HEALTH CAPITAL Topics
Volume 2, Issue 5
May 2009
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Senate Healthcare Reform

Senate Finance Committee Chairman Max Baucus (D-MT) and ranking Republican Charles Grassley (R-IA) published a forty-nine [49] page healthcare policy Report on April 29, 2009 regarding US healthcare reform. The Report, which was the result of a closed-door committee meeting, is intended to lay the groundwork for healthcare reform legislation in the coming year.[1] The Report offered policy suggestions covering a wide-range of topics, including: (1) creation of value based purchasing programs; (2) financial penalties for inappropriate diagnostic procedures; (3) bundling payments for hospital and post-acute care; (4) gainsharing arrangements for physicians; (5) the elimination of Stark's whole hospital and rural exceptions; (6) transparency for physician-supplier relationships; and, (6) the creation of a government-wide, multi-departmental information sharing database used to combat fraud.[2]

Payment Reforms

While hospitals that report quality data through the Reporting Hospital Quality Data for Annual Payment Update (RHQDAP) program receive higher Medicare payments than those who do not submit data, the Report proposed that higher payments be provided to hospitals based on the *actual results* of the quality reporting, i.e., performance. The proposed legislation would provide value-based bonuses to certain hospitals starting in its pilot/research year, FY 2012, with an expanded program with adjusted payments in 2013. Hospitals that participate in the new program would receive a reduction in IPPS payments and Medicare's savings would be deposited into an incentive pool used to distribute quality bonuses. Further, hospitals would be rewarded for attainment and improvement, in addition to the public reporting of their performance.[3] Hospitals that do not currently participate in RHQDAP would be excluded from the incentive program.

The Report also examined the overutilization of diagnostic imaging procedures and proposed that physicians who provide imaging services through the in-office ancillary services exception disclose their financial interest, in writing, to the patient. Further, the Report advised for collaboration amongst professional imaging organizations to establish appropriateness criteria for imaging procedures. Effective in 2011, the proposed program would include an educational and feedback program which would examine current adherence to the appropriateness criteria and would establish additional goals for adherence. By 2013, physicians who have inappropriate imaging usage would receive a five percent reduction to the conversion factor for *all services* provided.[4] Finally, the Report called for the creation of Diagnostic Imaging Networks that allow physicians to collaborate and determine appropriateness of imaging procedures. Both the American College of Radiology (ACR) and the Access to Medical Imaging Coalition support these legislative efforts as they will reduce overutilization and improve patient safety. However, the ACR also noted, that it was not in support of the Report's proposal to use Radiology Benefit Managers to monitor utilization.[5]

Also, the Report included proposals for incentive payments (over and above traditional fee schedule) for primary care physicians who had provided at least sixty percent [60%] of their services in an ambulatory care setting. These physicians would receive a bonus of at least five percent [5%] over the Medicare Physician Fee Schedule rates.[6]

Baucus and Grassley also recommended establishing a Chronic Care Management Innovation Center (CMIC) for testing innovations that provide patient-centered care coordination for the chronically ill. The program would focus on patients with co-morbidities. As a method of fostering care coordination amongst acute hospitals and post-acute providers, the Report also proposed bundling payments for diagnoses that have high levels of readmission within 30 days of initial discharge. Beginning in 2010, CMS would collect data on the eight diagnoses with the highest readmission rates. By 2013, hospitals with readmissions above the 75th percentile would receive a payment withhold of 20% of the Medicare Severity Diagnosis Related Groups (MS-DRG) payment. These hospitals would be reimbursed for the withhold only for patients without preventable readmissions within 30 days of discharge. The ultimate goal of the program is to have a bundled payment for all hospital services and post-acute services provided within 30 days of discharge. The bundled payment would include cost savings from efficiencies and would be intended to cover the current admission and any post-acute care that may be needed, regardless of whether it is actually utilized.[7]

The Report also included a proposal for physicians who meet high quality thresholds to share in the savings they

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create for Medicare, i.e., gainsharing. Participating physicians must agree to participate for two years and agree to report to the Secretary of Health and Human Services (HHS) clinical outcomes, utilization, and costs. Participating organizations would receive 50% of the savings amount they created for Medicare.[8]

Delivery Reform

The Report proposed several options for healthcare delivery reform. First, the Report suggested that incentive payments provided to physicians under the American Recovery and Reinvestment Act (ARRA, also known as the "*Economic Stimulus Package*") be expanded to include nurse practioners and physician assistants. Further, the Report recommended that the Secretary of HHS submit a biennial (every 2 years) report that outlines national priorities ands strategies for HC quality and improvement.

The Report also discussed creating a set of national priorities for comparative clinical effectiveness research that, (1) examine clinical outcomes for disease management, treatment and prevention; (2) examine objective research standards; (3) ensure research is relevant and open to public comment; 4) address and implement safeguards to ensure patient safety; and, (5) increase funding for comparative effectiveness research.

