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Health Panel

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A Rural Perspective/Commentary Regarding

(Description of Policy Options)

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

Senate Finance Committee April 29, 2009

Commentary provided by the RUPRI Health Panel

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This document includes commentary from the Rural Health Panel on proposed options we feel have special meaning for rural areas. An appendix describes proposed options for which we do not believe there is a differential rural impact.

Section I: Payment Reform

I.1: Linking Payment to Quality Outcomes

I.1a: Establishing a Hospital Value-Based Program (VBP)

Proposed Option

- Provide value-based payment to inpatient prospective payment hospitals (IPPS) beginning in FY 2012, with payment adjusted based on performance beginning in FY 2013
- Measures focus on heart attack, heart failure, pneumonia, surgical care activities, and patient perception of care, expand beginning in 2013
- Fund VBP through reducing Medicare IPPS payments to participating hospitals: 2.0 % in FY 2013; 3.0% in FY 2014; 4.0% in FY 2105; 5.0 % in FY 2016 and beyond
- Reductions apply only to DRG payment, not any add-ons (e.g., DSH, GME)
- Hospitals rewarded based on whichever level is higher – attainment or improvement
- Performance standards announced at least 60 days prior to performance period for which they apply and take into account past hospital experience with the measures historical performance standards, improvement rates, and opportunity for continued improvement
- Methodology to assess performance of each hospital for each condition would be developed and results would include condition-specific and total hospital performance scores; but determination of performance standard being met based only on the total performance score
- Bonus payments for hospitals that meet or exceed performance standards, applied to all MS-DRGs the hospital provides; based on sliding scale according to (1) no incentive in bottom quartile of performance, (2) linear sliding-scale incentive payment in the 26-75th percentile and (3) full incentive payment above 75th percentile; unused funds returned to Medicare Trust Fund
- All performance data is made public; hospitals have opportunity to review and correct first
- Appeals process to contest calculated scores and payments, not for the methodology, determination of the amount of funding available establishment of hospital performance standards, quality measures that are selected, methodology used to calculate score or validate hospital performance
- Three-year demonstration projects to test VBP models tailored toward CAHs and small hospitals that otherwise do not quality to participate in the VBP with Secretary required to submit a report 18 months after completion of the project

Rural Commentary

- Rural facilities should be included in any VBP program, but in a manner that does not unduly threaten financial survival.
- Among additional measures, consider clinical processes of care typically delivered in rural

hospitals such as patient transfers, ED handoffs (see "Measuring Rural Hospital Quality," *Working Paper Series #53*. Moscovice, Wholey, Klingener and Knott. Rural Health Research Center of the University of Minnesota. April 2004. Available at http://www.hpm.umn.edu/rhrc/pdfs/wpaper/wpaper053.pdf).

- Retain the option of allowing for rewards based on improvement—important for rural hospitals.
- Consider applying reductions to total Medicare payment in rural and urban hospitals; excluding GME and DSH creates disproportionate reduction in rural hospital payments.
- Mandate sophisticated statistical analysis to ensure that low volumes do not significantly reduce measure reliability.
- Select measures and analyze VBP with input from rural health experts, including clinicians and rural health researchers.
- Distribute all unearned withholds as local/regional quality improvement technical assistance, and provide quality improvement technical assistance to rural hospitals.
- Coordinate VBP with programs that provide important quality improvement technical assistance to rural hospitals.
- Expand quality improvement technical assistance to rural hospitals through quality improvement organizations and resources available in the Medicare Flex Program.
- Although CAHs are initially excluded they should be included in VBP and other quality improvement programs as soon as there is a program ready, following the steps described in the following bullets:
    - A CAH VBP program is essential, and should include measurement of services commonly provided by CAHs, including outpatient care.
    - Assisting CAHs with developing and acquiring appropriately scaled quality-enhancing knowledge, skills, and health information technology should be a priority.

I.1b: See appendix.

