults access to high quality healthcare
- Ensure that value-based purchasing and other quality initiatives take into account the unique healthcare needs of *all* older patients
- Step-up research concerning healthy aging, the prevention, diagnosis and treatment of age-related health problems, and the cost-effectiveness of various approaches to care; and ensure that older adults are adequately represented in research trials
- Expand older adults' healthcare options to include in-home and other care that enables them to live independently as long as possible; help older adults and their caregivers better understand their healthcare needs and make the most of Medicare and other benefits; and provide caregivers with adequate resources and support

### ***SPECIFIC PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (HR 3590) AS MODIFIED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT (HR 4872) THAT ADDRESS THESE OBJECTIVES***

#### **STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS**

##### National Health Care Workforce Commission (Sec. 5101)

Creates a National Health Care Workforce Commission to serve as a national resource, communicate and coordinate with various Departments, develop evaluations, identify barriers, and encourage innovation. The commission will set the nation on a path toward recruiting, training and retaining a health workforce that meets the nation's current and future health care needs.

##### National Center for Health Care Workforce Analysis (Sec. 5103)

Establishes a new center to describe and analyze the health care workforce. Authorization of appropriations, for the National Center is \$7,500,000 for each of FY 2010 through 2014 and then for State and Regional Centers, \$4,500,000 for each of FY 2012-2014.

##### Funding for National Health Service Corps (Sec. 5207)

Increases and extends the authorization of appropriations for the National Health Service Corps scholarship and loan repayment program for FY 2010-2015.

#### [Training Opportunities for Direct Care Workers \(Sec. 5302\)](#)

Grants to provide new training opportunities for direct care workers employed in long-term care settings such as nursing homes, assisted living facilities and skilled nursing facilities, and home and community based settings. Authorization of Appropriations, \$10,000,000 for FY 2011-2013.

#### [Geriatric education and training; career awards; comprehensive geriatric education \(Sec. 5305\)](#)

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

#### [Expanding Access to Primary Care Services and General Surgery Services \(Sec. 5501\)](#)

Would establish a new 10% bonus on select E&M codes under the Medicare fee schedule for five years, beginning Jan. 1, 2011 for primary care practitioners, including those in FM, IM, geriatric or pediatric medicine (also includes advanced practice nurse or physician assistant). Practitioners must furnish 60% of their services in the select codes. Half of the cost of the bonuses would be offset through an across-the-board reduction to all other codes.

#### [Distribution of Additional Residency Positions \(Sec. 5503\)](#)

Beginning July 1, 2011, directs the Secretary to redistribute residency positions that have been unfilled for the prior three cost reports and directs those slots for training of primary care physicians. In distributing the residency slots under this section, special preference will be given to programs located in States with a low physician resident to general population ratio and to programs located in States with the highest ratio of population living in a health professional shortage area (HPSA) relative to the general population.

#### [Demonstration Projects to Address Health Professions Workforce Needs; Extension of Family-to-Family Health Information Centers \(Sec. 5507\)](#)

Provides for a six-state demonstration to develop training and certification standards for personal and home care aides.

#### [Increasing Teaching Capacity \(Sec. 5508\)](#)

Would seek to increase training and improve access to primary care services. Qualified centers would be eligible for payments for DGME and other indirect expenses associated with operating a residency training program. A teaching health center would mean a facility which is community based, ambulatory patient care center and operates a primary care residency program (including geriatrics). \$230 million will be transferred from the Federal Hospital Insurance Trust Fund for FY 2011 to 2015. Would also create Teaching Health Center Development Grants.

#### [Graduate Nurse Education Demonstration \(Sec. 5509\)](#)

Establishes a demonstration program to increase graduate nurse education training under Medicare that would provide advance practice nurses with the skills necessary to provide primary and preventive care, transitional care, chronic care management, and other nursing services appropriate for Medicare-eligible population. Authorizes \$50 million to be appropriated from the Medicare Hospital Insurance Trust Fund for each of the FY 2012-2015.

#### [Payments to primary care physicians \(Sec. 1202\\*\)](#)

Requires that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of Medicare payment rates in 2013 and 2014. Provides 100% federal funding for the incremental costs of meeting this requirement.

