**Description of Policy Options**

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

Senate Finance Committee

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# Senate Finance Committee

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

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. 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. Today's payment systems more often reward providers for the quantity of care delivered, rather than the quality of care and discourage providers from working together to offer patients the best possible care.

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.

In 2008, the United States spends more than 17 percent of our gross domestic product (GDP) on health care – more than any other industrialized country in terms of total and per capita spending. By 2017, health expenditures are expected to consume almost 20 percent of GDP, or $4.3 trillion annually. While spending is high, our nation ranks low in many areas of quality. Various reports have concluded that our current health care system is not making progress toward improving quality or containing costs for patients or providers. This combination of high spending and lagging quality is unsustainable for patients, business and state and federal governments.

In addition to inefficiency, the current health system suffers from significant levels of fraud, waste, and abuse. Scarce health care dollars should be spent as effectively as possible. However, the improper payment rate for Medicare in 2008 was 3.6 percent or $10.4 billion. While it is difficult to know the exact amount of money lost through fraud and abuse, the National Health Care Anti-Fraud Association estimates that fraud is equal to at least three percent of total health care spending, or more than $60 billion per year. Protecting the integrity of federal health care programs and minimizing fraud, waste, and abuse are important components of reforming the health care system.

The dynamics in our health system affect the care that is delivered in both the public and private sectors. In many cases, changes to federal health programs like Medicare activate and pave the way for system-wide changes. The proposals contained in this document set forth ideas on ways to revise payment systems and policies in the Medicare program to promote higher-quality, and more cost-effective care and to reduce fraud, waste and abuse throughout the health system.

Proposals in this document are organized into the following categories:

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| **Section III** | **Health Care Infrastructure Investments – Tools to Support Delivery System Reform** |
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# Section I: Payment Reform - Options to Improve the Quality and Integrity of Medicare Payment Systems

## Linking Payment to Quality Outcomes

### Establishment of a Hospital Value-Based Program (VBP)

*Current Law*

As required by Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act (MMA, P.L. 108-173), since FY2005, acute care hospitals that submit required quality data have received higher payments than those hospitals that do not submit such information under Medicare's Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, which is also sometimes referred to as the hospital pay-for-reporting program. As subsequently modified by Section 5001(a) of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), beginning in FY2007, hospitals were required to submit data for an expanded set of quality measures to participate in the RHQDAPU program, and nonparticipating hospitals received a reduction of 2.0 percentage points in their Medicare annual update for that fiscal year. Today, nearly all acute care hospitals are successfully participating in the Medicare pay-for-reporting initiative.

The Secretary has authority to expand the set of measures that are included in the RHQDAPU program. Specifically, the Secretary can add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, can include measures set forth by one or more national consensus building entities. The Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

Currently, the total number of measures included in determining the FY2010 payment update is 42; however, hospitals are not required to report data for all 42 measures, since Centers for Medicare and Medicaid Services (CMS) calculates some measures by abstracting claims data. The quality data collected encompasses the following conditions: acute myocardial infarction; heart failure; pneumonia; surgical care improvement; 30-day mortality rates for acute myocardial infarction, heart failure and pneumonia patients; readmission rates for heart failure, AMI, and pneumonia; a nursing sensitive measure; several AHRQ Patient Safety and Inpatient Quality Indicators; and the patients' experience of care through the HCAHPS patient survey.

Procedures for making reported quality data available to the public must be established. These procedures must ensure that a hospital has the opportunity to review the data prior to such data being made public. The required quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in inpatient settings in hospitals must be reported on the Internet website of the CMS. Currently, individual hospital performance on specific quality measures and on certain conditions is available on Hospital Compare available on the CMS website.

DRA also required the Secretary of Health and Human Services to formulate and report on a plan to implement a value-based purchasing program for payments under the Medicare program for acute care hospitals (also referred to as IPPS or subsection(d) hospitals) beginning with FY2009. On November 17, 2007, CMS responded to this mandate by releasing the report, "Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program." This report recommends expanding the

RQHDAPU program in order to financially reward hospitals differentially for performance, rather than for simply reporting quality data. Public reporting of performance would be a key component, as well.

*Proposed Option*

Building on the success of the RHQDAPU program, the Committee's proposal would establish 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. This value-based purchasing program would provide value-based payments to acute care IPPS hospitals that meet certain quality performance standards beginning in FY 2012. This first year of the program would be a data collection/performance year. Beginning in FY2013, hospital payments would be adjusted based on performance under the VBP program. Certain hospitals would be excluded from the VBP program, including those who fail to report quality measures under the RHQDAPU program; those that have been cited by the Secretary for deficiencies that posed immediate jeopardy to the health or safety of patients during the performance period; and hospitals for which a minimum number of patients with conditions related to the quality measures or a minimum number of quality measures do not apply.

Measures for the hospital Value-based Purchasing Program would be selected from the measures used in the RHQDAPU program. The measures would focus on the same areas that are the focus of the RHQDAPU program: heart attack (AMI); heart failure; pneumonia; surgical care activities; and patient perception of care. Beginning in 2013 and beyond, the Secretary would have the authority to expand the measurement areas beyond those listed above.

Funding for value-based incentive bonuses for qualifying acute care hospitals would be generated through reducing Medicare IPPS payments to the participating hospitals. These reductions would be used to fund an incentive pool and be phased-in as follows: 2.0 percent in FY 2013; 3.0 percent in FY 2014; 4.0 percent in FY 2015; and 5.0 percent in FY 2016 and beyond. The reductions would apply to all MS-DRGs under which a hospital provides services.

IPPS add-on payments such as disproportionate share hospital (DSH) payments, indirect medical education payments (IME) for teaching hospitals, low-volume adjustment payments and outlier payments would not be impacted by the payment reductions. Payment adjustments under the hospital Value-based Purchasing Program would only apply to a relevant fiscal year and not be taken into account in calculating payments in future fiscal years

Performance standards that reward hospitals based on either attaining a certain performance standard or making improvements on performance relative to a previous performance period would be established. Hospitals would be rewarded based on whichever level is higher, attainment or improvement.

Performance standards would be announced at least 60 days prior to the performance period for which they would apply. The standards would be required to take into account the following factors: past hospital experience with the measures; historical performance standards; improvement rates; and opportunity for continued improvement.

The Secretary would establish a performance period for the Value-based Purchasing Program that would begin and end before the beginning of the fiscal year in which value-based incentive bonuses are awarded. A methodology for assessing the performance of each hospital for each condition during the performance period would be developed. Results would include both condition-specific and total hospital performance scores. However, determination of whether the performance standard was met would be based on the hospital's total performance score. The Secretary would have discretion to determine how to weight various categories of measures/conditions when determining the hospital's total score.

Hospitals that meet or exceed performance standards would receive value-based bonus payments. The incentive payments would apply to all MS-DRGs under which a hospital provides services. These incentive payments would be provided on a sliding scale basis depending on levels of performance, according to the following criteria: (1) no incentive payment for hospitals in the bottom quartile of performance; (2) a linear, sliding-scale incentive payment in the $26^{th}$-$75^{th}$ percentile; and (3) full incentive payment for those above $75^{th}$ percentile. Any unused incentive pool funds would be returned to the Medicare Trust Fund. Payment adjustments under the hospital Value-based Purchasing Program would only apply to a relevant fiscal year and not be taken into account in calculating payments in future fiscal years.

Individual hospital performance on each specific quality measure; on each condition or procedure; and on total performance would all be publicly reported. Data regarding the total number of hospitals receiving incentive payments or payment reductions under the Value-based Purchasing Program would periodically be published. Hospitals would continue to be provided with an opportunity to review and correct information before it is publicly reported.

An appeals process would be established that allows hospitals to contest calculated performance scores and value-based bonus payments. There would be no judicial or administrative review of the following items: (1) the methodology used to determine the amount of value-based bonus payments; (2) the determination of the amount of funding available for value-based bonus payments; (3) the establishment of the hospital performance standards; (4) the quality measures that are selected for inclusion in RHQDAPU or the Value-based Purchasing Program; (5) the methodology that is used to calculate hospital performance scores; (6) the methodology for validating hospital performance; and (7) the design of the transition to the Value-based Purchasing Program.

The selection of measures, the development of the methodology for assigning scores and the development of the methodology for calculating payments would be transparent and public through rulemaking.

The Secretary would be required to work with hospitals, patients, researchers, policymakers and other stakeholders to modify the Hospital Compare website to make it more user-friendly.

The Secretary and the Government Accountability Office (GAO) would conduct ongoing monitoring and submit reports to Congress on the program, including any unintended consequences. GAO would be required to submit an interim report to Congress on the program no later than October 1, 2015 and a final report by July 1, 2017. The Secretary would be required to submit a report by January 1, 2015.

The Secretary would be provided the necessary funding to administer the program (amount to be determined)**.**

Three-year demonstration projects would be established to test value-based purchasing models tailored toward critical access hospitals (CAHs) and small hospitals that otherwise would not qualify to participate in the Value-based Purchasing Program. The Secretary would be required to submit a report to Congress 18 months after completion of the project.

## Medicare Home Health Agency and Skilled Nursing Facility Value-based Purchasing Implementation Plans

*Current Law*

As required by Section 5201(c) of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), beginning in 2007, home health agencies were required to submit data for a set of quality measures. Home health agencies that did not submit these data received a reduction of 2.0 percentage points in their Medicare annual update for that year. As a Medicare condition of participation, skilled nursing facilities are required to submit data on quality to the Secretary.

Currently, individual home health agency and skilled nursing facility performance on specific quality measures and on certain conditions is available on *Home Health Compare* and *Nursing Home Compare* available on the CMS website.