I.1c: Physician Quality Reporting Initiative (PQRI) Improvements and Requirement

Proposed Option

- Adds a new participation option to PQRI, incentive payments for two successive years if on a biennial basis the physician participates in a qualified American Board of Medical Specialties certification program and completes a qualified Maintenance of Certification (MOC) assessment
- Three additional CMS improvements to the program: 1) establish an appeals process; 2) provide more timely feedback during the course of the performance period; 3) calculate incentive payments without regard to existing geographic adjustments
- Considering two options for continuing program beyond 2010: 1) bonuses through 2011 and 2012 and penalties on those who did not participate 2012 and 2013 and penalties thereafter; 2) incentives only for 2011

Rural Commentary

- Calculating physician incentive payments without regard to geographic adjustment will make this more meaningful to rural providers.
- Timely feedback will benefit rural providers who may learn from this program despite not having resources to participate in vendor-driven efforts.
- Opportunities for technical assistance and funding assistance to implement new information systems in small rural practices need time to have an impact prior to any use of penalties.

I.1d and I.1e: See appendix.

I.2: Primary Care

I.2a: Primary Care and General Surgery Bonus

Proposed Option

- Providers who furnish at least 60% of their services in specified settings would receive a bonus of at least 5% for office visits (codes 99201-99215), nursing home visits (99304-99340) and home visits (99341-99350)
- Bonus applies to all patients (new and established) for five years (1-1-2010 through 12-1-2014)
- Cost of bonuses offset by across-the-board reduction in payments for services under all other codes

Rural Commentary

- The proposed level of bonuses for primary care will be only marginally beneficial for rural providers, and therefore insufficient to effect change in physician distribution.
- Geographic differences in physician payment could be addressed through changes in the work expense component of the geographic practice cost index.
- Benefit of payment increases for office and other visits may be partially offset within rural primary care practices by reductions in other codes those physicians also use because their practices are more likely to engage in procedures than are their urban counterparts.

I.2b: Payment for Transitional Care Activities

Proposed Option

- Reimburse physicians for certain care management activities performed by nurse care managers (or other qualified non-physician professionals)
- Physicians could hire or contract for the services
- Only for patients discharged for hospital within the previous 6 months for admissions classified by DRG as related to: congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, asthma, diabetes, and depression
- Medicare pay a “modest supplemental fee” to primary care practice for each patient discharged from hospital after major chronic disease, receives at least only currently evaluation and management service or a newly covered care management service within 30 days after

discharge and is not readmitted for the same DRG within 60 days after initial discharge

Rural Commentary

- This could be especially beneficial to small practices, often found in rural areas, as it may enable rural primary care practices to hire nurse care managers.

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

II.1: CMS Chronic Care Management Innovation Center

Proposed Option

- Establish a Chronic Care Management Innovation Center (CMIC) in CMS "for the purpose of testing and disseminating payment innovations that foster patient-centered care coordination for high-cost, chronically ill Medicare beneficiaries"
- Initial testing on models meeting these criteria: 1) places the patient, including family and informal caregivers, at center of team; 2) focuses on in-person contact with beneficiaries; 3) close relationship between care coordinators and primary care physicians; and 4) team-based approach to interventions
- Examples include Advanced Patient-Centered Medical Homes, Transitional care teams, patient/physician shared decision-making aids

Rural Commentary

- Innovations in chronic care management should include ways of adapting approaches to low patient volume environments (including achieving economies of scale by combining patients from several independent physician practices).
- Require that a fixed percentage of the CMIC budget be devoted to test models originating in rural primary care practices.

