

## Comprehensive Healthcare Reform Legislation Side-by-Side

Provision	Senate Finance Committee America's Healthy Future Act of 2009 (ACS Does Not Support)	House Bill America's Affordable Health Choices Act, H.R. 3200 (ACS Supports)
<b>Use of SGR to Determine Medicare Payment</b>	<ul style="list-style-type: none"> <li>● Does not repeal the flawed SGR formula.</li> <li>● Replaces the scheduled 21.5% Medicare payment cut with a 0.5% increase in 2010.</li> <li>● Medicare payments face a 26%+ reduction in 2011.</li> </ul>	<ul style="list-style-type: none"> <li>● Permanently repeals the flawed SGR formula.</li> <li>● Updates the physician fee schedule conversion factor in 2010 by the percentage increase in the MEI.</li> <li>● Updates in 2011 and beyond determined by new SGR structure comprising two categories of physician services with separate expenditure target: 1) E/M at GDP plus 25 and 2) all other services at GDP plus 1%.</li> </ul>
<b>Bonus Payments for Generalist Services</b>	<ul style="list-style-type: none"> <li>● Institutes budget neutrality to pay for 10% bonus payments to primary care physicians and general surgeons in health professional shortage areas. Half of bonuses would be offset through cuts to all other physicians and surgeons beginning in 2011.</li> </ul>	<ul style="list-style-type: none"> <li>● No budget neutrality.</li> <li>● Effective January 1, 2011, mandates 5% payment bonus for E/M services and such other physicians' services as the Secretary of HHS determines are associated with ensuring accessible, continuous, coordinated, and comprehensive care when provided by a generalist physicians and practitioners.</li> <li>● 10% bonus for practitioners in health professional shortage areas.</li> </ul>
<b>Medicare Commission</b>	<ul style="list-style-type: none"> <li>● 15-member commission appointed by the President.</li> <li>● Requires Congress to reduce growth of Medicare cost by a determined percentage annually beginning in 2015.</li> <li>● Hospitals "carved-out" of commissions' purview - limited to Part B providers.</li> </ul>	<ul style="list-style-type: none"> <li>● No provision.</li> </ul>
<b>Physician Feedback Program</b>	<ul style="list-style-type: none"> <li>● In 2012, Secretary required to provide reports comparing physician resource use. 5% penalty begins in 2014 if use is above 90 percentile of national utilization.</li> </ul>	<ul style="list-style-type: none"> <li>● No provision.</li> </ul>
<b>PQRI</b>	<ul style="list-style-type: none"> <li>● Mandatory.</li> <li>● 1% bonus in 2010 and 0.5% bonus in 2011.</li> <li>● Penalties for non-participation begin in 2013 with a 1.5% reduction.</li> <li>● 2% penalty for non-participation in 2014 and beyond.</li> <li>● New participation option: qualifies eligible professional if they participate in a qualified American Board of Medical Specialties (MOC) and complete a qualified MOC practice assessment.</li> <li>● Timely feedback on reports.</li> <li>● Provides a reasonable appeals process.</li> </ul>	<ul style="list-style-type: none"> <li>● Remains voluntary.</li> <li>● Bonus extended until 2012.</li> <li>● 2012 plan to integrate PQRI measures with meaningful use of EHRs.</li> <li>● Timely feedback on reports.</li> <li>● Appeals process established.</li> </ul>
<b>Provider Screening Fee</b>	<ul style="list-style-type: none"> <li>● All providers required to pay \$350 application fee to be screened before granted Medicare billing privileges.</li> </ul>	<ul style="list-style-type: none"> <li>● No provision.</li> </ul>
<b>Medical Liability Reform</b>	<ul style="list-style-type: none"> <li>● Expresses sense of the Senate that: health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance and states should be encourage to develop and test ADR.</li> </ul>	<ul style="list-style-type: none"> <li>● New provision would provide incentive payments to states that enact or implement ADR mechanisms. HHS Secretary will determine effectiveness of ADR programs in preventing and/or prompting fair resolution of disputes and access to affordable liability insurance.</li> </ul>