Medicare payment demonstrations have been or are to be implemented that will test value-based purchasing for home health agencies and skilled nursing facilities.

Section 5201(d) of the DRA also required the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress on recommendations on a detailed structure of value-based payment adjustments for Medicare home health services. MedPAC submitted this report to Congress in June 2007.

*Proposed Option*

The Secretary would be directed to complete Medicare value-based purchasing implementation plans for home health agencies and skilled nursing facilities by 2011 and 2012, respectively. Each plan would include consideration of the following issues: (1) The on-going development, selection, and modification process of measures of quality and efficiency; (2) The reporting, collection, and validation of quality data; (3) The structure of value-based payment adjustment, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the source of funding for the value-based bonus payments; and (4) The disclosure of information on performance. In developing each plan, the Secretary would be required to consult with relevant stakeholders and take into consideration experiences with demonstrations that are relevant to value-based purchasing in each setting.

## Physician Quality Reporting Initiative (PQRI) Improvements and Requirement

*Current Law*

The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system that would include an incentive payment, based on a percentage of the allowed Medicare charges for all such covered professional services, to eligible professionals who satisfactorily report data on quality measures. CMS named this program the Physician Quality Reporting Initiative (PQRI). MIPPA made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5 percent in 2007 and 2008 to 2 percent in 2009 and 2010. However, no additional bonus payments were specified for the years following 2010. The following professionals are eligible to participate in PQRI: Medicare physicians, practitioners (e.g. nurse practitioners, physician assistants, clinical psychologists), and therapists.

As directed in MIPPA, CMS is currently developing a plan for transitioning PQRI to a value-based purchasing program that will financially reward physicians based on their performance, rather than for simply reporting quality data. CMS is required to submit the plan to Congress by May 2010.

*Proposed Option*

A new PQRI participation option would be added to the existing options described above. Eligible professionals could also receive PQRI incentive payments for two successive years if, on a biennial (every two year) basis, the physician (1) participates in a qualified American Board of Medical Specialties certification, known as the Maintenance of Certification or MOC, or equivalent programs, and (2) completes a qualified MOC practice assessment.

For purposes of this proposal, the following definitions would apply.

1. Qualified American Board of Medical Specialties Maintenance of Certification (MOC) or equivalent program would mean a continuous assessment program to advance quality care and the lifelong learning and self-assessment of board-certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism and systems-based practice;

2. MOC programs or equivalent other programs must include the following assessment components: (a) Professional standing – Programs must require physicians to maintain a valid, unrestricted medical license in at least one state or jurisdiction in the United States, its territories, or Canada. A qualified MOC program must also include a survey of patient experience with care; (b) Lifelong learning and self-assessment – Programs must require physicians to participate in educational and self-assessment programs that require an assessment of what was learned; (c) Demonstration of cognitive expertise – Programs must require physicians to demonstrate, through a formalized, secure examination, that they have the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty; (d) Practice performance assessment - A practice assessment must include an initial assessment of physician clinical quality compared to peers and national benchmarks. It also needs to include implementation of a quality improvement intervention to address an identified practice weakness, and a reassessment of performance in the area focused on for improvement; and (e) An audit process that meets standards defined by the Secretary.

3. Qualified MOC practice assessment would mean an initial assessment of a participant's practice, designed to demonstrate the physician's ability to use best evidence and practices in comparison to peers and national benchmarks, and apply best evidence and consensus recommendations to improve quality care using follow-up assessments. Such assessment tools must: (a) Use National Quality Forum (NQF) national endorsed measures, where appropriate, to derive a set of clinical metrics that are at least equivalent in both the methods and measures used to those of the PQRI program; and (b) Require the physician to implement a quality improvement intervention to address a practice weakness identified in the performance assessment report, and then to re-measure to assess performance after this intervention.

Proposals to improve the PQRI program would require CMS to make three additional improvements to the program. First, they would be required to establish an appeals process for providers who participated in the PQRI program but did not qualify for incentive payments during their performance period. Second, CMS would be required to provide more timely feedback to providers during the course of the performance period. Third, CMS would be required to calculate incentive payments in the PQRI program without regard to the existing geographic adjustments in the physician fee schedule since PQRI incentive

payments should be based on the quality of the service performed rather than the eligible professional's geographic location.

The Committee is considering two options for extending PQRI incentive payments beyond 2010. Option 1 would extend the 2 percent bonuses through 2011 and 2012 (for the 2010 and 2011 reporting periods). For the years 2013-2014, eligible professionals who failed to participate successfully in the program in the 2012 and 2013 reporting periods would face a 2 percent penalty, which would be calculated as 2 percent of their total allowable charges. The penalty would be assessed on an annual basis and would not be cumulative. If the Secretary determines that less than 85 percent of eligible professionals are satisfying the requirement to participate in the program, then the Secretary would increase the penalty by 1 percentage point per year (to a max of 5 percent in a single year) until 85 percent of eligible professionals enrolled in the Medicare program comply.

The second option under consideration would be identical to option 1 except that the incentive payments would only be available in 2011 (for the 2010 reporting period) and a non-compliance penalty of 1 percent would begin in 2012 (for the 2011 reporting period) The penalties for non-compliance in 2012 and 2013 for the previous year's reporting period would remain at 2 percent, and the requirement that the Secretary increase the penalty (by 1 percentage point per year up to a 5 percent cap until 85 percent of practitioners meet the requirement) would be the same.

## Transparency and Evidence-Based Decision-Making for Imaging Services

### Transparency in Self-referrals

*Current Law*

The Ethics in Patient Referrals Act (the Stark law) prohibits physicians from referring Medicare patients for certain services to providers with which the physician has a financial relationship and prohibits those entities from submitting claims for services provided to patients referred by those physicians with a financial relationship. The law applies to a set of "designated health services" which includes imaging services such as MRI and CT scans. Certain services provided in the physician's office are exempted from the statute through the "in-office ancillary services" exception so physicians can provide radiology services in their offices or facilities and bill Medicare if conditions determined by the Secretary of Health and Human Services are met.

*Proposed Option*

The proposal would amend the in-office ancillary services exception to the physician self-referral prohibitions under Stark to require that physicians 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" that the Secretary determines appropriate. The referring physician would be required to inform the individual in writing at the time of referral that the individual could obtain services from another person. The referring physician would also be required to provide the individual with a list of suppliers in the area in which the individual resides. The requirement would be effective January 1, 2010.

## Promotion of Adherence to Appropriateness Criteria for Imaging Services

*Current Law*

In recent years, MedPAC, GAO and other observers have established that the volume of imaging services has increased more than other Medicare physician services. DRA capped the technical component of the payment for services performed in a doctor's office at the level paid to hospital outpatient departments for such services, effective January 1, 2007.

MedPAC has noted that providers vary in their ability to perform quality imaging services and has recommended that the Congress direct the Secretary to set standards for all providers who bill Medicare for performing and interpreting diagnostic imaging services. Beginning January 1, 2012, MIPPA requires that payment may only be made under the physician fee schedule for the technical component of advanced diagnostic imaging services if the supplier is accredited by an accreditation organization. The Secretary is required to establish procedures to ensure that the criteria used by an accreditation organization to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services is specific to each imaging modality.

GAO would be required to conduct a study by imaging modality of the new accreditation requirement and any other relevant questions involving access to and the value of advanced diagnostic imaging services for beneficiaries.

*Proposed Option*

Several new proposals offered for consideration would modify how Medicare imaging services are delivered and paid. The Secretary would be required to work with national standards organizations to designate nationally recognized appropriateness criteria and related measures for reporting the appropriate use of imaging services. The Secretary would work with medical societies and others to establish transparent standards for reporting patterns of adherence to appropriateness criteria. A new education and confidential feedback program would be developed to report patterns of adherence to these standards of imaging use to physicians. Differential payments to physicians would be established that would include a lower payment for ordering physicians who were determined to be outliers for inappropriate ordering. New imaging information organizations would be established to share information about the use of imaging services and to assist physicians in minimizing duplicative scans and radiation exposure to patients.

Effective in 2010, the Secretary, working with national standards organizations, physician specialty societies, and other stakeholders, would designate nationally recognized, transparent appropriateness criteria and use measures, and would report through vendors and registries the adherence pattern of physicians to these measures and criteria.

In 2011, the Secretary would develop an education and confidential feedback program on these patterns of adherence to imaging appropriateness criteria through standardized reporting, with priority on advanced diagnostic imaging services (ADIS). The feedback would include baseline rates of adherence and goals for patterns of adherence to appropriateness criteria for medical imaging. The confidential comparison reports on patterns of adherence to appropriateness criteria when ordering an advanced diagnostic imaging study, including top inappropriate indications, would be aggregated by ordering physician, ordering practice and interpreting practice, and would be sent to all ordering and interpreting practices. Through rulemaking and in consultation with physician specialty groups, the Secretary would designate the imaging procedures for which mandatory and voluntary reporting will be established. The

designated imaging procedures could include those performed for specified conditions, indications and diagnoses, including but not limited to: low back pain, shoulder pain, musculoskeletal disease, abdominal pain, and headaches. The GAO would develop a report to Congress on the results of the program, including the impact that the appropriateness criteria and the education and feedback program have on ordering patterns.

Beginning in 2013, the Secretary would vary payment to physicians ordering imaging services according to the physician's adherence to appropriateness criteria for Medicare ADIS. Through rulemaking and in consultation with physician specialty groups, the Secretary would designate the imaging procedures for which reporting and differential payment will be mandatory and imaging procedures for which reporting will be voluntary based on baseline rates and amount of progress toward goals. The Secretary would establish a lower payment for ordering physicians who exceed a threshold for inappropriate ordering patterns, based on their patterns of adherence to appropriateness criteria for imaging services designated for mandatory reporting. The Secretary would use 2011 data to identify ordering physicians who are outliers for inappropriate ordering, and apply a reduction of 5 percent to the 2013 conversion factor for outlier physicians who do not incorporate appropriateness criteria into their practice. This reduction would apply to all services furnished by the physician in 2013.