II.2: Hospital Readmissions and Bundling

Proposed Option

- Starting in 2010 CMS directed to begin evaluating national and hospital-specific data on readmission rates of IPPS hospitals related to 8 conditions with highest volume and highest rates of readmission; list to be updated as appropriate
- Exclude readmissions deemed by Secretary not to be potentially preventable
- Starting in FY 2013 hospitals with readmissions above 75th percentile for selected conditions subject to payment withhold on MS-DRG-by-MS-DRG basis
- Beginning in FY 2015, acute IPPS hospital services and post-acute care within 30 days of discharge paid through bundled payment; includes home health, skilled nursing facility, rehabilitation hospitals, and long-term care hospital services
- In FY 2015 phase one applies to admission for conditions that account for top 20% of post-acute spending; required to be a mix of chronic and acute, surgical and medical, conditions with significant variation in readmission and post-acute spending and conditions with high-volume

and high post-acute spending

- Phase in with next 30% in FY 2017, final 50% in FY 2018
- Payments made to one entity such as hospital but CMS has authority allow other entities to receive bundled payments as long as hospital is involved

Rural Commentary

- Many rural residents receive inpatient services at larger urban hospitals. Bundling through hospital payment may create disincentives for urban hospitals to use rural providers for post-acute care services, creating access burdens for patients and possibly affecting quality of care and outcomes.
- Contracting issues in bundled payment schemes (and the lack of attractiveness to larger hospitals of negotiating with low-volume providers such as rural practices) may inadvertently also affect the patient base and financial status of rural providers.
- Need to monitor implications for sources of patient care, both from the patient and the local provider perspective.

II.3: Moving from Fee-for-Services to Payment for Accountable Care

II.3a: See appendix.

II.3b: Medicare Shared Savings Program (i.e., Accountable Care Organizations [ACOs])

Proposed Option

- Groups of providers have opportunity to qualify for sharing cost savings they achieve in Medicare starting in 2012
- To qualify as an organization: 1) agree to minimum 2 year participation, 2) have formal legal structure that allows organization to receive/distribute bonuses to participating providers, 3) include primary care providers of at least 5,000 Medicare beneficiaries; 4) provide CMS with list of primary care and specialist physicians participating in the organization; 5) have contracts with a core group of specialist physicians; 6) have management and leadership structure in place for joint decision making; 7) define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care
- Spending baseline for ACO determined on organizational level using most recent 3 years of total beneficiary spending
- Under consideration: 3 year performance period, flat-dollar per beneficiary spending target to the ACO based on expected national growth rate; adjusting and/or capping rate of savings; applying a fee-for-service withhold to earn back; allow Secretary to transition ACO payments from fee-for-service to fully or partially capitated payment structures; targeted relief from legal or regulatory impediments to provider cooperation

Rural Commentary

- There should be opportunity for rural providers to participate in this program, even where there are no current examples of ACOs; the ACO approach is based in part on Geisinger's success, but Geisinger is an atypical way of organizing rural health care delivery.

- Operational definition of "formal legal structure" will be important for rural provider networks formed without unified governance but with signed agreements among providers (such as single signature capability).
- Definition of specialist physicians participating in the organization is also important; for rural-based organizations it may be problematic to include a wide range of specialties, although it could perhaps be done based on the percentage of patient care services covered by the group, e.g., ACO viable if responsible for 80% or more of all care received by the patient population served.

II.3c: Extension and Expansion of the Medicare Health Care Quality Demonstration Program

Proposed Option

- Permanently authorize Section 646 of MMA, demonstration program for physician groups, integrated health care delivery systems or regional coalitions to implement alternative payment systems, waiving provisions of the Stark, anti-kickback and civil monetary penalties; must include multi-payer projects

Rural Commentary

- Set aside for high risk/high potential for success (in terms of measurable differences) projects in sparsely populated rural areas (use rural-urban commuting area [RUCA] codes to determine).

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

III.1: Health IT

III.1a: Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals

Proposed Option

- Exploring expanding eligibility for HER Medicare incentive payments to include nurse practitioners and physician assistants under certain conditions such as those who practice in settings outside of physician office
- Explore providing additional IT incentives to other providers such as post-acute services that were not included in ARRA; especially if additional incentives within Medicare would help support care coordination and quality improvement goals and activities described elsewhere in this document

Rural Commentary

- Health information technology incentives for physician assistants and nurse practitioners will support technology implementation in rural health clinics and other rural practices.
- To be inclusive with post-acute services, policy makers may want to include human service providers as well as health care professionals/providers.

