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Reform Proposals

Baucus, Grassley Unveil Policy Options For Reforming Health Care Delivery System

Senate Finance Committee Chairman Max Baucus (D-Mont.) and committee ranking minority member Chuck Grassley (R-Iowa) late April 28 released a 48-page set of policy options for reforming the nation's health care delivery system that would make sweeping changes in the way Medicare operates, including shifting the program from volume-based purchasing to value-based purchasing.

It also would provide bonus payments for primary care physicians, and possibly base Medicare managed care payments on a competitive bidding model as proposed by President Obama.

The document contains numerous policy options that could be included in a final health care reform bill. The process of deciding which options will be included in the legislation will begin April 29 when Baucus and Grassley are scheduled to brief committee lawmakers on the document and solicit their feedback. Baucus has said he intends to mark up health reform legislation in June with the aim of securing Senate passage by the August congressional recess.

The document, the first of three outlining committee options for health care reform legislation expected over the next few weeks, is divided into improving quality and promoting primary care, fostering medical care coordination and provider collaboration, improving health care infrastructure, making changes to the Medicare Advantage program, and combating waste, fraud, and abuse.

The cost of the reforms was not included in the document.

'Nothing Is Set in Stone.'

"Everyone agrees that America's health care system is broken," Baucus said in a press release. "Over the past year, I've been talking to members of the health care community and listening to innovative ideas about how to improve quality in the way health care is delivered to patients. The policy options Senator Grassley and I are releasing today put some meat on the bones of those ideas to strengthen our discussion moving forward. But nothing is set in stone."

"We have escalating costs, inefficient delivery systems, and 47 million people who lack health coverage at some point during the year," Grassley added. "We need to make significant improvements to our health care delivery system. And we need to do it [in] a fiscally responsible way. The options for delivery reform are meant to take the best ideas from people who are doing things well and apply them everywhere we can."

Health care stakeholders were briefed on some of the options April 28 by committee staff. One meeting participant told BNA after the meeting that committee staff told them to "keep their powder dry" and not publicly criticize the options in the paper.

"Our nation's health care providers—physicians, nurses, hospitals, and others—work hard to provide life-saving and life-improving care to millions of Americans," the paper stated. "However, the level of quality and efficiency of care provided varies significantly across the country. It has become increasingly evident that the way health care is paid for in our system does not always encourage the right care, at the right time, for each and every patient."

Reorient Payment Incentives

"A reformed health care delivery system will re-orient payment incentives toward services and activities that improve patient care in an effective and efficient manner and bend the curve of growth in national health care spending," the paper added.

Baucus and Grassley said they are considering establishing a hospital value-based purchasing program that “moves beyond paying for reporting on quality measures and activities, to paying for hospitals’ actual performance on these measures.” Under the proposal, Medicare would make value-based payments to acute care inpatient hospitals that meet certain quality performance standards beginning in fiscal 2012.

Funding for value-based incentive bonuses for qualifying acute care hospitals would be generated through reducing Medicare inpatient prospective payments to the participating hospitals, according to the document. The reductions would be used to fund an incentive pool, it added.

Instituting Medicare value-based purchasing implementation plans for home health agencies and skilled nursing facilities by 2011 and 2012, respectively, also is under consideration, according to the paper. Improvements to Medicare’s Physician Quality Reporting Initiative also are under consideration, it added.

Readmission Data

In another option under consideration, beginning in 2010, the Centers for Medicare & Medicaid Services would be directed to begin calculating national and hospital-specific data on the readmission rates of hospitals participating in Medicare’s inpatient prospective payment system related to eight medical conditions with the highest volume and the highest rates of readmission, according to the document.

Beginning in fiscal 2013, hospitals with readmissions above the 75th percentile for selected conditions would have some Medicare payments withheld, it added.

Beginning in fiscal year 2015, acute inpatient prospective payment system hospital services and post-acute care services occurring or initiated within 30 days of discharge from a hospital would be paid through a bundled payment. Under this policy, post-acute payments would include home health, skilled nursing facility, rehabilitation hospitals, and long-term care hospital services, Baucus and Grassley said.

Another option involves amending the in-office ancillary services exception to the physician self-referral prohibitions to require physicians to disclose their 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 chosen by the Department of Health and Human Services, according to the document.

Some physicians also would be eligible for primary care bonus payments, according to the document. For example, one option under consideration is that providers who furnish at least 60 percent of their services in specified ambulatory settings would receive a bonus of at least 5 percent greater than the Medicare fee schedule amount for providing certain evaluation and management services, it added. Bonuses also would be available for general surgeons practicing in newly defined rural general surgeon scarcity areas. The bonuses would be in effect for five years, beginning in 2010, the document stated.

Reimbursement Cut Options

Baucus and Grassley also are exploring ways to cancel a scheduled Medicare 21 percent reimbursement cut for physicians scheduled to take effect in 2010. Complete reform of the payment system is not listed as an option.

The first option would update the fee schedule by 1 percentage point in 2010 and 2011 and freeze it in 2012, the document said. The calculations under the sustainable growth rate formula (SGR) to determine updates would then revert to the current law for 2013, it added.

“The second option would have the same schedule of updates for 2010-2012 as under option 1[;] however, once the update calculation reverted to current law SGR for 2012, a floor of [minus] 3 percent would be in effect. Beginning in 2014, the fee schedule update for localities with 2-year average fee-for-service growth rates at or greater than 110 percent of the national average would have a [minus] 6 percent floor,” the document stated.

“Based on the estimated cost of these two options, the committee is continuing to explore other options for physician payment updates,” the document said.

The committee also is considering 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," the document stated.

One option would be to fund existing Department of Health and Human Services agencies through annual appropriations, Baucus and Grassley said. Another option would be to establish a private, nonprofit corporation that would generate and synthesize evidence on what works in health care through a focus on comparative clinical effectiveness research, it added.

The document also includes several options for changing how Medicare pays managed care plans, including moving to a payment blend of local and national fee-for-service spending rather than move the benchmarks to 100 percent of local fee-for-service spending, the document said. Another option would be to use the competitive bidding model put forth by Obama in his fiscal 2010 budget proposal, it added.

Reducing Fraud and Abuse

The document also includes several options for reducing fraud and abuse in Medicare. Under one option, Medicare program applications for all providers and suppliers would be evaluated before billing privileges would be granted, the document said. CMS would determine the level of screening according to assessed risk of providers' noncompliance with statutory and programmatic requirements.

This may include submission of fingerprints, investigation of criminal background, licensure checks, unannounced site visits, and multistate database inquiries, it added.

Public comments on the options are due by May 15. They should be sent to Health_Reform@finance-dem.senate.gov.

By Steve Teske

The document is available at <http://finance.senate.gov/sitepages/leg/LEG%202009/042809%20Health%20Care%20Description%20of%20Policy%20Option.pdf>.

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