The Secretary would establish a Diagnostic Imaging Exchange Network (DIEN) in five regions of the country, beginning in 2011. The DIEN would assist physicians in determining the necessity, safety and appropriateness of ordering an imaging study, with the intent of minimizing duplicative scans and radiation exposure to patients. Using the Nationwide Health Information Network (NHIN) infrastructure and existing HIT standards, the Secretary would establish an information exchange network that would equip physicians and providers with HIT-enabled systems to access a patient's entire imaging history prior to ordering an imaging study.

The Committee is also exploring other imaging-related options, including the use of radiology benefit managers (RBMs) for certain imaging services.

## Medicare Inpatient Rehabilitation Facility and Long-Term Acute Care Hospital Quality Reporting

*Current Law*

None

*Proposed Option*

The Secretary would be directed to establish quality reporting programs for inpatient rehabilitation and long-term care hospital providers. Under this policy, the Secretary would be required to select quality measures for inpatient rehabilitation facilities and long-term acute care hospitals by 2011 and implement mandatory quality measure reporting programs for both types of providers by 2012. Selected measures would be endorsed by a consensus-based entity that the Secretary is directed to identify and contract with under the Social Security Act. The selected measures would cover, to the extent feasible and practicable, all dimensions of quality as well as efficiency of care.

# Primary Care

## Primary Care and General Surgery Bonus

*Current Law*

Medicare uses a fee schedule to reimburse physicians for the services they provide. In certain circumstances, physicians receive an additional payment to encourage targeted activities. These bonuses, typically a percentage increase above the Medicare fee schedule amounts, can be awarded for a number of activities including demonstrating quality achievements, participating in electronic prescribing, or practicing in underserved areas. For instance, physicians who provide covered services in any rural or urban health professional shortage area (HPSA) are entitled to an incentive payment which is a 10 percent bonus over the fee schedule amount.

*Proposed Option*

Certain Medicare providers would be eligible for a primary care services bonus payment. Providers who furnish at least 60 percent of their services in specified ambulatory settings would receive a bonus of at least 5 percent over the fee schedule amount for providing certain evaluation and management services, defined as follows: office visits (codes 99201–99215); nursing home visits (codes 99304–99340); and home visits (codes 99341–99350). The bonus would apply to services furnished to both established and new patients. The provision would be in effect for five years, from January 1, 2010 through December 31 2014.

This option would also establish bonus payments for general surgeons practicing in newly defined rural general surgeon scarcity areas. Beginning January 1, 2010 and ending December 31, 2014, in addition to the amount of payment that would otherwise be made, these physicians would also be paid a bonus of 5 percent or some other amount over the fee schedule amount for the services. The Committee is working with HHS and CBO to determine the appropriate threshold and definitions for these bonuses.

MedPAC recommended in June 2008 that Congress enact a budget-neutral bonus for primary care services. For this reason, the cost of the bonuses in this option would be offset by an across-the-board reduction in payments for services under all other codes. Alternatively, the increases could be paid for through funding from other sources. However, this approach would require finding new offsets.

## Payment for Transitional Care Activities

*Current Law*

None

*Proposed Option*

This option would support integrated, transitional care management for chronically ill patients who experience hospitalization by reimbursing providers for targeted interventions that have proven successful in the Medicare Coordinated Care Demonstration program, the Medical Home, and other care management models.

Under this option, Medicare would reimburse physicians for certain care management activities performed by nurse care managers (or other qualified non-physician professionals, such as diabetes educators). Qualified activities would include providing in-person care assessment and management, coaching, education, and self-management support to patients. To be eligible for reimbursement, physicians could directly hire qualified care managers or contract with care managers in their community. These services would only be paid for beneficiaries who have been discharged from the hospital within the previous six months for a stay classified by a DRG related to the following major chronic diseases:

- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Asthma
- Diabetes, and
- Depression

Medicare would also pay a modest supplemental fee to a primary care practice for each patient who (1) has been discharged from the hospital after a stay classified in a DRG for one of the major chronic diseases, (2) receives at least one currently covered evaluation and management service or one of the newly covered care management services within 30 days after discharge, and (3) is not readmitted to a hospital for a stay classified as a chronic disease DRG within 60 days after the initial discharge.

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

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

## Chronic Care Management

### CMS Chronic Care Management Innovation Center

*Current Law*

CMS's Medicare Research and Demonstration Program tests new approaches to paying providers, delivering health care services, or providing benefits to Medicare beneficiaries. In accordance with Medicare's demonstration authority, demonstration projects are required to determine whether or not changes in reimbursement would increase the efficiency and economy of health care services without adversely affecting quality. Demonstrations, which typically run from 1 to 5 years, are conducted in select geographic regions and with certain subgroups of beneficiaries. CMS requires that all demonstrations be evaluated. If successful, administrative or payment changes may be implemented nationwide across the Medicare program. For example, results from various demonstration studies helped facilitate the adoption of the inpatient prospective payment system (IPPS) and Medicare managed care. Although demonstrations may be initiated by either the agency or Congress, the number of congressionally mandated demonstrations has increased in recent years and the number of CMS-initiated pilots has declined.

CMS is currently conducting approximately 30 Medicare demonstrations. Many of these demonstrations are designed to test alternative approaches towards improving the care delivered to beneficiaries with chronic conditions. For example, Medicare's Coordinated Care Demonstration, which began in April 2002, tests the use of case management and various coordinated care models to improve the quality of care for beneficiaries with congestive heart failure, coronary artery disease, and diabetes. Another CMS-initiated pilot, the Care Management for High Cost Beneficiaries demonstration, is currently examining various models such as intensive case management, increased provider availability, and restructured physician practices to improve quality and reduce costs for chronically ill beneficiaries.

*Proposed Option*

Under this option, the Secretary of HHS would establish at CMS a Chronic Care Management Innovation Center (CMIC) for the purpose of testing and disseminating payment innovations that foster patient-centered care coordination for high-cost, chronically ill Medicare beneficiaries. CMIC would be given permanent authority to broadly test care coordination models that show promise of improving the quality and cost-effectiveness of care delivered to chronically ill beneficiaries in fee-for-service Medicare. CMIC would act in consultation with an advisory board comprised of members from relevant federal agencies and outside clinical and analytical experts.

To be considered for wide-scale testing, care models must focus on patients with multiple chronic conditions who are at highest risk for hospitalization or readmission. CMIC would have flexibility in targeting patient populations most appropriate for care management interventions but would be encouraged to include: (1) beneficiaries with multiple chronic conditions and an inability to perform 2 or more activities of daily living (i.e. homebound patients); and (2) beneficiaries with multiple chronic conditions, at least one of which is a cognitive impairment (including dementia).

Initial testing would focus on models that met at least the following criteria: (1) places the patient, including family members and other informal caregivers, at the center of the care team; (2) focuses on in-person contact with beneficiaries; (3) maintains a close relationship between care coordinators and primary care physicians; and (4) relies on a team-based approach to interventions such as comprehensive care assessments, care planning (including end-of-life care planning, such as advanced directives), and self-management coaching. Additional criteria, or amendments to these criteria, could be made by CMIC in consultation with its advisory board.

Examples of models that might qualify include:

- Advanced Patient-Centered Medical Homes
- Transitional care teams
- Patient/physician shared decision-making aids

To reduce the start-up times of new testing, CMIC would develop a standard process for evaluating the design and performance of payment models under consideration for broad-scale testing. Testing in the pilot phase would not be required to meet up-front budget neutrality, but CMIC would have the authority to terminate or modify the design and implementation of models that were determined to be unsuccessful once testing began.

The Secretary would measure and evaluate the initial phase of these pilots based on demonstrated improvement in quality of care (including patient-level outcomes measures) and achievement of cost-reduction or budget-neutrality. The Secretary could expand the duration and the scope of projects under this section, to an extent determined appropriate by the Secretary, if the Secretary were to determine – and the Office of the Actuary certify – that such expansion would result in any of the following conditions

being met: (1) the expansion of the project is expected to improve the quality of patient care without increasing spending under the Medicare program; or (2) the expansion of the project is expected to reduce spending under the Medicare program without reducing the quality of patient care.

This option would also establish a Medicare Rapid Learning Network within CMIC for the purpose of smaller-scale evaluation of emerging evidence-based care management models. CMS would recruit and competitively contract with a diverse network of providers/practices for the purpose of rapid-cycle demonstration testing across a broad array of settings and geographic areas. These sites would exhibit diversity across region, provider size, provider type/setting, and other appropriate factors. The Secretary would have the authority to expand testing to additional populations via the above pilot authority.

The Committee is seeking input from members, CBO, and CMS on the design, score, and implementation of the options proposed in this section.

## Hospital Readmissions and Bundling

*Current Law*

Medicare pays for most acute care hospital stays and post-acute care services, including inpatient rehabilitation facility stays, long-term acute care hospitals stays, skilled nursing facility stays, and home health care visits, under prospective payment systems (PPS) established for each type of provider. Under each PPS, a predetermined rate is paid for each unit of service, such as a hospital discharge, or a payment classification group. Payment classification groups are based on an estimate of the relative resources needed to care for a patient with a specific diagnosis and set of care needs. The patient classification system used by hospitals, for example, is referred to as Medicare Severity Diagnosis Related Groups, or MS-DRGs.