III.1b: Improving Quality Measurement

Proposed Option

- Provide additional resources (to what was provided in MIPPA) to HHS to contract with a consensus-based entity to conduct these activities: convene multi-stakeholder group to provide guidance to Secretary in development of national priorities and goals and identify gaps in performance measurement for national priority areas; convene a multi-stakeholder group for guidance in selection of performance measures to include in public reporting and/or for purposes of payment initiatives in public programs; endorse and maintain measures for national use through process including providers
- Measures applicable to all age groups and focus at minimum on
    - patient outcomes and functional status
    - coordination of care across episodes of care and care transitions
    - meaningful use of HIT
    - efficiency and equity of health services and health disparities
    - patient experience and satisfaction

Rural Commentary

- Measures related to coordination of care across episodes of care and care transitions will be especially meaningful in rural places.

III.2: Comparative Effectiveness Research

Proposed Option

- Exploring having private, non-profit corporation to generate and synthesize evidence on what works in health care; could contract with AHRQ, NIH
- Establish independent expert committee to develop methods and standards for comparative effectiveness research
- Establish expert advisory panels to be certain research and findings are relevant to decision-makers at point of service; public comment and input integral
- Consider potential differences between patient subgroups and their responses to different health care strategies when design each study
- Fund annually by mix of public and private sector funds

Rural Commentary

- Evidence of what works in health care should encompass what works in rural practices with limited resources.
- Relevance to decision makers at point of service should include relevance specific to rural practice environments.
- Patient subgroups of interest should include rural patients as a subgroup, and subgroups within rural based on race/ethnicity.

III.3: See appendix.

III.4: Workforce

III.4a: Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians

Proposed Option

- 80% of unused slots over last 2 years included in a pool for redistribution
- Rural teaching hospitals with less than 250 beds exempt from the redistribution of unfilled positions
- 75% of new slots allocated toward primary care or general surgery residency training positions for at least 5 years
- Teaching hospitals allowed to request up to 50 resident FTE positions from pool of redistributed slots
- Program priorities based on criteria including but not limited to:
    - Location in a primary health HPSA
    - Location in a rural area
    - Location in urban areas with population of million or less
    - Location in states with proportion of medical graduates relative to number of available residency slots within the state
    - States with higher than average population growth
- Slots would be redistributed among teaching hospital sponsors that maintain level of primary care residency positions at a level at least equal to number of primary care positions over past 3 years
- If primary care positions cannot be filled through match over that time hospital allowed to transfer slot to different specialty, subject to the same IME and DGME payment formulas as used to reimburse hospitals' previous residents

Rural Commentary

- Policies to address rural physician shortages that rely on redistribution of residency slots will only be effective if they are combined with increases in financial incentives/reimbursement.
- Assuming effective policies generating interest in primary care careers, the strategies for reallocating unused residency slots as outlined in this proposal appropriately target areas of high priority need.

III.4b: Promoting Greater Flexibility for Residency Training Programs

Proposed Option

- To consider Committee proposals to include counting time for non-patient care activities (didactic and scholarly activities in nonhospital setting) for purposes of calculating GME payments, remove disincentives placed on training programs that rely on volunteer supervisory

physicians for training in outpatient settings and providing flexibility in operation of residency programs involving more than one teaching hospital

Rural Commentary

- These are helpful provisions for rural areas.

III.4c: See appendix.

III.4d: Proposal on Development of a National Workforce Strategy

Proposed Option

- Recommendations from studies and experts include a national health workforce commission, additional resources to support workforce-related activities of CMS and HRSA and encouraging collaboration among these agencies
- Secretary should be directed to work with external stakeholders on a national workforce strategy to meet current and future health care needs

Rural Commentary

- Funding should support a national workforce commission and state or regional commissions charged to assess provider supply/distribution and recommend policies to address specialty and geographic shortages.
- Legislation should support new outpatient practice models that optimize the training, experience, and licensure of all rural health care professionals.

