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Senate Finance Committee Policy Options Paper Delivery System and Payment Reform

On April 28, the Senate Finance Committee released the first of three policy options papers entitled, *Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*. The document outlines an incremental approach to delivery system and payment reform and includes many of the topics that have been considered at the recent Finance Committee roundtable, including a bonus for primary care, care coordination, quality and health information technology.

Section I: Payment Reform – Options to Improve the Quality and Integrity of Medicare Payment Systems

- Establish a hospital value-based purchasing (VBP) program that would move from paying for reporting on quality measures to paying for hospitals' actual performance on these measures beginning in FY2013. Value-based incentive bonuses would be awarded on a sliding scale basis depending on levels of performance. Hospital performance would be publicly reported.
- Medicare VBP implementation plans for home health agencies and skilled nursing facilities would be in place by 2011 and 2012, respectively.
- New PQRI participation options would be available to physicians. CMS would be required to establish an appeals process, provide more timely feedback and calculate incentive payments without regard to the existing geographic adjustments in the physician fee schedule. The Committee is considering two options for extending PQRI incentive payments:
 1. The 2 percent bonuses would be extended through 2011 and 2012. For the years 2013-2014, eligible professions who failed to participate successfully in the program in 2012 and 2013 would face a 2 percent penalty which would be assessed annually and would not be cumulative. The Secretary would increase the penalty by 1 percent per year (to a max of 5 percent in one year) until 85 percent of eligible professionals comply.
 2. This option would be identical to option 1 except the incentive payments would only be available in 2011 and a non-compliance penalty of 1 percent would begin in 2012. The 2012 and 2013 non-compliance penalties would remain 2 percent, as would the requirement for the Secretary to increase the penalty.

- Physicians would be required to disclose financial interests in office-based imaging services as of January 1, 2010. The Secretary would be required to formulate appropriateness criteria and use measures in 2010 and an education and confidential feedback program in 2011.
- Providers furnishing at least 60 percent of their services in specified primary care setting would receive a 5 percent bonus for providing specified evaluation and management services. This provision would be in effect for five years. General surgeons practicing in rural general surgery scarcity areas would also receive a 5 percent bonus. These bonus payments would be budget neutral and be offset by across the board cuts to all over codes.
- Provides reimbursement to primary care physicians and practices for certain care management activities provided by nurse care managers. These services would only be paid for beneficiaries who have been discharged from the hospital in the previous 6 months for a stay related to specified chronic diseases.

Section II: Long Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration

- CMS would establish a Chronic Care Management Innovation Center (CCMIC) to test and disseminate payment innovations that foster patient-centered care coordination. A Medicare Rapid Learning Network would also be established within the CCMIC for smaller-scale evaluation of emerging evidence-based care management models.
- CMS would establish hospital readmission benchmarks for the eight conditions with the highest volume and the highest rates of readmission. Beginning in FY 2013, payments to hospitals with readmission rates above the 75th percentile for selected conditions would be cut by 20 percent. This policy would expire when the bundled payment policy is fully implemented.
- Beginning in FY 2015, services within 30 days of discharge would be paid through a bundled payment. The bundled payment which would be implemented in three phases would be calculated as the inpatient amount plus post-acute care costs.
- SGR Reform Options:
 1. Update the fee schedule by 1 percent in 2010 and 2011 and by 0 percent in 2012. Updates would revert to the current law for 2013.
 2. Includes the same schedule of updates for 2010-12 as option 1, but once the update calculation reverts to current law, a floor of -3 percent would be applied. Beginning in 2014, the update for localities with 2 year average FFS growth rates at or greater than 110 percent of the national average would have a -6 percent floor.



- Beginning in 2012, groups of providers (including accountable care organizations) would be able to share the cost-savings they achieve in Medicare. To earn the incentive, organizations would have to meet specified quality thresholds.
- Permanently authorizes the Medicare Health Care Quality Demonstration Program, which examines factors that encourage improved patient care quality. The program must include multi-payer projects and would be given pilot authority.

Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform

- Consider expanding the eligibility for the EHR Medicare incentive payments to include NPs and PAs under certain conditions. Considers providing additional health IT incentives to other health care providers not included in ARRA.
- Provide resources to the Secretary working with AHRQ and CMS to strengthen and improve the quality measurement and development processes. Improvements in these processes would be aligned to support delivery system reform.
- Consider options to establish a long-term or permanent framework to set national priorities for comparative clinical effectiveness research and to provide for the conduct of such research, outlining that this can be done by funding existing HHS entities or by establishing a private, non-profit corporation.
- Require the submission of payment and ownership information and procedures to make the information about the relationship between physicians and applicable manufacturers public.
- Eliminate the “whole” hospital and rural exceptions to the general ban on self referral. Create a new exception for hospitals that physician ownership and a Medicare provider agreement in effect on July 1, 2009.
- Improve transparency of information about SNF and nursing homes, enforcement of SNF and nursing home standards and training of SNF and nursing home staff.
- Establish a re-distribution of currently unused residency training slots to encourage increased training, particularly in the areas of primary care and general surgery. 80 percent of unused slots would be included in a pool for redistribution (rural teaching hospitals would be exempt from the redistribution). 75 percent of the new slots would be allocated towards primary care and general surgery residency training positions for at least 5 years.
- Provide more flexibility in laws and regulations governing GME funding to promote training in outpatient settings and to ensure the availability of residency programs in rural and underserved areas.



- Provide competitive awards for research and demonstration projects to provide disadvantaged parents with the opportunity to obtain education and training for occupations in the health care field that are expected to either experience labor shortages or be in high demand.
- Direct the Secretary to work with stakeholders to develop a national workforce strategy that will improve the recruitment, training and retention of a health workforce that meets current and future health care needs.

Section IV: Medicare Advantage – Options to Promote Quality, Efficiency and Care Management

- Tie some portion of payment to MA plans to quality.
- Modify current MA benchmarks to encourage plans to provide benefits more efficiently and promote improvements in quality of care.
- Consider proposals to pay plans a bonus for chronic care management along with competitive bidding.
- Consider reducing the variation in the amount and type of extra benefits offered by MA plans and funded by Medicare.

Section V: Public Program Integrity – Options to Combat Fraud, Waste and Abuse

- Increased funding for cross-agency coordination. Create a new program integrity database and require providers to implement compliance programs.