Generally, PPS payments include a national standardized amount adjusted by a wage index that is associated with the area where the provider is located or, for some hospitals, where it has been reclassified. Medicare law provides for annual updates of payments to reflect inflation and other factors. In some cases, these updates are linked to the consumer price index for all urban consumers (CPI-U) or to a provider-specific market basket (MB) index which measures the change in the price of goods and services purchased by the provider to produce a unit of output.

As some Medicare beneficiaries with complex health conditions and multiple co-morbidities move between hospital stays and a range of post-acute care providers, Medicare makes separate payments to each provider for covered services across the entire episode of care. The Medicare Payment Advisory Commission (MedPAC), among others, has expressed concern that providers do not have financial incentives to coordinate across episodes of care nor to evaluate the full spectrum of care a patient may receive. There is also a lack of accountability of providers for all care provided during the episode. In addition, in its June 2008 report, MedPAC reported that 18 percent of Medicare hospital admissions result in readmissions within 30 days post-discharge. These readmissions accounted for $15 billion in spending in 2005, and according to MedPAC, $12 billion of this spending may represent potentially preventable readmissions. In light of these findings, MedPAC has recommended that Medicare payments to hospitals with relatively high readmission rates for select conditions be reduced. MedPAC also recommended that a bundled payment system be explored for an episode of care where separate payments for distinct types of providers would be eliminated. Under this model, a single provider entity would receive a bundled payment intended to cover the costs of the full range of care needed over the hospitalization episode, including 30 days post-discharge.

*Proposed Option*

## Hospital Readmissions and Post-Acute Bundling Policy

The Committee's proposal would take steps to reduce avoidable and preventable hospital readmissions and establish new payment incentives intended to improve patient care through encouraging greater care coordination among acute hospitals and post-acute providers. Specifically, starting in 2010, CMS would be directed to begin calculating national and hospital-specific data on the readmission rates of hospitals participating in the Medicare inpatient prospective payment system (IPPS) related to the eight conditions with the highest volume and the highest rates of readmission. In 2011, CMS would be directed to provide readmission rate information to participating hospitals and would inform such providers of their readmission rates in relation to a national readmissions benchmark for each of the selected conditions.

In developing the readmission policy, the Secretary would have the authority to update the list of conditions subject to the policy as deemed appropriate and would be directed to also consider those conditions with the most significant variation in readmission rates among providers when determining which conditions should be subject to the readmissions policy. Such calculations would include the development of a readmissions benchmark by condition that is based on a weighted average of all DRGs related to each condition and is risk-adjusted for patient's severity of illness and differences in case types. The readmissions benchmark would include all readmissions that are the result of complications or related conditions, but would exclude readmissions deemed by the Secretary not to be potentially preventable, such as planned readmissions or readmissions related to cancer care, burn care, trauma care, scheduled surgeries or other admissions deemed appropriate by the Secretary. If a hospital was the site of a patient's original admission and the patient were to be readmitted to a different hospital, the readmission would count toward the original hospital's readmission rate.

Starting in fiscal year 2013, hospitals with readmissions above the 75$^{th}$ percentile for selected conditions would be subject to a payment withhold on a MS-DRG-by-MS-DRG basis. Such awithhold would be based on the prior year's performance and would be equal to 20 percent of the MS- DRG payment amount. Hospitals subject to a payment withhold could be reimbursed for these funds, not to exceed the withhold amounts in a single year, if the patients involved do not have preventable readmissions within 30 days of discharge. Withheld funds that are not repaid to hospitals would be returned to the Medicare Trust Funds.

The readmissions policy would not apply to any conditions that are included in the bundled payment discussed below. This readmissions policy would expire once the bundled payment policy is fully implemented.

## Bundling Policy

Beginning in fiscal year (FY) 2015, acute IPPS 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.

Bundled payments would be implemented in three phases. Starting in October 2014 (FY2015), phase one of the bundling policy would be implemented and would apply to admissions for conditions that account for the top 20 percent of post-acute spending. In determining which conditions to include in the bundle for phase one, CMS would be required to include a mix of chronic and acute conditions, a mix of surgical and medical conditions, conditions with significant variation in readmission and post-acute spending, and

conditions with high-volume and high post-acute spending. Starting in October 2016 (FY 2017), phase two of the bundling policy would be implemented and apply to admissions for conditions that would account for the next 30 percent of post-acute care spending. Starting in October 2018 (FY 2019), the final phase of bundling would be implemented and would include all other conditions and MS-DRGs that account for the remaining 50 percent of post-acute care spending.

The bundled payments would be calculated as the inpatient MS-DRG amount plus post-acute care costs of treating patients in that MS-DRG. This bundled payment amount would be adjusted to capture savings from the expected efficiencies gained from improving patient care and provider coordination within the bundled payment system. Also included in the bundled payment would be expected or planned readmissions within the 30-day post-acute timeframes. Hospitals or other eligible entities would receive the bundled payment for each patient served, regardless of whether the patient receives post-acute care services. No additional payments would be made to the hospital or organizing provider for readmissions during this timeframe and Medicare would no longer make separate payments to post-acute providers for care initiated within 30 days post-discharge.

Under this policy, payments would be made to one entity, such as the hospital, but CMS would have the authority to allow other legal entities (such as non-profits that include the hospital and/or post-acute care providers) to receive bundled payments, as long as the hospital would be involved.

CMS would be directed to waive applicable laws, as appropriate, to implement these policies and to develop patient protection rules to ensure that patients receive appropriate post-acute care and that access to care is maintained. In addition, as this policy is further developed, consideration must be given to whether payment rules in the existing post-acute payment systems must be modified or are still appropriate in order to allow proper coordination and care management of patients in the bundled payment model. After 3 years, CMS would be required to conduct an evaluation and report to Congress and would be required to conduct on-going monitoring to ensure against unintended consequences.

**Proposed Timeline for Implementation of Readmissions and Bundling Policy**

| Calendar Year | Readmission Policy | Bundled Payment Policy |
|---|---|---|
| 2010 | CMS would develop readmissions policy and data parameters | CMS would develop bundling policy |
| 2011 - 2012 | CMS would provide readmission rate information to hospitals and compare that to national readmissions benchmarks for selected conditions | CMS would develop bundling policy |
| 2012 | April-August: CMS would issue proposed and final rules<br><br>FY 2013: Readmissions policy would start in October<br><br>CMS would publicly report readmission rates | CMS would develop bundling policy |
| 2013 | Readmissions policy would continue for those hospitals not paid under the new bundled rates | CMS would develop policy |

| | | |
|---|---|---|
| 2014 | Policy would continue for those hospitals not paid under the new bundled rates | April-August: CMS would release proposed and final rule<br><br>FY 2015: 1st phase would start in October (would apply to first 20% of post-acute spending) |
| 2015 | Readmissions policy would continue for those hospitals not paid under the bundled rates | 1st phase continues |
| 2016 | Readmissions policy would continue for those hospitals not paid under the bundled rates | April-August: CMS would release proposed and final rules<br><br>FY 2017: 2nd phase would start in October (would apply to next 30% of post-acute spending) |
| 2017 | Readmissions policy would continue for those hospitals not paid under the bundled rates | 1st and 2nd phases would continue |
| 2018 | FY 2019: Readmissions policy would end in October | April-August: CMS would release proposed rule on final phase of bundling<br><br>FY 2019: final phase would start in October (would apply to remaining 50% of post-acute spending ) |

# Moving From Fee-for-Service to Payment for Accountable Care

## Sustainable Growth Rate (SGR)

*Current Law*

Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variation in costs. The adjusted relative values are then converted into dollar payment amounts by a conversion factor. The law specifies a formula for calculating the annual update to the conversion factors and, therefore, the resultant fees. Section 101 of the MMSEA increased the update to the conversion factor for Medicare physician payment by 0.5 percent compared with 2007 rates for the first six months of 2008. MIPAA extended the 0.5 percent increase in the physician fee schedule that was set to expire on June 30, 2008, through the end of 2008 and set the update to the conversion factor to 1.1 percent for 2009. The conversion factor for 2010 and subsequent years will be computed as if this modification had never applied; so unless further legislation is passed, the update formula will require a 21 percent reduction in physician fees beginning January 1, 2010 and by additional reductions of roughly 6 percent annually for at least several years thereafter.

The cost of applying a ten-year freeze on physician payment rates is approximately $285 billion.

*Proposed Option*

Two policy options are currently under consideration. The first option would update the fee schedule by 1 percent in 2010 and 2011 and by 0 percent in 2012. The calculations under the SGR system to determine updates would then revert to the current law for 2013.

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 –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 –6 percent floor.

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

## Medicare Shared Savings Program (i.e. Accountable Care Organizations)

*Current Law*

There are no existing laws that directly address the ability of organizations or systems of integrated providers to share in the efficiency gains resulting from the joint responsibility and care of fee-for-service Medicare beneficiaries. While some providers who deliver care in a vertically integrated managed care environment under Medicare are able to achieve these efficiency gains (e.g., a staff model managed care organization through Medicare Advantage), other providers face obstacles to this type of practice integration. MedPAC has been among the proponents that have encouraged this type of gain sharing through accountable care organizations (ACOs).

Medicare has some practical experience with ACO-like organizations. The Medicare Physician Group Practice (PGP) Demonstration, mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, created pay-for-performance incentives for physician groups (being paid fee-for-service) to coordinate the overall care delivered to Medicare patients. The physician groups were rewarded for improving the quality and cost efficiency of health care services through increased coordination of Part A and Part B services, investment in care management programs, process redesign, and improved patient health outcomes, especially for beneficiaries with chronic illness, multiple co-morbidities and those near the end of life. CMS selected ten physician groups on a competitive basis to participate in the demonstration, favoring multi-specialty physician groups with well-developed clinical and management information systems. The ten physician groups represented 5,000 physicians and 224,000 Medicare fee-for-service beneficiaries. Groups that were able to meet quality-of-care benchmarks and reduce their total expected Medicare spending by more than 2 percent were allowed to share in the savings they generate to the Medicare program.

