



THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

Summary of U.S. Senate Finance Committee Description of Policy Options

Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs

Payment Reform—Improving Quality and Promoting Primary Care

Hospital Value-based Purchasing (VBP)—The paper proposes establishing a VBP program to pay hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in federal fiscal year (FY) 2013.

- The VBP program would apply to all acute-care prospective payment system (PPS) hospitals. Certain hospitals would be excluded, including those that do not have a sufficient number of patients within the related conditions.
- Measures would be selected from those used in the Medicare pay-for-reporting program, including measures for heart attack, heart failure, pneumonia, and surgical care, and measures assessing patients' experience of care. The Secretary of the Department of Health and Human Services (HHS) would have the discretion to expand the list after the first year. It is unclear whether the measures would need to be endorsed by the National Quality Forum (NQF) or adopted by the Hospital Quality Alliance (HQA).
- The first year of the program, FY 2012, would be a data collection year.
- Funding for the program would be generated by reducing all Medicare inpatient PPS Medicare-severity diagnosis-related group (MS-DRG) payments to participating hospitals by 2 percent during FY 2013; the reduction would grow each year until the funding is 5 percent in FY 2016 and beyond.
- The reduction would be applied to all MS-DRGs but would not affect disproportionate share, indirect medical education, low-volume adjustment, or outlier payments.
- A hospital's single, composite performance score would be used to determine whether the hospital meets the overall performance standard.
- A hospital would be rewarded for quality improvement or quality attainment, whichever level is higher.
- A hospital that meets or exceeds the performance standard would be eligible to earn back the initially withheld money. A hospital with a score in the bottom 25th percentile would receive no VBP payment. A hospital with a score in the 26th to 75th percentile would receive payment based on a sliding scale, while a hospital with a score above the 75th percentile would receive its total withheld amount.
- Unused incentive funds would be returned to the Medicare Trust Fund.
- Demonstration projects would be created to test VBP models for critical access hospitals and small hospitals that did not qualify for the VBP program.





Inpatient Rehabilitation Facility (IRF) Quality Reporting—The proposal would direct the Secretary to establish a quality reporting program for IRFs by selecting quality measures by 2011 and implementing a mandatory quality reporting program by 2012. Selected quality and efficiency measures would be endorsed by a consensus-based entity identified by the Secretary.

Long-term Acute Care Hospital (LTCH) Quality Reporting—The proposal would direct the Secretary to establish a quality reporting program for LTCHs by selecting quality measures by 2011 and implementing a mandatory quality reporting program by 2012. Selected quality and efficiency measures would be endorsed by a consensus-based entity identified by the Secretary.

Home Health Agency (HHA) VBP Implementation Plan—In consultation with stakeholders, the Secretary would be directed to develop a Medicare VBP implementation plan for HHAs by FY 2011. The plan would consider development and selection of measures, collection, and information reporting of data, the structure of the payment adjustment, and the disclosure of performance.

Skilled Nursing Facility (SNF) VBP Implementation Plan—In consultation with stakeholders, the Secretary would be directed to develop a Medicare VBP implementation plan for SNFs by FY 2012. The plan would consider development and selection of measures, collection, and information reporting of data, the structure of the payment adjustment, and the disclosure of performance.

Physician Quality Reporting—The options included modifying the physician quality reporting initiative (PQRI) to:

- Allow eligible professionals to receive incentive payments if they participate in a qualified American Board of Medical Specialties maintenance of certification program (or an equivalent program), and complete a maintenance of certification practice assessment.
- Establish an appeals process for providers who participated in the program but did not qualify for incentive payments.
- Require the Centers for Medicare & Medicaid Services (CMS) to provide more timely feedback to providers about their performance.
- Require CMS to calculate incentive payments without regard to the existing geographic adjustments in the physician fee schedule.

Additionally, the proposal contains two options for extending the PQRI incentive program beyond 2010 to currently eligible professionals (physicians, nurse practitioners, physician assistants, clinical psychologists, and therapists). The first option would extend the 2 percent bonus payment through 2011 and 2012, and would initiate a 2 percent payment penalty during 2013 and 2014 to nonparticipating eligible professionals. If less than 85 percent of eligible professionals are participating during that time, the Secretary would increase the payment penalty by one percentage point each year (up to a 5 percent cap) until 85 percent of eligible professionals are participating.