### **IMPROVING CARE COORDINATION AND DEVELOPING NEW PATIENT CARE MODELS**

#### [5-Year Period for Demonstration Projects \(Sec. 2601\)](#)

Clarifies that Medicaid waivers for coordinating care for dual eligible beneficiaries could be authorized for as long as five years.

#### [Providing Federal Coverage and Payment Coordination for Dual Eligible Beneficiaries \(Sec. 2602\)](#)

Requires the Secretary to establish a Federal Coordinated Health Care Office within CMS no later than March 1, 2010. The office will aim to more effectively coordinate benefits between Medicare and Medicaid and improve the coordination for individuals eligible for benefits under both programs to ensure full access to the services they are entitled to.

#### [State Option to Provide Health Homes for Enrollees with Chronic Conditions \(Sec. 2703\)](#)

Would create a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition could designate a provider as their home health. The designated provider or team of health professionals would offer comprehensive care management; care coordination and health promotion; comprehensive transitional care, and referral to community and social support services, if relevant and as feasible use health information technology to link such services. The option would be evaluated based on its impact on hospital admission rates, chronic disease management, and coordination of care for the chronically ill.

#### [Establishment of Center for Medicare and Medicaid Innovation within CMS \(Sec. 3021\)](#)

Establish an Innovation Center within CMS to test, evaluate, and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. Requires that elements of Lincoln's RE-Aligning Care Act be included in models to be tested. AGS recommended the following language: The Center would consider models that target beneficiaries who are dually-eligible for both Medicare and Medicaid, and beneficiaries "with multiple chronic conditions and at least one of the following: (1) an inability to perform 2 or more activities of daily living; and (2) a cognitive impairment, including dementia." The Center would be established by Jan. 1, 2011.

#### [Medicare Shared Savings Program \(Sec. 3022\)](#)

The Medicare program would allow groups of providers who voluntarily meet certain statutory criteria, including quality measurements, to be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicare program. Beginning on Jan. 1, 2012, eligible ACOs would have the opportunity to qualify for an incentive bonus. Part of the criteria to qualify as an ACO requires the organization to define processes to promote evidence-based medicine and patient engagement, report on quality and costs measure, and coordinate care and to demonstrate that the ACO meets patient-centeredness criteria, such as use of patient and caregiver assessments or the use of individualized care plans.

#### [Pilot Program on Payment Bundling \(Sec. 3023\)](#)

Requires the HHS Secretary to develop a five-year pilot program to encourage physicians, hospitals and post-acute care providers to test a bundled-payment model to achieve improvement in quality of care and cost savings. The program would begin in 2013. After January 2016, the HHS Secretary may expand the duration and scope of the pilot program, if determined to be successful.

#### [Independence at Home Demonstration Program \(Sec. 3024\)](#)

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. Interdisciplinary teams of health care professionals caring for patients with multiple chronic conditions in their homes would be eligible for shared-savings if they achieve quality outcomes, costs savings and patient satisfaction. Those already enrolled in MA, PACE, medical homes, ACOs are not eligible.

#### [Hospital readmissions reduction program \(Sec. 3025\)](#)

Beginning in FY 2012, this provision would adjust payments for hospitals paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum.

#### [Community-Based Care Transitions Program \(Sec. 3026\)](#)

Establishes a 3-year Medicare pilot program called the Community-Based Care Transitions Program to fund eligible hospitals and community-based partnership organizations to provide patient-centered, evidence-based care transition services to Medicare beneficiaries at the highest risk of preventable re-hospitalization.

#### [Medicare Advantage Payments \(Sec. 1102\\*\)](#)

Freezes Medicare Advantage payments in 2011. Beginning in 2012, the provision reduces Medicare Advantage benchmarks relative to current levels. Benchmarks will vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas. The changes will be phased-in over 3, 5, or 7 years, depending on the level of payment reductions. The provision creates an incentive system to increase payments to high-quality plans by at least 5%. It also extends CMS authority to adjust risk scores in Medicare Advantage for observed differences in coding patterns relative to fee-for-service.

#### [Saving from limits on MA plan administrative costs \(Sec. 1103\\*\)](#)

Ensures Medicare Advantage plans spend at least 85% of revenue on medical costs or activities that improve quality of care, rather than profit or overhead.