Results from the PGP demo suggest that the concept shows promise. Preliminary results from the demonstration and reports from participants suggest that the program has achieved its goals of better coordination of care for the chronically ill, careful attention to hospital discharge processes, expanded role for non-physician providers, and investments in IT. In the most recent year of the PGP demo, all participants demonstrated improvements in quality and achieved below average growth in costs. In addition, four were awarded with incentive payments for reducing costs below the 2 percent threshold. Accountable care organizations would go beyond the PGP model, which is based on physician groups, to include additional provides.

*Proposed Option*

Under this option, the Medicare program would allow groups of providers who voluntarily meet quality thresholds to share in the cost-savings they achieve for the Medicare program. Beginning in 2012, groups of providers – such as individual physician practices, physician group practices, networks of physician practices, hospital/physician joint-ventures, hospitals employing physicians, etc. – would have the opportunity to qualify for sharing of the cost savings they achieve for Medicare.

To qualify, an organization would have to meet at least the following criteria: (1) agree to a minimum two-year participation, (2) have a formal legal structure that would allow the organization to receive/distribute bonuses to participating providers, (3) include the primary care providers of at least 5,000 Medicare beneficiaries, (4) provide CMS with a list of the primary care and specialist physicians participating in the organization, (5) have contracts in place with a core group of specialist physicians, (6) have a management and leadership structure in place that allows for joint decision making (e.g., for capital purchases), and (7) define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care.

To earn the incentive payment the organization would have to meet certain quality thresholds. The ACOs must agree to report annually to the Secretary on a specified set of quality indicators. ACOs would be allowed to report at the group or individual level on measures specified by the Secretary, including measures of: (1) clinical processes and outcomes (e.g. mortality, improvements in functionality), (2) patient perspectives on care, and (3) utilization and costs (e.g. ambulatory-sensitive admissions). For the purposes of calculating quality and cost performance, CMS would assign beneficiaries to ACOs based on the physician from whom the beneficiary received the most primary care services in the preceding year. [Note: This is for the purpose of gauging performance only, and does not impact the ability of beneficiaries to choose their own site of care.] ACOs would continue to be paid on a fee-for-service basis.

The spending baseline for an ACO would be determined on an organizational level by using the most recent three years of total per beneficiary spending (Parts A and B) for those beneficiaries assigned to the ACO. The prospective spending target would be set using the expected national growth rate in fee-for-service Medicare, as determined by CMS. ACOs whose two-year average Medicare expenditures for assigned beneficiaries (Parts A and B) are at least 2 percent below their benchmark for the corresponding period would be eligible to share in 50 percent of the savings generated to the Medicare program.

Other design features under consideration include requiring a three-year performance period; applying a flat-dollar, per-beneficiary spending target to the ACO based on the expected national growth rate; adjusting and/or capping the rate of shared savings; applying a fee-for-service withhold that ACOs could earn back by meeting quality and cost benchmarks; allowing the Secretary to transition ACO payments from fee-for-service to fully- or partially-capitated payment structures; and targeted relief from legal or regulatory impediments to provider cooperation. Committee staff is exploring with CBO the budgetary effects of these design adjustments.

### Extension and Expansion of the Medicare Health Care Quality Demonstration Program

*Current Law*

Section 646 of the Medicare Modernization Act required the Secretary to establish the Medicare Health Care Quality Demonstration Program (MHCQ), a 5-year demonstration program to examine factors that encourage improved patient care quality, including incentives to improve the safety of care; examination of service variation and outcomes measurement; shared decision making between providers and patients; among others. Under this program, certain physician groups, integrated health care delivery systems, or regional coalitions may implement alternative payment systems, streamline documentation and reporting requirements, and offer benefit packages distinct from those currently available under the Medicare program. The MMA allows the Secretary to waive provisions of the Stark, anti-kickback, and civil monetary penalties (CMP) statutes as they relate to the MHCQ demonstration. Otherwise, these statutes would prohibit hospitals from rewarding physicians for efficiencies achieved in the care of patients, regardless of whether reductions were due to the elimination of duplicative services or other quality improvements.

In contrast to disease management and coordinated care demonstrations that focus on specific patient populations with specific medical conditions, the MHCQ demonstrations are intended to achieve quality improvements through a major redesign of the health care delivery system and by addressing the entire patient population. CMS has approved two demonstrations, which will begin in 2009. Two others are currently in the final review process.

*Proposed Option*

The proposal would permanently authorize Section 646, with some modifications. The program must include multi-payer projects and would be given pilot authority. The Secretary could expand the duration and the scope of MHCQ projects if the Secretary determines – and the Office of the Actuary certifies – that expansion is expected to improve the quality of patient care without increasing spending under the Medicare program or that the expansion is expected to reduce spending under the Medicare program without reducing the quality of patient care.

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

## Health IT

### Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals

*Current Law*

The recently enacted Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act (ARRA), authorized Medicare and Medicaid incentive payments and penalties to encourage physicians and hospitals to adopt and use electronic health records (EHRs). To be eligible for these incentives, physicians and hospitals must demonstrate the "meaningful" use of electronic health record (EHR) technology that is certified as meeting standards of

interoperability, clinical functionality, and security. ARRA directs the Secretary to develop and approve EHR standards by the end of 2009 and to establish a program to certify which EHR systems meet these standards.

Starting in 2011, physicians who meet the definition of a "meaningful" EHR user (including exchanging electronic health information to improve health care quality and coordination) will be eligible for up to $44,000 in Medicare bonus payments over a five-year period. Physicians who are not meaningful EHR users by 2015 will see their Medicare reimbursement reduced by up to 5 percent in 2019 and subsequent years if the Secretary finds that the proportion of meaningful users is less than 75 percent. Eligible professionals are those that meet the Medicare definition of a physician, i.e., state-licensed doctors of medicine, osteopathy, dentistry, podiatry, and optometry, as well as licensed chiropractors. Eligible professionals are those that meet the Medicare definition of a physician section 1861(r) of the Social Security Act.

Beginning in 2011, hospitals who meet the definition of "meaningful" EHR user will also be eligible for bonus payments. For hospitals subject to the inpatient prospective payment system (IPPS), the amount of the payment incentive depends on when the hospital first demonstrates meaningful use of a certified EHR system, the size of the facility, and the hospital's Medicare share. The incentive payment will phase-out over a four year period, such that hospitals receive 75 percent of the applicable bonus payment in year two; 50 percent in year three; and no incentive payment in subsequent years. Hospitals that are meaningful users beginning in 2011, 2012 or 2013 will receive a full four year of incentive payments based on the aforementioned schedule. Hospitals that become meaningful users in 2014 or 2015 will only receive three or two years of incentive payments, respectively. Starting in 2015, hospitals that do not show meaningful use of a certified EHR system during the prior year will be subject to reductions in the annual IPPS market basket update.

Starting in 2011, Critical Access Hospitals (CAHs) who demonstrate meaningful use of EHR will receive expedited and increased payments for health IT costs that would otherwise be subject to depreciation. In 2011 through 2015, CAHs can expense health IT costs that would otherwise be eligible for depreciation, which will allow them to receive Medicare reimbursement for these costs shortly after incurring the expense, rather than over a multi-year depreciation schedule. In addition, Medicare reimbursement to CAHs for health IT costs will be enhanced by providing an additional 20 percentage points in extra depreciation payments in addition to the allowable depreciation amount that is calculated based on the Medicare share formula set forth in the bonus payment policy for IPPS hospitals. Starting in 2015, CAHs that do not show meaningful use of a certified EHR system during the prior year will face a reduction in their payment rate that will phase-up over three years to 1 percent of the currently 101 percent cost-based reimbursement available to CAHs.

The HITECH Act also included health IT incentives for eligible professionals and hospitals through the Medicaid program. Beginning in 2011, eligible professionals who treat a high volume of Medicaid patients and demonstrate meaningful use of a certified health IT system are eligible for temporary health IT payments. Payments are not to exceed 85 percent of the cost of purchase, implementation, and maintenance and upkeep of certified systems, subject to an overall cap. Maximum program participation is six years. Eligible professionals include non-hospital professionals (doctors, dentists, nurse practitioners, certified nurse mid-wife, and certain physician assistants) who have at least 30 percent of their patient volume from Medicaid; pediatricians with at least 20 percent of their patient volume from Medicaid; and federally-qualified health centers (FQHCs) or rural health clinics (RHCs) with at least 30 percent of their volume from needy individuals. Eligible providers participating in the Medicaid incentives program are not allowed to participate in the Medicare incentives program described above.

Children's hospitals, and acute-care hospitals that have at least 10 percent of their volume from Medicaid, are also eligible for Medicaid health IT incentives. The formula for determining the amount of Medicaid payment is similar to the Medicare formula referenced above for IPPS hospitals, but with slight modification.

*Proposed Option*

The Committee is exploring the possibility of expanding eligibility for the EHR Medicare incentive payments to include nurse practitioners and physician assistants under certain conditions, such as those who practice in settings outside of a physician office. Eligible providers would receive the same EHR incentive payments as physicians.

In addition, the Committee intends to further explore providing additional health IT incentives to other health care providers, such as those offering post-acute services, that were not included in the Medicare and Medicaid incentives included in ARRA. In particular, the Committee is analyzing whether additional health IT incentives within Medicare are warranted to help support the care coordination and quality improvement goals and activities related to various proposals included in this document, such as the establishment of value-based purchasing programs, chronic care management models and proposals to bundle acute and post-acute payments. The Committee looks forward to receiving additional input on this topic.