The second option would provide a 2 percent bonus payment during 2011 only, with a non-participation penalty of 1 percent for 2012. While unclear, it appears there would be a 2 percent reduction during 2013 and 2014. If less than 85 percent of eligible professionals are participating



during that time, the Secretary would increase the payment penalty by one percentage point each year (up to a 5 percent cap) until 85 percent of eligible professionals are participating.

Transparency of Imaging Services and Adherence to Appropriateness Criteria—The draft options paper proposes to require physicians to disclose their financial interests in certain imaging services beginning January 1, 2010. A physician providing imaging services through the in-office ancillary services exception would need to inform a patient in writing during the time of referral that the patient could obtain services from another provider. The physician also would be required to supply the patient with a list of other area providers offering imaging services.

Also effective during calendar year (CY) 2010, the Secretary would designate national appropriateness criteria and imaging use measures for certain services. During CY 2011, the Secretary would develop a confidential feedback program on physician adherence patterns. Also in this year, the Secretary would establish a Diagnostic Imaging Exchange Network to assist physicians in assessing the appropriateness of imaging studies and would equip physicians and other providers with health information technology-enabled systems to access a patient’s entire imaging history prior to ordering an imaging study.

Using CY 2011 data, during CY 2013, the Secretary would identify ordering physicians who are outliers for inappropriate ordering, and would lower payments to these physicians by instituting a 5 percent reduction in the conversion factor. This reduction would be applied to all services furnished by outlier physicians during that year.

Primary Care and General Surgery Bonus—Certain providers who furnish at least 60 percent of their services in specified ambulatory settings would receive at least a 5 percent bonus payment above the fee schedule amount for certain “evaluation and management services” provided in offices, nursing homes and patient homes. Additionally, general surgeons practicing in newly defined rural general surgeon scarcity areas would be paid an unspecified bonus amount. Both bonuses would be budget neutral and effective for five years, starting during January 2010. Budget neutrality would be achieved either by an across-the-board reduction in payments for all other fee schedule services or, alternatively, paid for through “funding from other sources,” requiring new offsets to be found.

Payment for Transitional Care Activities—Medicare would provide payment to physicians for certain care management activities performed by nurse care managers (or other qualified non-physician professionals) to chronically ill patients hospitalized during last six months for six conditions— congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, asthma, diabetes, and depression. These services would include such things as care management, diabetes education, and self-management support. Physicians would be able to hire care managers directly or contract with care managers in their communities.

A “modest” supplemental incentive payment would be made to a primary care practice for each patient discharged from the hospital with certain major chronic conditions when the patient receives at least one currently covered evaluation and management service, or one of the newly covered care management services within 30 days of hospital discharge and is not readmitted within 60 days for a



chronic disease. The committee is seeking input about whether this policy should be expanded to include care coordination payments for beneficiaries with high-cost, chronic illnesses who are at highest risk for hospitalization.

Long-term Payment Reform—Fostering Care Coordination and Provider Collaboration

Chronic Care Management—The proposal would direct the Secretary to establish at CMS a Chronic Care Management Innovation Center that would test payment innovations designed to improve quality while decreasing or maintaining costs for Medicare patients with multiple, chronic illnesses. The payment models being tested would initially begin with pilots, but the Secretary would be given authority to expand the duration and scope of each project as the Secretary sees fit, once the initial pilot has been evaluated and found successful. Examples of models that might qualify include the medical home, transitional care teams, and patient-physician shared decision-making aids.

Hospital Readmissions and Bundling—The proposal seeks to establish a readmission and post-acute care bundling policy to encourage greater coordination of care among acute and post-acute care providers.

Regarding readmissions:

- Starting during 2010, CMS would calculate national and hospital-specific data on the readmission rates of PPS hospitals for eight conditions with the highest volume and the highest rates of readmissions. It appears that the selection of the eight conditions would be left to the discretion of the Secretary, and that the Secretary would be given the authority to update the list as he or she deems appropriate. In doing so, the Secretary would consider those conditions with significant variation in readmission rates.
- During 2011, CMS would provide data to hospitals on their risk-adjusted readmission rates, and how those rates relate to a national average readmission benchmark for each selected condition.
- The readmissions benchmark would include all readmissions due to complications or related conditions, but would exclude readmissions that are not “potentially preventable.” The Secretary would determine which readmissions are not potentially preventable, such as planned readmissions, readmissions related to cancer or burn care, scheduled surgeries, or others deemed appropriate.
- The policy would count all hospital readmissions, even when a patient is readmitted to a different hospital, in which case the readmission would count toward the original hospital’s readmission rate.
- Starting during FY 2013, hospitals with readmission rates above the 75th percentile for selected conditions would be subject to a 20 percent payment withhold for the selected MS-DRGs. This withhold would be based on the prior year’s performance.