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

IV.1: Linking Payment to Quality

Proposed Option

- Payment to MA plans should be tied to performance on quality measures

Rural Commentary

- Must include all forms of MA plans, including Private Fee-For-Service plans.

IV.2: Developing a More Efficient Payment Structure

Proposed Option

- Consider changing current MA benchmarks to encourage plans to provide Medicare covered benefits more efficiently and promote improvement in quality of care
- Explore approaches to modifying MA benchmark formula
    - Option: blend local and national FFS spending, 75/25, phased in over 3 years
    - Option: gradually reduce benchmarks through combination of across-the-board reductions and phase-downs to a target ratio of counties in which rates most exceed local FFS expenditures

- Option: beginning in 2012 benchmarks set as enrollment-weighted average of MA plan bids in each county or geographic area and all plans paid the new benchmark
- Option: competitive bidding with bonus payments linked to quality improvement targets

Rural Commentary

- Rural residents are less likely to enroll in MA plans, especially those from remote rural areas; more balance between the support given to the MA and traditional Medicare fee-for-service programs would benefit rural beneficiaries.
- The option to blend to local and national FFS rates would seem in theory to raise many rates in rural areas because spending is below the national average, however benchmark rates would fall below current rates in many if not most rural areas due to historical payment changes. Thus this change would lead to significant payment reductions in rural areas, potentially leading to reductions in benefits and drops in the number of plans available.
- The option to make these changes more gradual would be more beneficial to rural areas and would soften the blow, but ultimately would lead to the same effect.
- The option to set benchmarks based on current plan bids would have the effect of benchmark rates bunching around FFS rates, which would tend to lead to reductions in payment in most rural areas, leading to reductions in benefits and plan offerings.
- The option of competitive bidding would lead to less connection to FFS payment, but competitive bids would still likely be tied initially and eventually to FFS payment in the local area, thus leading initially to cuts in benefit offerings and enrollment cuts in rural areas.
- Changes to the calculation of payment to MA plans should include analysis of changing the geographic area used as the basis for rate setting, moving from county boundaries to more rational service areas to smooth wide variation in payments.

IV.3: Pay for Chronic Care Management

Proposed Option

- Could consider proposals to pay plans a bonus for chronic care management along with competitive bidding

Rural Commentary

- Making bonus payment a flat payment and not depending on current payment would be geographically neutral, providing the full benefit in rural areas.

IV.4: Simplify Extra Benefits

Proposed Option

- Could consider reducing amount of variation in amount and type of extra benefits offered by MA plans and funded by Medicare payments
- Could link ability to offer extra benefits to plan performance and not solely dependent on how high MA benchmarks are set
- Option: require MA plans that can offer extra benefits to use these priorities: 1) set maximum

limit on beneficiary out-of-pocket copayments; 2) reduce Parts A/B cost sharing; 3) add new benefits

Rural Commentary

- Any specification of extra benefits should require that those benefits be available at the same out-of-pocket cost to all beneficiaries enrolled in the plan, regardless of where they live or receive care.
- While the provisions make sense to target the extra benefits to beneficiaries, another option is to suggest the extra payments should go back to taxpayers.

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

Appendix

This appendix describes proposed options for which we do not believe there is a differential rural impact.