## Improving Quality Measurement

*Current law*

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.110-275) includes a provision that directed the Secretary to identify and contract with a consensus-based entity regarding performance measurement, such as the National Quality Forum, that meets the requirements described below, and required the entity to perform a number of specified duties. Duties of the consensus-based performance measurement organization include:

(a) synthesize evidence and convene key stakeholders to make recommendations on an integrated national strategy and establish priorities for health care performance measurement in all applicable settings. In making such recommendations, the entity would ensure that priority is given to measures: (1) that address the health care provided to patients with prevalent, high-cost, chronic diseases; (2) with the greatest potential for improving the quality, efficiency, and patient-centeredness of health care; and (3) that may be implemented rapidly due to existing evidence, standards of care, or other reasons. The organization would also take into account measures that: (1) may assist consumers and patients in making informed health care decisions; (2) address health disparities across groups and areas; and (3) address the continuum of care a patient receives, including services furnished by multiple health care providers or practitioners and across multiple settings.

(b) endorse standardized health care performance measures. The endorsement process would consider whether a measure: (1) is evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and (2) would be consistent across types of health care providers, including hospitals and physicians.

(c) establish and implement a process to ensure that the standardized health care performance measures endorsed are updated (or retired if obsolete) as new evidence is developed.

(d) promote the development and use of electronic health records that contain the functionality for automated collection, aggregation, and transmission of performance measurement information.

(e) prepare an annual report to Congress and the Secretary by March 1 of each year (beginning with 2010). The report would describe: (1) the implementation of quality measurement initiatives included in MIPPA and the coordination of such initiatives with quality initiatives implemented by other payers; (2) the recommendations made; and (3) the performance by the entity of the duties required under the contract entered into with the Secretary. Not later than 6 months after receiving such a report for a year, the Secretary would review and publish the report in the *Federal Register*, together with any comments of the Secretary on the report.

There are several requirements for the consensus-based performance measurement organization. The organization would be required to be a private nonprofit entity governed by a board, whose members would include: (a) representatives of health plans and health care providers and practitioners or representatives of groups representing health plans and health care providers and practitioners; (b) health care consumers or representatives of groups representing health care consumers; and (c) representatives of purchasers and employers or groups representing purchasers or employers. The membership of the organization would include persons who have experience with urban health care issues, safety net health care issues, rural and frontier health care issues, and health care quality and safety issues.

If the entity were to require a membership fee for participation in other functions of the entity, such fees would be reasonable and adjusted based on the capacity of the potential member to pay the fee. In no case would membership fees pose a barrier to the participation of individuals or groups with low or nominal resources to participate in the functions of the entity.

With respect to matters related to the contract with the Secretary as described above, the organization would be required to conduct its business in an open and transparent manner and to provide the opportunity for public comment on its activities. The entity would operate as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104– 113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).
For purposes of carrying out this subsection, the Secretary would provide for the transfer of up to $40 million from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (in such proportion as the Secretary determined appropriate), to the CMS Program Management Account for the period of fiscal years 2009 through 2012.

The contract with such consensus-based performance measurement organizations would be for a period of 4 years, and may be renewed after a subsequent bidding process.

*Proposed Option*

Building on the provision set forth in MIPPA, this proposal would provide additional resources to the Secretary of the Department of Health and Human Services (HHS), working in cooperation with the Agency for Health Care Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS), to further strengthen and improve quality measurement and development processes.

In this proposal, the Secretary would be required to submit a biennial report to Congress that outlines national priorities and strategies for health care quality improvement and performance and a status report on progress toward meeting such goals. The Secretary would also be directed to set forth a process for the development, endorsement, selection, and implementation of quality measures. The Secretary would be

directed to align these quality improvement processes and activities to support the delivery system reform proposals outlined in this document and to support the priorities and goals set forth in the biennial report To fulfill these tasks, the Secretary would be directed to continue contracting with a consensus-based entity, such as the National Quality Forum. Building on the requirements included in MIPPA, such entity would be directed to conduct, at minimum, the following activities:

- Convene a 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 to provide guidance to Secretary on the selection of performance measures to be included in public reporting and/or for purposes of payment initiatives in public programs and establish a formal process to receive this input; and

- Endorse and maintain measures for national use through a multi-stakeholder process. Stakeholders must include, but are not limited to representatives of:

    - hospitals, physicians, post-acute providers, quality alliances, nurses and other health providers, health plans, consumer representatives, life sciences industry, employers and public purchasers, labor organizations, and relevant government agency representatives

Measures would be applicable to all age groups, where appropriate, and available to the public free of charge and focus at minimum on the following areas:

- Patient outcomes and functional status
- Coordination of care across episodes of care and care transitions
- Meaningful use of health information technology
- Efficiency and equity of health services and health disparities
- Patient experience and satisfaction
- Other areas deemed appropriate in support of other delivery system reforms set forth in this paper

The Secretary would also develop a strategy for improving the public reporting of quality and performance information that includes making information available on the internet in a standardized, understandable and easy-to-use format for consumers, providers and purchasers.

For purposes of carrying out these activities, the Secretary would provide for the transfer of funding from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (in such proportion as the Secretary determined appropriate), to the CMS Program Management Account. The level of funding will be identified as the Committee continues to develop this policy.

The Committee looks forward to working in cooperation with the Senate Committee on Health, Education, Labor and Pensions (HELP) to further develop these proposals. In addition, the Committee also intends to work with the HELP Committee to explore whether additional funding and requirements should be set forth regarding (1) the development of quality measures in areas that are aligned with national priorities and/or represent gaps in measurement; and (2) the assessment and dissemination of clinical best practices to health care providers related to these quality improvement measures.

## Comparative Effectiveness Research

*Current Law*

Several HHS agencies have authority to synthesize and conduct research comparing the effectiveness of different health care treatments and strategies within their authorizing statutes. In addition, Section 1013 of the Medicare Modernization Act of 2003 directs the Agency for Healthcare Research and Quality (AHRQ) to develop priorities for and conduct an evaluation and synthesis of research comparing the clinical effectiveness and appropriateness of health care items and services covered under Medicare, Medicaid and CHIP. The recently enacted American Recovery and Reinvestment Act of 2009 (ARRA) included $1.1 billion in discretionary spending for comparative effectiveness research. Of the total, $400 million was allotted to the National Institutes of Health (NIH), $300 million to AHRQ, and $400 million to the Secretary of Health and Human Service (HHS) to fund comparative research as well as support the development of diseases registries that could be reliable data sources for research. The ARRA funds are temporary and must be obligated for research by the end of 2010.

*Proposed Options*

The Committee will 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.

**Finding Out What Works in Health Care.** Comparative clinical effectiveness research compares clinical outcomes of alternative therapies or strategies used to prevent, treat, diagnose, and manage the same condition. The purpose of this type of research is to assist patients and clinicians in making informed health care decisions. Better evidence on what works will lead to better health care choices and thus to improved quality of care and improved efficiency.

One option to support this type of research would be to fund existing HHS entities through annual appropriations, as done through ARRA. One limitation of this option is that discretionary funding can be inconsistent and unstable. Also, the research agenda could be unduly influenced through the political process.

An alternative option, as presented in S. 3408 ($110^{th}$), would be to establish a private, non-profit corporation that would generate and synthesize evidence on what works in health care through a focus on comparative clinical effectiveness research.

As outlined in S. 3408, an independent Institute could be governed by a multi-stakeholder board that would include clinicians, patients, manufacturers, as well as researchers, scientists and private and public payers. The Board composition should be balanced so that no stakeholder interest dominates. As outlined in S. 3408, the duties of an independent Institute could be to establish a national agenda of research priorities, based on the need for better evidence, disease burden, practice variations, the potential for improved care and health, and expenditures associated with a given health condition or care strategy. The Institute could contract with AHRQ, the NIH and other appropriate federal and private entities to conduct comparative clinical effectiveness research, including systematic reviews, observational studies, clinical trials, and randomized controlled trials. Placing the Institute outside of the government would help maintain objectivity and minimize undue political influence. Regular reviews by the Government Accountability Office (GAO) would ensure that the Institute is accountable to the public.

**Ensuring Credible and Objective Research.** A critical component of supporting comparative clinical effectiveness research is the development of methods and standards for such research. To accomplish this,

an independent, expert committee charged with developing methodological standards for this type of research should be established. Such a committee could be formed by an independent Institute or by the Secretary of HHS. Research conducted by an Institute or HHS could be required to adhere to these standards. To further ensure adherence to methodological standards and to the principles of scientific integrity, research could be guided by expert advisory panels or subject to a peer review process.

**Transparency and Public Input.** HHS agencies or an independent Institute charged with providing for this type of research should consult with stakeholders broadly and continually during its activities, ensuring that the research is relevant to the needs of patients, physicians, and other stakeholders and that the research is disseminated in ways most useful to health care decision-makers. Expert advisory panels should be established to make certain that research and its findings are relevant to decision-makers at the point of service. Public comment and input should be integral to comparative clinical effectiveness research. Options could include: 1) public comment periods on the research agenda and priorities, 2) peer-review of research designs and findings, and 3) public comment periods on research design, draft reports and dissemination approaches. Research findings should be publicly disseminated in ways that patients and healthcare providers can easily understand.

**Patient Safeguards.** Any entity approving or conducting comparative clinical effectiveness research should consider potential differences between patient subgroups and their responses to different health care strategies when designing and approving each study. The entity conducting the research should broadly disseminate research findings, but should be prohibited from issuing medical practice recommendations or from making reimbursement or coverage decisions or recommendations.