- If a patient assigned to the relevant MS-DRG during FY 2013 was not readmitted within 30 days for a “preventable” readmission, the full payment would be restored for that patient. If a patient were readmitted for a preventable readmission, the money would be returned to the Medicare Trust Fund.
- The readmission policy would not apply to any condition that is included in the bundled payment (below), and the readmission policy would expire once the bundled payment policy is fully implemented during FY 2019.

Regarding bundling:

- Starting during FY 2015, acute inpatient hospital services and post-acute care services—including HHA, SNF, IRF, and LTCH services—occurring or initiated within 30 days of the acute hospital discharge, would be paid through a bundled payment.
- Physician services would be excluded from the bundle.
- The bundling policy would be implemented through a three-stage process beginning during FY 2015 and ending by FY 2019:
 - Phase 1, beginning in FY 2015, would apply bundling to those conditions that account for the top 20 percent of post-acute care spending. These conditions would be determined by the Secretary, but would include a mix of chronic and acute conditions, a mix of surgical and medical conditions, and conditions with significant variation in readmission.
 - Phase 2, beginning in FY 2017, would apply bundling to those conditions that account for the next 30 percent of post-acute care spending.
 - Phase 3, beginning in FY 2019, would apply bundling to all other conditions that account for the remaining 50 percent of post-acute care spending.
- Consequently, by FY 2019, all hospital/post-acute care services would be paid in a bundle. The payment for the bundle would be the inpatient MS-DRG amount plus post-acute care costs of treating patients in that MS-DRG, plus expected or planned readmissions within the 30-day post-acute time frame, adjusted for efficiencies that are expected to be gained from improved care coordination.
- The bundled payment would be made to one entity, such as a hospital or other organizing entity (such as non-profits that include the hospital and post-acute care provider), as long as the hospital is involved.
- CMS would waive certain applicable laws to implement these policies and would develop patient protection rules to ensure patients receive appropriate post-acute care and that access to care is maintained. CMS also would examine payment rules in the existing post-acute payment system to determine if modifications are needed to allow proper coordination and care management of patients.

Accountable Care Organizations (ACOs)—Beginning during 2012, groups of qualifying providers—such as individual physician practices, physician group practices, hospital-physician joint ventures, and hospitals employing physicians—would be allowed to voluntarily form ACOs and have the opportunity to share in the cost savings they achieve for the Medicare program.



To qualify as an ACO, an organization would have to meet several criteria. For example, it must:

- Agree to a minimum two-year participation.
- Have a formal legal structure enabling it to receive and distribute bonuses to participating providers.
- Include the primary care providers of at least 5,000 Medicare beneficiaries.
- Have contracts in place with a core group of specialist physicians.
- Have a management and leadership structure in place that allows for joint decision-making.
- Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.

To earn incentive payments, ACOs must meet certain quality thresholds and, as organizations, have total Medicare expenditures that are at least 2 percent below their benchmark. Reporting measures would be set by CMS and include: (1) clinical processes and outcomes; (2) patient perspectives on care; and (3) utilization and costs. The ACO would then be able to share in 50 percent of the savings generated to the Medicare program. Benchmarks would be based on the past per-beneficiary spending of the beneficiaries that belong to the ACO, increased by the national growth rate in fee-for-service Medicare program. Beneficiaries would be assigned by CMS to ACOs based on the physicians from whom they received the most primary care the previous year, but the assignments would be only for the purpose of assessing ACO performance—beneficiaries would still be free to seek care from any provider.

The committee is considering a number of design issues, including establishing certain targeted growth rates, capping the rate of shared savings, allowing these entities to receive full or partially capitated payment, and targeted relief from legal or regulatory impediments to provider cooperation.

Sustainable Growth Rate (SGR)—The committee draft proposes two options to fix the SGR problem under the physician fee schedule (PFS). The first option provides a 1 percent update for CY 2010 and CY 2011, a zero percent update for CY 2012, and then reverts back to current law for the update for CY 2013 and beyond. The second option would implement the same schedule of updates for CY 2010-2012, but would place a floor of negative 3 percent in effect for CY 2013. Beginning during CY 2014, the PFS update for localities with two-year average fee-for-service growth rates at or greater than 110 percent of the national average would have a negative 6 percent floor.