#### [Extension for Specialized MA Plans for Special Needs Individuals \(Sec. 3205\)](#)

Would extend SNP authority through December 31, 2013. It would also create a new payment adjustment for fully-integrated dual-eligible SNPs – giving the Secretary authority to provide a frailty adjustment for fully-integrated dual-eligible SNPs that have similar average levels of frail beneficiaries as PACE plans. Also, beginning in 2011, the Secretary would use a risk score for new enrollees in SNPs that reflects the known underlying risk profile and chronic health status of each enrollee.

### **IMPROVING PAYMENT ACCURACY AND ENSURING MEDICARE SUSTAINABILITY**

#### [Payment adjustments for home health care \(Sec. 3131\)](#)

This provision would direct the Secretary to improve payment accuracy through rebasing home health payments starting in 2013 based on an analysis of the current mix of services and intensity of care provided to home health patients. The provision would also establish a 10% cap on the amount of reimbursement a home health provider can receive from outlier payments and would reinstate an add-on payment for rural home health providers from April 1, 2010 through 2015. In addition, it would require the Secretary to submit a report to Congress by March 1, 2011 on recommended payment reforms related to serving patients with varying severity of illness or to improve beneficiary access to care.

#### [Improvement to Medicare disproportionate share hospital \(DSH\) payments \(Sec. 3133 and Sec. 1103\\*\)](#)

This provision would require the Secretary to update hospital payments to better account for hospitals' uncompensated care costs. Starting in FY 2014, hospitals' Medicare Disproportionate Share Hospital (DSH) payments would be reduced to reflect lower uncompensated care relative to increases in the number of insured.

#### [Misvalued Codes under the Physician Fee Schedule \(Sec. 3134\)](#)

The Secretary would be required to periodically identify physician services as being potentially misvalued, and make appropriate adjustments to the relative values of such services under the fee schedule.

#### [Revision of Certain Market Basket Updates \(Sec. 3401 and Sec. 1105\\*\)](#)

Incorporates a productivity adjustment into the market basket update for certain providers, including inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and outpatient hospitals.

#### [Independent Payment Advisory Board \(Sec. 3403\)](#)

Creates an independent advisory board to present Congress with proposals to slow cost growth and improve quality of care under Medicare and the private sector. The board's proposals would take effect unless Congress passes an alternative measure that achieves the same level of savings. The board's proposals cannot ration care, raise taxes or Part B premiums, or change the Medicare benefit, eligibility or cost-sharing standards.

### LINKING PAYMENT TO QUALITY AND QUALITY MEASURE DEVELOPMENT

#### [Hospital value-based purchasing program \(Sec. 3001\)](#)

Would establish a value-based purchasing program for hospitals starting in FY 2013. Under this program, a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions. Quality measures included in the program will be developed chosen with input from external stakeholders.

#### [Improvements to the physician quality reporting initiative \(Sec. 3002\)](#)

Extends through 2014 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare. Creates appeals and feedback processes for participating professionals in PQRI. Establishes a participation pathway for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine. Beginning in 2014, physicians who do not submit measures

#### [Improvements to the physician feedback program \(Sec. 3003\)](#)

Expands Medicare's physician resource use feedback program to provide for development of individualized reports by 2012. Reports will compare the per capital utilization of physicians to other physicians who see similar patients. Reports will be risk-adjusted and standardized to take into account local health care costs.

#### [Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs \(Sec. 3004\)](#)

Establishes a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, and hospice providers by requiring the Secretary to implement quality measure reporting programs for these providers in FY 2014. Providers under this section who do not successfully participate in the program would be subject to a reduction in their annual market basket update.

#### [Plans for a value-based purchasing program for skilled nursing facilities and home health agencies \(Sec. 3006\)](#)

Direct the Secretary to submit a plan to Congress by FY 2012 outlining how to effectively move these providers into value-based purchasing payment system.

[Value-based payment modifier under the physician fee schedule \(Sec. 3007\)](#)

Directs the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized. The Secretary will phase in the new payment system over a 2-year period beginning in 2015.

[Payment adjustment for conditions acquired in hospitals \(Sec. 3008\)](#)

Starting in FY2015, hospitals in the top 25<sup>th</sup> percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare. This provision also requires the Secretary to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a healthcare acquired condition policy related to other providers participating in Medicare.

[National Strategy to Improve Health Care Quality \(Sec. 3011\)](#)

Requires the Secretary to establish and update annually a national strategy to improve the delivery of health care services, patient health outcomes, and population health. Establishes, not later than January 1, 2011, a Federal health care quality internet website.