In addition, the Committee should consider ways of addressing the need for patient safeguards with respect to the use of this type of research, particularly by public programs like Medicare and Medicaid. One option is to create limits on the use of the research by HHS. For example, Medicare could be allowed to use the findings only in circumstances where the processes by which it uses the information is transparent, relies on all available evidence (not only research from the Institute), considers the potential for effects on subpopulations of beneficiaries, and allows for public comment on any draft proposals that use the information. This would prohibit HHS agencies from creating a fast-track process for automatically linking the research findings to coverage or reimbursement decisions in public programs. Such measures could ensure that the information produced by the Institute is used by HHS in an open and transparent manner.

**Funding.** Comparative clinical effectiveness research could be funded annually by appropriations or by a mix of public and private sector funds. S. 3408 proposes funding this research through a mix of general revenues, contributions from the Medicare trust funds, and an assessment on private insurance in proportion to the share of total national health expenditures accounted for by Medicare, other public programs, and the private sector.

# Transparency

## Physician Payment Sunshine

*Current Law*

None

*Proposed Option*

This proposal would amend part A (General Provisions) of title XI of the Social Security Act to provide for transparency in the relationship between physicians and applicable manufacturers with respect to payments and other transfers of value and physician ownership or investment interests in manufacturers. It calls for the submission of payment and ownership information and procedures to make this information public.

The proposal would require any manufacturer of a covered drug, device, biological, or medical supply that makes a payment or another transfer of value to a physician to report annually, in electronic form, specified information on such transactions to the Secretary of Health and Human Services. The Committee seeks input on whether the reporting of payments and other transfers of value should include additional individuals and entities. The report would include the transfer recipient's name, business address, value of the payment, date of the payment, a description of the form of the payment, a description of the nature of the payment, if the payment is related to marketing, education, or research specific to a covered drug, device, biological or medical supply and its name, National Provider Identifier, and any other category of information that the Secretary determines appropriate. If the recipient requests a transfer of payment to another entity or individual, the manufacturer should disclose that information.

For payments made pursuant to a product development agreement or clinical trial, payments would not be published until the earlier of (1) the date of approval or clearance by the FDA, or (2) four calendar years after the date of payment. Some information would be excluded from these reporting requirements, including payments or transfers of $10 or less, samples intended for patient use, patient educational materials, loan of a covered device for a short-term time period, discounts and rebates, in-kind items used for charity care, and profit distributions from publicly traded companies. The reporting requirement would begin on March 31, 2012 and remain in effect on the 90th day of each subsequent calendar year. The Committee seeks input on whether a *de minimis* threshold for payments and transfers of value should be implemented or an annual aggregate reporting threshold of $100 per recipient.

The proposal also requires any such manufacturer or related group purchasing organization to report annually to the Secretary, in electronic form, certain information regarding any ownership or investment interest (other than in a publicly traded security and mutual fund) held by a physician (or an immediate family member) in the manufacturer or group purchasing organization during the preceding year. The Committee seeks input on whether small business entities should be exempted from reporting or if all manufacturers, regardless of size, should be required to comply with the reporting requirements.

Manufacturers or group purchasing organizations would be subject to a civil monetary penalty (CMP) of not less than $1,000 but not more than $10,000 for each payment or transfer not reported. The total amount of the penalties for any annual submission shall not exceed $150,000. Any manufacturer or group purchasing organization that knowingly fails to submit information would be subject to a CMP of not less than $10,000 but not more than $100,000 for each payment or transfer not reported. The total amount of the penalties for this failure to report category of submissions shall not exceed $1,000,000 annually.

The proposal would require the Secretary to establish procedures no later than June 1, 2010 to ensure public availability of this information. Beginning September 30, 2012, and on June 30 of subsequent years, submitted information would be available on an Internet website that meets formatting, search, and usability requirements. In addition to the payment and value transfer information, the website would include information on enforcement actions during the preceding year, background information on industry-physician relationships, a separate listing for payments related to clinical research, and other information that the Secretary deems appropriate. The Secretary would also allow recipients,

manufacturers, and group purchasing organizations an opportunity to submit corrections to their information.

This reporting procedure would be established after consulting the Office of the Inspector General (OIG), affected industry, consumers and other parties in order to ensure that the information is presented in an appropriate context. The Secretary would be required to submit an annual report summarizing the payment and value transfer information to Congress and the states beginning April 1, 2012. Effective January 1, 2011, these provisions would preempt any state law or regulation that requires manufacturers to disclose information regarding payments or transfers. This preemption does not affect information that is not required under this proposal. The Committee seeks input on the extent to which these provisions would preempt state laws or regulations.

The Secretary should consult with the OIG on the implementation of this section.

## Physician-Owned Hospitals

*Current Law*

Physicians are generally prohibited from referring Medicare patients for designated health services to facilities in which the physician (or an immediate family member) has a financial interest. However, among other exceptions, physicians are not prohibited from referring patients to hospitals if they have ownership or investment interests in the whole hospital. An additional exemption from the general ban on "self-referral" is made for providers that furnish substantially all of their designated health services to individuals residing in rural areas.

*Proposed Option*

The "whole hospital" and rural exceptions to the general ban on self-referral would be eliminated. However, a new exception would be created for hospitals that have physician ownership and a Medicare provider agreement in effect on July 1, 2009. These facilities would be "grandfathered" and allowed to continue to self-refer, subject to certain other specified requirements. These requirements would address potential conflicts of interest and ensure bona fide investments and patient safety.

Specifically, to avoid conflicts of interest, a "grandfathered" hospital would (1) submit an annual report containing the identity of each physician owner or investor and any other information on the nature and extent of all ownership or investment interests in the hospital; (2) have procedures in place to require that any referring physician owner or investor discloses to each patient (by a time that permits the patient to make a meaningful decision regarding the receipt of care) their ownership or investment interest in the hospital and, if applicable, any such ownership or investment interest of the treating physician; (3) not condition ownership or investment, either directly or indirectly, on the physician owners or investors making or influencing referrals to the hospital; and (4) disclose the fact that the hospital is partially owned or invested in by physicians on any public website for the hospital and in public advertising for the hospital. Information from the annual report would be published and updated annually on the Internet website of the Centers for Medicare & Medicaid Services.

"Grandfathered" hospitals would ensure bona fide investment and proportional returns by meeting the following requirements: (1) physician owners or investors in the aggregate could not own more than the value of such ownership or investment interest held in the hospital (or an entity whose assets include the hospital) on the date of enactment; (2) any ownership interest offered to a physician owner or investor could not be offered on more favorable terms than those offered to an individual who is not a physician

owner or investor; (3) the hospital could not provide loans or financing for physician investments in the hospital; (4) the hospital could not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, to any individual physician owner or investor or group of physician owners or investors that is related to investing or acquiring ownership interest in the hospital; (5) ownership or investment returns must be distributed to owners or investors in the hospital in an amount that is directly proportional to the ownership or investment interest in the hospital of such owner or investor; (6) compensation of and ownership or investment returns to physician owners or investors must not include the guaranteed receipt of or an exclusive right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital; and (7) the hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under hospital control on more favorable terms than offered to an individual who is not a physician owner or investor.

To ensure patient safety, those "grandfathered" hospitals that do not have a physician on the premises to provide services during all hours in which the hospital is providing services to such a patient would have to disclose such a fact to the patient before admitting the patient. Following such a disclosure, the hospital would receive informed consent from the patient to receive services in the hospital when no physician will be present. The hospital also would be required to have the capacity to provide assessment and initial treatment for patients and procedures for the referral and transfer of patients to hospitals with the capability to treat the patient.

Generally, grandfathered hospitals would not be permitted to increase the number of operating rooms, procedure rooms, or beds above the number for which the hospital is licensed on the date of enactment. However, a process would be established to allow hospitals that qualify and apply to increase the number of operating rooms, procedure rooms, or beds. In order to qualify to increase the number of procedure rooms, operating rooms, or beds, the hospital must: (1) be located in a county where the population increased during the most recent five-year period at a rate that is at least 150 percent of the state's population increase; (2) have a Medicaid inpatient admission percentage equal to or greater than the average percentage for all hospitals located in the county; (3) not discriminate against beneficiaries of federal health care programs and not permit physicians practicing at the hospital to discriminate against such beneficiaries; (4) be located in a state with a state average bed capacity less than the national average; and (5) have an average bed occupancy rate that is greater than the state average bed occupancy rate.

Any increases in capacity would be limited to facilities on the main campus of the hospital and could not exceed 200 percent of the number of operating rooms, procedure rooms, or beds on the date of enactment over the hospital's lifetime. The process for expansion should allow the opportunity for community input and should permit applicable qualifying hospital to apply for an increase in capacity up to once every two years. The Secretary should publish final decisions on an increase no later than 60 days after receiving a complete application. The Secretary should implement this process on January 1, 2011 and shall promulgate regulations to carry out this process no later than December 1, 2010. There shall be no administrative or judicial review of this process.

The Secretary would be required to establish policies and procedures to ensure compliance with these requirements, beginning on their effective date. The Secretary would conduct audits to determine if hospitals violate the requirements beginning not later than April 1, 2011.

## Nursing Home Transparency

*Current Law*

Medicare and Medicaid laws require skilled nursing facilities (SNF) and nursing homes to be administered in a manner that will ensure residents' well-being. The Secretary establishes requirements for SNF and nursing homes that will protect the safety, health, welfare, and rights of residents. Facilities undergo regular survey and certification inspections to ensure their compliance with these standards. SNF and nursing home inspections identify deficiencies where facilities fail to meet federal standards. Deficiencies can range from minor problems to major safety and life-threatening conditions. State and federal officials may impose civil monetary penalties on facilities that fail to meet standards or fail to correct deficiencies. In extreme cases, federal and state officials can install new facility management, assume control of facilities, or even close SNF or nursing homes that jeopardize residents' well-being.