Health Care Quality Demonstration Program—The proposal would make permanent the Medicare Health Care Quality (MHCQ) Demonstration Program, as established in Section 646 of the Medicare Modernization Act (MMA), a five-year demonstration program that allows certain physician groups, integrated health care delivery systems, or regional coalitions to implement alternative payment systems and benefit packages to encourage improvements in patient care quality. Under this demonstration program, the Secretary has the authority to waive provisions of the Stark, anti-kickback and civil monetary penalties statutes, so that hospitals can reward physicians for efficiencies achieved in the care of patients. The proposal would give pilot project authority to the Secretary, and the program would have to include multi-payer projects. The program would allow the Secretary to expand the scope and duration of MHCQ projects, as long as the expansion is expected to improve



the quality of patient care without increasing spending or reduce spending without decreasing quality of care.

Health Care Infrastructure Investments

Health Information Technology (IT)—The options document considers additional investments in health IT beyond those contained in the American Recovery and Reinvestment Act (ARRA). First, it considers expanding eligibility for the physician electronic health record Medicare incentive payments to include nurse practitioners and physician assistants who practice outside of a physician’s office. Second, the committee seeks input about providing health IT incentives to post-acute care providers and others not included in the ARRA. The committee also inquires as to whether additional financial incentives are needed within Medicare to support care coordination and quality improvement efforts related to VBP and chronic care management and bundling, as outlined elsewhere in the options document.

Improving Quality Measurement—The options paper proposes to provide additional resources to HHS to strengthen and improve quality measurement and development. It would require the Secretary to submit a biennial report to Congress about national priorities for improvement, as well as strategies for achieving those improvements, and a status report about reaching those goals. The proposal would expand HHS’ current contract with the NQF to convene a multi-stakeholder group to provide guidance about national priorities and convene a multi-stakeholder group to guide the Secretary in selecting measures for public reporting and/or for payment purposes. The measures are to be applicable to all patients, free, and focused on patient outcomes, care coordination, meaningful use of IT, efficiency, equity, patient experience of care, and other issues.

Comparative Effectiveness Research (CER)—The document includes two options to establish a permanent framework for CER. The first option would continue to fund existing HHS entities through annual appropriations (similar to the ARRA). However, the second option would create an independent institute outside the government to be led by a multi-stakeholder board. It is envisioned that such an institute could contract with the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), and other federal and private entities to conduct CER. This proposal is similar to that outlined by Sen. Baucus in the Comparative Effectiveness Research Act of 2008 (S. 3408, introduced in the 110th Congress).

Additionally, the paper calls for the establishment of an independent expert committee (whether formed by HHS or the institute) to develop methods and standards for CER to ensure credible and objective research. The paper also calls for measures to ensure transparency of research and stakeholder input in all steps of the process. The committee suggests that the entity conducting the research be prohibited from issuing medical practice recommendations or from making reimbursement or coverage decisions.

A number of funding options for CER are discussed, including using annual appropriations, general revenues, contributions from Medicare trust funds, or an assessment on private insurance.



Physician Self-referral—The paper proposes that the current “whole hospital” and rural exceptions be repealed under the Ethics in Patient Referrals Act, better known as the “Stark” law. They would be replaced by an exception for physician-owned hospitals with a Medicare provider number as of July 1, 2009. These hospitals would be “grandfathered” and allowed to continue to self-refer, subject to certain conditions. This new grandfathering exception includes several conditions for those physician-owned hospitals such as:

- Ethical investment practice rules to ensure bona fide investment and proportional returns on investment.
- Disclosure of physician ownership interests in hospitals to patients at the point of referral and again at the earliest point of an admission, to the public through notices on the hospital’s website, and in reporting to CMS, which is charged with providing ownership information on their website.
- Patient safety requirements to ensure that such hospitals are capable of responding appropriately to complications or emergencies and safely transferring patients who need care beyond their ability, as well as patient disclosure at admission if the hospital does not have 24-hour/7-day onsite physician coverage.
- Required approval by HHS of any increase in the number of operating rooms, procedure rooms and beds, as well restrictions on growth overall and conditions that must be met.

Transparency

Nursing home transparency—The committee proposes a number of significant changes to improve transparency of information about SNFs and nursing homes, including: disclosure of ownership, implementation of an ethics and compliance program, creation of a quality assurance and performance improvement program, public reporting of staffing data, standard complaint forms, civil monetary penalties for deficiencies that would harm patients, and demonstration projects on use of IT.