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<b>Trauma and Emergency Services</b>	<ul style="list-style-type: none"> <li>● No provision in Senate Finance. Provisions similar to H.R. 3200 in Senate HELP legislation.</li> </ul>	<ul style="list-style-type: none"> <li>● Authorizes the ECCC and a Council on Emergency Care.</li> <li>● Establishes emergency care regionalization pilot projects.</li> <li>● Supports and expands emergency medicine research.</li> <li>● Provides financial support to economically challenged trauma centers.</li> </ul>
<b>Misvalued Codes</b>	<ul style="list-style-type: none"> <li>● Requires HHS Secretary to periodically identify potentially misvalued physician services and to make adjustments to the relative values of such services under the Medicare physician fee schedule.</li> </ul>	<ul style="list-style-type: none"> <li>● Requires HHS Secretary to periodically identify and review potentially misvalued codes and to make adjustments in the relative value units (RVUs), including consolidating individual services into bundled payments.</li> <li>● Requires that the HHS Secretary establish a process to validate RVUs,</li> </ul>
<b>Public Health Plan Option</b>	<ul style="list-style-type: none"> <li>● No public plan option.</li> <li>● Establishes not-for-profit member-owned cooperatives to compete with private insurers.</li> </ul>	<ul style="list-style-type: none"> <li>● Creates public health insurance option.</li> <li>● Allows providers to negotiate rates.</li> <li>● Providers are not required to participate.</li> <li>● Provides a 5% bonus payment for providers who participate in both Medicare and the public plan and for pediatricians and other physicians who do not typically participate in Medicare.</li> </ul>
<b>Payment for Imaging Services</b>	<ul style="list-style-type: none"> <li>● Raises the presumed utilization rate assumption for calculating payment for advanced imaging equipment from 50% to 65% for 2010 to 2013 and to 75 percent beginning in 2014.</li> <li>● Ultrasound is excluded from increase.</li> <li>● HHS Secretary would be required to study the estimated impact of the utilization rate change.</li> </ul>	<ul style="list-style-type: none"> <li>● Changes the presumed rate of utilization of imaging equipment used to compute the number of practice expense RVUs from 50% to 75%.</li> <li>● Ultrasound is excluded from increase.</li> <li>● Increases the payment deduction applicable to the technical component of certain imaging services when multiple imaging procedures involving contiguous body parts are performed in a single session.</li> </ul>
<b>Physician Referrals to Hospitals</b>	<ul style="list-style-type: none"> <li>● Eliminates "whole hospital" and rural exceptions to the general ban on self-referrals. Create new exemption for hospitals that have physician ownership and a Medicare provider agreement in effect on November 1, 2009.</li> <li>● Provides rules on how exempt hospitals should address.</li> </ul>	<ul style="list-style-type: none"> <li>● Requires hospitals to report detailed information on physician ownership and investment and to publicly disclose physician ownership/investment interests.</li> <li>● Requires referring physician owners/investors to disclose their ownership or investment interest to patients being referred.</li> <li>● Fine for each failure to disclose set at \$10,000/day.</li> </ul>
<b>Graduate Medical Education</b>	<ul style="list-style-type: none"> <li>● Redistributes unused residency slots to increase training, particularly in primary care and general surgery.</li> </ul>	<ul style="list-style-type: none"> <li>● Reduces authorized residency levels if an institution's actual residency level for any of three most recent reporting periods is less than authorized by 90% of the difference between actual and authorized levels. Unused slots would be redistributed to primary care.</li> </ul>

Key: ADR: alternative dispute resolution; ACGME: Accreditation Council on Graduate Medical Education; AMA: American Medical Association; CME: continuing medical education; CMS: Centers for Medicare & Medicaid Services; DRG: diagnosis-related group; ECCC: Emergency Care Coordination Center; E/M: evaluation and management services; FPL: federal poverty level; FY: fiscal year; GDP: gross domestic product; HELP: Health, Education, Labor and Pensions Committee (Senate); HIE: Health Insurance Exchange; HHS: U.S. Dept. of Health & Human Services; MEI: Medicare Economic Index; MOC: maintenance of certification; PPS: prospective payment system; PQRI: Physician Quality Reporting Initiative; RVUs: relative value units; SCHIP: State Children's Health Insurance Program; SGR: sustainable growth rate.

**Note: If you have any additional questions, please email Kristen Hedstrom, Assistant Director, Legislative Affairs at [khedstrom@facs.org](mailto:khedstrom@facs.org).**

**The table was last updated on October 9, 2009.**