The Report also called for several programs to increase physician pricing and quality transparency. First, it proposed a Physician Payment Sunshine program in which any manufacturer of drug, device, biological, or medical supply company that makes a payment or transfer of value to physician of more than ten dollars to report these payments annually to the Secretary of HHS. The program would begin March 31, 2012 and would include civil monetary penalties of at least $1,000 (not to exceed $10,000) for each transfer or payment not reported. Additionally, the Report recommended that nursing homes submit, on demand, information regarding ownership (direct and indirect) and organizational structure. Nursing homes would also be required to implement compliance and ethics programs; report on employee wages and benefits; standardize complaint forms; and, would be at risk for CMPs if cited by the Secretary of HHS.[9]

One major element of system reform included in the Report was the proposal for the elimination of whole hospital and rural exceptions to Stark Law. Hospitals with physician ownership and a Medicare provider agreement in effect on July 1, 2009, would be grandfathered in. However, even grandfathered hospitals would be subject to the following qualifying requirements[10]:

1) The percent of physician ownership on date of enactment must not increase;
2) Ownership investment opportunities must not be more favorable for physician investors than non-physician investors;
3) The hospital cannot loan money for physician investment;
4) The hospital cannot guarantee, subsidize, or make a payment on a loan to any physician owner or investor for the purpose of acquiring partial ownership of the hospital;
5) Ownership returns must distributed proportional to ownership investment;
6) Compensation cannot include the right to purchase interest in the hospital; and,
7) The hospital does not offer physician owners or investors more favorable opportunities to lease or purchase land than non-physician owners or investors.

Furthermore, grandfathered hospitals would not be allowed to expand the number of operating rooms, procedure rooms, or bed capacity unless the hospital meets *all* of the following[11]:

1) The five-year population growth rate in the county in which the hospital is located, must be at least 150% of the state's population growth rate for that same period;
2) The Medicaid inpatient admission percentage must be greater than or equal to the average Medicaid percentage for all hospitals in the county;
3) The hospital, and its physicians, cannot discriminate against federal healthcare beneficiaries;
4) The hospital must be in a state where the bed capacity is lower than the national average; and,
5) The average bed occupancy rate must be greater than the state's average.

The proposed restrictions would likely restrict patient access (particularly for Medicare and Medicaid patients) to services provided by physicians having ownership interest in hospitals. There are currently 85 physician-owned hospitals under development.[12] If these hospitals do not receive Medicare Certification by July 1, 2009, they will not be eligible for the whole hospital exception, i.e., they would not be allowed to continue to treat Medicare and Medicaid patients if the physicians who own the hospital continue to refer to that hospital. [13]

Medicare Advantage

The Report advised linking payment to Medicare Advantage (MA) plans with quality, thus resulting in higher quality plans receiving higher payments. Further, the Report recommended that current MA benchmarks payment rates be modified to encourage MA plans to provide more efficient and higher quality of care.

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Benchmarks could be modified through one of two approaches: (1) a blend of national and local benchmark rates; or, (2) use benchmarks based on competitive bidding process.[14]

The Report also proposed that MA providers receive a bonus payment for the management of chronically ill patients. Plans with evidence-based programs that manage care in an effective and efficient manner would receive higher bonuses.[15]

Anti-Fraud Initiatives

To aid in the reduction of fraud within the Medicare & Medicaid programs, the Report proposed the creation of a "*One PI*" database that includes data sharing among several government organizations, including HHS, the Social Security Administration (SSA), the Department of Veterans Affairs(VA), the Department of Defense (DOD), and the Department of Justice (DOJ). The database would include information on Medicaid encounters, performance, business relationships, certification as well as information on neglect, penalties, and settlements. All Medicaid and Medicare providers would be included in database and the database could be used to investigate fraud and abuse. Additionally, the Report called for increased funding for Healthcare Fraud and Abuse Control (HCFAC) program.

The Report is the first of several closed-door discussions set to take place throughout the summer.

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[2] "Description of Policy Options – Transforming the Healthcare Delivery System: Proposals to Improve Patient Care and Reduce Healthcare Costs," United States Senate Finance Committee, April 29, 2009, http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf (Accessed 5/6/09)

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[4] "Description of Policy Options – Transforming the Healthcare Delivery System: Proposals to Improve Patient Care and Reduce Healthcare Costs," United States Senate Finance Committee, April 29, 2009, p. 7-9, http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf (Accessed 5/6/09)

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[6] "Description of Policy Options – Transforming the Healthcare Delivery System: Proposals to Improve Patient Care and Reduce Healthcare Costs," United States Senate Finance Committee, April 29, 2009, p. 10 http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf (Accessed 5/6/09)

[7] "Description of Policy Options – Transforming the Healthcare Delivery System: Proposals to Improve Patient Care and Reduce Healthcare Costs," United States Senate Finance Committee, April 29, 2009, p. 13-15, http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf (Accessed 5/6/09)

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[9] "Description of Policy Options – Transforming the Healthcare Delivery System: Proposals to Improve Patient Care and Reduce Healthcare Costs," United States Senate Finance Committee, April 29, 2009, p. 25-26, 30-32, http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf (Accessed 5/6/09)

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[12] "Bring the Fight Over Physician-Owned Hospitals Into the Open," By Eluas Bakhtiari, Health Leaders Media, January 22, 2009, http://www.healthleadersmedia.com/content/226920/topic/WS_HLM2_PHY/Bring-the-Fight-Over-PhysicianOwned-Hospitals-Into-the-Open.html

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