[Interagency Working Group on Health Care Quality \(Sec. 3012\)](#)

Requires the President to convene an Interagency Working Group on Health Care Quality comprised of Federal agencies to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.

[Quality measure development \(Sec. 3013\)](#)

Authorizes \$75 million over 5 years for the development of quality measures at AHRQ and the Centers for Medicare and Medicaid Services (CMS). Quality measures developed under this section will be consistent with the national strategy.

[Quality measurement \(Sec. 3014\)](#)

Provides \$20 million to support the endorsement and use of endorsed measures by the HHS Secretary for use in Medicare, reporting performance information to the public, and in health care programs.

[Public Reporting of Performance Information \(Sec. 10331 of the Manager's Amendment to HR 3590\)](#)

Requires CMS to develop a "Physician Compare" website.

## INVESTING IN COMPARATIVE EFFECTIVENESS RESEARCH

### [Patient-Centered Outcomes Research \(Sec. 6301\)](#)

Adds integrative health practices to services described and expands conflict of interest. Establish a private, non-profit corporation known as the Patient-Centered Outcomes Research Institute. The institute would assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis. Research would focus on the manner in which health conditions can effectively be prevented, diagnosed and treated.

### [Federal Coordinating Council for Comparative Effectiveness Research \(Sec. 6302\)](#)

Terminates the Federal Coordinating Council for Comparative Effectiveness Research

## IMPROVING LONG-TERM CARE SERVICES

### [Funding to expand State and Aging and Disability Centers \(Sec. 2405\)](#)

Appropriates, to the Secretary of HHS, \$10 million for each of FYs 2010 through 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives.

### [Sense of the Senate regarding long-term care \(Sec. 2406\)](#)

Expresses the Sense of the Senate that during the 111<sup>th</sup> Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need, in the community as well as institutions.

### [Establishment of national voluntary insurance program for purchasing community living assistance services and support \(CLASS program\) Sec. 8002](#)

Establishes a new, voluntary, self-funded public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations.

### [Elder Justice Act \(Secs. 6701-6703\)](#)

Requires the Secretary of HHS, in consultation with the Departments of Justice and Labor, to award grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. Owners, operators, and certain employees of these facilities would be required to report suspected crimes committed at a facility. Owners or operators of such facilities would also be required to submit to the Secretary and to the State written notification of an impending closure of a facility within 60 days prior to the closure. In the notice, the owner or operator would be required to include a plan for transfer and adequate relocation of all residents.

## MEDICARE BENEFICIARY ACCESS TO PREVENTION AND OTHER BENEFITS

### Closing the Medicare prescription drug “donut hole” (Sec. 3301 and Sec. 1101\*)

Provides a \$250 rebate for all Medicare Part D enrollees who enter the donut hole in 2010. Builds on pharmaceutical manufacturer’ 50% discount on brand-name drugs beginning in 2011 to completely close the donut hole with 75% discounts on brand-name and generic drugs by 2020.

### Medicare coverage of annual wellness visit providing a personalized prevention plan (Sec. 4103)

Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services. Such services would include a comprehensive health risk assessment.

### Removal of barriers to preventive services in Medicare (Sec. 4104)

This section would waive beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100% of the costs. Services for which no coinsurance or deductible would be required are the personalized prevention plan services and any covered preventive service if it is recommended with a grade of A or B by the U.S. Preventive Services Task Force.

### Evidence-based coverage of preventive services in Medicare (Sec. 4105)

This section would authorize the Secretary to modify the coverage of any currently covered preventive service in the Medicare program to the extent that the modification is consistent with U.S. Preventive Services Task Force recommendations and the services are not used for diagnosis or treatment.

### Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries (Sec. 4202)

The goal of this program is to improve the health status of the pre-Medicare eligible population to help control chronic disease and reduce Medicare costs. The CDC would provide grants to States or large local health departments to conduct pilot programs in the 55-64 year old population. Pilot programs would evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk. Pilot programs would be evaluated for success in controlling Medicare costs in the community. Additionally, CMS would conduct a comprehensive assessment of community-based disease self-management programs that help control chronic diseases. The Secretary would then develop a plan for improving access to such services for Medicare beneficiaries.

**\* As amended by The Health Care and Education Reconciliation Act**