Section I: Payment Reform

I.1b: Medicare Home Health Agency and Skilled Nursing Facility Value-based Purchasing Implementation Plans

Proposed Option

- Secretary completes Medicare VBP implementation plans for home health agencies and skilled nursing facilities by 2011 and 2012, respectively
- Each plan will consider development, selection and modification process of measures; reporting, collection, and validation of data; structure of value-base payment adjustment; and disclosure of information on performance

I.1d: Transparency and Evidence-Based Decision-Making for Imaging Services

Proposed Option

- Physicians must disclose financial interest in certain imaging services provided through the in-office ancillary services exception, including magnetic resonance imaging, computed tomography, positron emission tomography, and other radiology "designated health services"
- Effective in 2010 the Secretary would designate nationally recognized, transparent appropriateness criteria and use measures, and repro through vendors and registries the adherence pattern of physicians to these measures and criteria
- Beginning in 2013 vary payment to physicians ordering imaging services accordance to adherence to appropriateness criteria for Medicare advanced diagnostic imaging services

I.1e: Medicare Inpatient Rehabilitation Facility and Long-Term Acute Care Hospital Quality Reporting

Proposed Option

- Secretary required to select quality measures for facilities and hospitals by 2011 and implement mandatory reporting by 2012
- Measured endorsed by consensus-based entity would cover, to the extent feasible and practicable, all dimensions of quality as well as efficiency of care

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

II.3a: Sustainable Growth Rate (SGR)

Proposed Option

- First option to update fee schedule by 1% in 2010 and 2011 and 0 in 2012, current law in 2013
- Second option same for 2010-2012, with floor of -3% afterward and in 2014 update for localities with 2 year average fee-for-service growth rates at or greater than 110% of national average have floor of -6%

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

III.3: Transparency

III.3a: Physician Payment Sunshine

Proposed Option

- Transparency in relationship between physicians and applicable manufacturers with respect to payments and other transfers of value and physician ownership or investment interests

III.3b: Physician-Owned Hospitals

Proposed Option

- "Whole hospital" and rural exceptions to general ban on self-referral would be eliminated, new exception for hospitals that have physician ownership and a Medicare provider agreement in effect on July 1, 2009
- Grandfathered hospitals without a physician on premises at all hours in which hospital provides services would have to disclose that before admitting a patient
- Grandfathered hospitals not permitted to increase the number of operating rooms, procedure rooms, or beds above number for which it is licensed on date of enactment

III.3c: Nursing Home Transparency

Proposed Option

- SNFs and nursing facilities required to make available information on ownership, governing body and organizational structure of the facility
- additional information on Nursing Home Compare website: standardized staffing data on nursing staff and other staff providing medical and therapy services; links to websites regarding state survey and certification programs, standardized complaint form and how to file a complaint with state survey and certification program; information enforcement action against the facility that includes substantiated complaints and remedies; summary of facility expenditures for direct care staffing based on data submitted
- Secretary would develop, test and implement a two-year pilot for an independent monitor program that oversees large interstate and intrastate SNF and nursing home chains

- SNF and nursing homes would be required to notify in a timely fashion state, federal, and stakeholder officials, as well as residents and their representatives of impending nursing facility closure
- Two demonstration projects for nursing homes and SNF: 1) for development of best practices for facilities involved in culture change; 2) development of best practices in facilities for use of information technology and improve resident use
- Secretary study and prepare a report on content of certified nurse aide and supervisory staff training and whether number of required training hours is adequate and if not what it should be

III.4c: TANF Health Professions Competitive Grants

Proposed Option

- Competitive awards for research and demonstration projects to provide disadvantaged parents opportunity to obtain education and training for occupations in health care field

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

V.1: Provider Screening

Proposed Option

- Medicare program applications for all providers and suppliers evaluated before billing privileges granted for compliance with statutory and programmatic requirements

V.2: Database Creation and Data Matching

Proposed Option

- New comprehensive "One PI" (provider integrity) data base required of CMS

V.3: Provider Compliance and Penalties

Proposed Option

- Providers required to implement compliance programs as condition of participation in Medicare and Medicaid

Rural Commentary

No particular rural impact

V.4: Program Integrity Funding and Reporting Requirements

Proposed Option

- Increase funding to allow HHS and DOJ to engage in more of integrity activities allowed in Health Care Fraud and Abuse Control program

RUPRI Health Panel

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