Physician payment sunshine—The committee proposes requiring transparency in the relationship between physicians and applicable manufacturers or related group purchasing organizations with respect to payments and other transfers of value and physician ownership or investment interests in manufacturers. It would require the reporting and public display of these relationships, and it would impose civil monetary penalties for failures to disclose relationships.

Graduate Medical Education (GME)—The committee draft proposes to redistribute unused GME slots to increase access to primary care and general surgery. Specifically, it proposes to reallocate 80 percent of unused slots, and allows hospitals to request up to 50 new slots. Seventy-five percent of new slots would be designated for primary care or general surgery for five years. Slots would be redistributed based on a set of criteria, such as whether the receiving hospital is in a health professional shortage area. While it is unclear, it appears that the newly reallocated slots would be subject to the same indirect medical education (IME) and direct GME payment formulas as previous resident slots.



The committee requests input on ways to provide more flexibility in law and regulations governing Medicare GME to encourage greater training in outpatient settings, and to ensure residency programs in rural and underserved areas.

National Workforce Strategy Development—The committee will be working with the Senate Health, Education, Labor, and Pensions (HELP) Committee to develop a comprehensive strategy to address workforce shortages. This may include creating a national health workforce commission to advise Congress and HHS about policy and recommendations. At a minimum, the committee calls on the Secretary to work with external stakeholders to plan a path towards recruiting, training, and retaining a robust workforce.

Medicare Advantage (MA)—Options to Promote Quality, Efficiency, and Care Management

MA Plan Quality—The document proposes linking an undefined portion of MA payment to plan performance on quality measures. It suggests utilizing CMS' current five-star plan rating system, which is based on performance measures and consumer satisfaction data.

Plan Benchmarks—The committee discusses a number of options for modifying the current MA benchmarks to encourage MA plans to provide benefits more efficiently and to promote improvements in quality care.

Their first approach would modify how the current benchmarks are calculated:

Blending benchmark rates—This option would blend local and national fee-for-service spending. Specifically, it would set the MA benchmark at 75 percent of local spending and 25 percent national spending on traditional Medicare, phased-in over three years beginning during CY 2012.

Benchmark reduction and gradual phase-down to a target ratio—This option would gradually reduce the MA benchmark from CY 2011 to 2014, but would implement different formulas based on the MA plan location and the counties' current MA-to-fee-for-service expenditure ratio. This option also would include a 2 percent reduction in plan payments for those plans that do not emphasize primary care, utilization of health IT, and VBP.

The second approach would rely on competitive bidding to set the benchmarks:

Competitive bidding—Similar to the President's budget proposal, this option calls for the MA benchmarks to be set by MA plan bids rather than by the Secretary.

Competitive bidding with bonus payments—This option would be similar to the above, but phases in the new benchmarks over three years, and would provide bonus payments for achieving quality improvement targets and implementing evidence-based chronic care management programs.



MA Funding for Chronic Care Management—The committee is considering paying plans a 3-5 percent bonus for chronic care management activities, such as having a medical home, gain sharing with primary care providers, or for achieving quality improvement targets.

MA Benefits—The committee indicates a desire to reduce the variation in amount and type of extra benefits offered by MA plans. It suggests requiring that extra funds be used to limit beneficiary cost-sharing before being used for new benefits.

Public Program Integrity—Options to Combat Fraud, Waste, and Abuse

Provider Screening—Applications for Medicare provider enrollment would be expanded to include more required information (as determined by the Secretary). A fee would be assessed to pay for screening costs, and penalties would be applied for false statements made on the application. New providers would be granted a provisional participation agreement with enhanced oversight, such as prepayment review and payment limitations.

Database Creation and Data Matching—CMS would be required to establish a new comprehensive program integrity (“One PI”) database. The new single database would allow for the integration of existing and new sources of data, including survey and certification data, encounter data and adverse actions data. It would enhance sharing of claims and payment data across federal and state Medicaid programs, as well as across other federal departments (HHS, the Social Security Administration, the Departments of Veterans Affairs, Defense, and Justice, and the Federal Employees Health Benefit Program).

Provider Compliance and Penalties—Medicare and Medicaid providers, as a condition of participation, would be required to have a compliance program in place that includes the full range of requirements such as health and safety standards, accreditation standards, and adherence to federal law on false and fraudulent claims. Civil Monetary Penalties (CMP) law would be expanded. Penalties for false claims and EMTALA violations would be increased.

Program Integrity Funding and Reporting Requirements—Funding would be increased for Medicare and Medicaid program integrity and anti-fraud activities, as well as for better coordination of reporting requirements between the two programs.