*Proposed Option*

A number of changes aimed at improving transparency of information about SNF and nursing homes, enforcement of SNF and nursing home standards and rules, and training of SNF and nursing home staff are proposed. These changes would amend both title XVIII and title XIX of the Social Security Act. They include:

**Required disclosure of ownership.** SNFs and nursing facilities would be required to make available on request by the Secretary, the HHS OIG, the states, and the state long-term care ombudsman, information on ownership (including direct and indirect ownership) and additional disclosable parties as well as information describing the governing body and organizational structure of the facility. Information would be made available to the Secretary, the HHS OIG, the state and state long-term care ombudsman programs upon request. To the extent that the required information is submitted to the IRS as part of Form 990, to the SEC, or to the Secretary, facilities would be permitted to make the information available in these formats.

Information to be disclosed would include the identity of and information on each member of the governing body of the facility (name, title, period of service); each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility; and each person or entity who is an additional disclosable party of the facility.

Additional disclosable parties would be defined as any persons or entities (1) that exercise operational, managerial or financial control over the facility or part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility; (2) lease or sublease real property to the facility, or owns a whole or part interest equal to or exceeding five percent of the total value of such real property; (3) lend funds or provide financial guarantees which is equal to or exceeds $50,000; and (4) that provide management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

The reporting of a person or entity's organizational structure would also be required. Organizational structure would be defined as officers, directors and shareholders who have an ownership interest equal to or greater than five percent in the case of corporations. For a limited liability company, organizational structure would be defined as members and managers; for a general partnership, the partners; for a limited partnership, general partners and any limited partners who have an ownership interest equal to ten percent or greater in the limited partnership; for a trust, the trustees; for an individual, contact information; and for any other person or entity, such information as the Secretary determines appropriate.

The Secretary and the states would be required to develop a standardized format through regulation for facilities to report information about ownership and additional disclosable parties within two years of enactment.

The Secretary, within one year of promulgating regulations requiring reporting by facilities, would be required to make available to the public information about ownership and additional disclosable parties. The Secretary would also be required to provide guidance and technical assistance to states on how to adopt the standardized format.

**Accountability requirements.** SNF and nursing homes would be required to develop and implement compliance and ethics programs to be followed by their employees and agents. The Secretary would be required to develop regulations, working with the HHS Inspector General, for an ethics and compliance program, which may include a model compliance program, within two years of enactment. The Secretary may vary program requirements on the elements and formality of the program based on the size of the organization. The compliance program would be required to have standards and procedures designed to detect criminal, civil and administrative violations under the Social Security Act.

The Secretary would create regulations on quality assurance and performance improvement (QAPI) plans. SNF and nursing homes would be required to implement QAPI plans and submit those plans to the Secretary. The Secretary would be required to provide technical assistance to facilities on development of "best practices" in order to meet QAPI standards.

***Nursing Home Compare* website.** The Secretary would be required to include additional information in the Medicare *Nursing Home Compare* website. This additional information includes: (1) standardized staffing data on nursing staff and other staff providing medical and therapy services available on facilities that is submitted by facilities in a uniform format; (2) links to state internet websites regarding state survey and certification programs, and links to Form 2567 (or successor form) inspection reports, links to facility plans of correction or responses to such reports and information to guide consumers in how to interpret and understand these reports; (3) a standardized complaint form including explanatory material on how to use the complaint forms, and how to file a complaint with the state survey and certification program and the state long-term care ombudsman program; (4) a summary of information on enforcement action against the facility that includes substantiated complaints and remedies proposed and imposed during the preceding three years; and (5) a summary of facility expenditures for direct care staffing based on data submitted.

The Secretary would be required to establish a process to review the accuracy, clarity of the presentation, timeliness, and comprehensiveness of information currently reported on *Nursing Home Compare*; and a process to modify or revamp the site in accordance with comments received after review. In conducting the review, the Secretary would be required to consult with state long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, and other representatives of programs or groups as the Secretary determines appropriate.

States would be required to submit survey information to the Secretary no later than they send such information to the facility, and requires the Secretary to use this information to update *Nursing Home Compare* as expeditiously as practicable. Facilities would be required to have available on request the preceding three years' of inspection reports (Form 2567 reports), complaint investigations and the facility's plan of correction or other response to the Form 2567 report. Facilities would also be required to post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. The Secretary would be required to issue guidance to states on establishing electronic links to Form 2567 reports, to facility plan of correction reports or other responses to 2567 reports, and posting of complaint investigation reports.

**Reporting of expenditures.** This change would amend the Social Security Act by adding requirements that SNF and nursing homes report expenditures for wages and benefits for direct care staff on facility cost reports. The reporting of expenditures on wages and benefits for direct care staff would be required to be broken out into categories including registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff.

The Secretary would be required to consult with government and private sector cost report experts to assist in categorizing by functional area SNF expenditure data, as well as in making it available.

**Standardized complaint form.** The Secretary would be required to develop a standardized form for SNF and nursing facility residents and their representatives to use in submitting quality of care complaints. States would be required to develop a process for resolving complaints. The new standard complaint form would not prevent nursing facility residents from submitting claims in other ways too, including orally.

States would be required to establish complaint resolution processes with procedures to assure accurate tracking of complaints received, including a notification to the complainant that a complaint has been received; procedures to determine the likely severity of a complain and for the investigation of a complaint; and deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation. Such processes would be required to ensure that legal representatives or other responsible parties are not denied access to a resident or otherwise retaliated against if they have complained about the quality of care provided by the facility, or other issues relating to the facility.

**Ensuring staffing accountability.** The Secretary would establish a process to require SNF and nursing facilities to regularly report staffing data, including agency and contract staff, by staff position categories (based on payroll and other verifiable and auditable data). The reporting requirements would include the category of work an employee performs, resident census data, information on employee turnover and tenure, and the hours of care provided per resident per day. The Secretary would be required to consult with stakeholders in developing the reporting requirements. The process would be electronic and data would be reported in a uniform format. The Secretary would submit a report to Congress no later than six months after the completion of a one-year design phase. Not later than one year following the evaluation, the Secretary would require facilities to begin electronically submitting staffing information in a uniform format.

The Secretary would develop a program for facilities to report staffing information in a uniform format based on payroll data, and to also take into account services provided by any agency or contract staff. These standards must specify the category of work an employee performs, such as whether the employee is an RN, LPN, LVN, CNA, or other medical or therapy staff providing direct resident services. Standards must also include resident census data, information on employee turnover and tenure, and the hours of care provided per resident per day.

The Secretary is charged with submitting a report to Congress no later than six months after the one-year design phase has ended. Not later than one year following the evaluation, the Secretary shall require facilities to begin electronically submitting nurse staffing information in a uniform format.

**Civil monetary penalties.** The Secretary would be require to promulgate regulations providing facilities with the opportunity for participation in an independent informal dispute resolution process that would produce a written record and occur within 30 days of imposition of the penalty. In instances where deficiencies are cited at the level of actual harm and immediate jeopardy, the Secretary would have the authority to place civil monetary penalties (CMPs) in an escrow account following completion of the

informal dispute resolution process, or the date that is 90 days after the date of the imposition of the CMP, whichever is earlier. Monetary amounts collected and placed in escrow would be kept in an interest-bearing escrow account pending the resolution of any appeals. The Secretary and states would have the authority to reduce CMPs if the deficiency was self-reported and promptly corrected within ten calendar days after imposition. Reductions would not be made for self-reported deficiencies cited at the immediate jeopardy level, at the actual harm level if the harm was found to be a "pattern" or "widespread," and for deficiencies that result in the death of a resident. Facilities cited for a repeat deficiency that had been self-reported during the preceding year would not eligible for a reduction.

The Secretary would be authorized to use a portion of collected CMPs to fund activities that benefit residents. These activities include projects that strengthen and support resident and family councils, offset the costs of relocating residents to home and community-based settings or another facility, and support and protect residents in situations where a facility closes or is decertified. Such funds would also be used for facility improvement initiatives approved by the Secretary, including joint training of facility staff and surveyors; technical assistance for facilities implementing quality assurance programs; and appointment of temporary management firms.

**National independent monitor pilot program.** The Secretary would be required to develop, test, and implement a two-year pilot for an independent monitor program. The independent monitor program would oversee large interstate and intrastate SNF and nursing home chains. The Secretary would develop protocols for addressing quality and safety problems at the corporate management level occurring in individual homes that are owned or operated by certain chains, including those with homes in the Special Focus Facility program, and those with a record of repeated serious safety and quality of care deficiencies.

Chains that receive a report containing findings and recommendations from the independent monitor would be required to submit a report outlining corrective actions that will be taken within ten days. If a chain declines to implement the independent monitor's recommendations, the chain would be required submit reasons why it will not do so. After receiving the chain's response, the independent monitor would be required to finalize recommendations and to submit a report to the chain and the facilities of the chain, the Secretary, and the relevant state or states, as appropriate. Chains would be responsible for a portion of the costs associated with appointment of independent monitors. The Secretary would have authority to waive Medicare and Medicaid laws under in order to carry out the independent monitor pilot program. The OIG would evaluate the independent monitor program to determine the feasibility of establishing a permanent independent monitor program, as well as appropriate procedures and mechanisms to implement such a permanent program.

**Notification of facility closure.** 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 an impending nursing facility closure. Facilities would be required in the notice to issue a plan for the transfer and relocation of residents.

The administrator of a facility that is preparing to close would be required to provide written notification to residents, legal representatives of residents or other responsible parties, the state, the Secretary and the long-term ombudsman program. This notification would have to me made at least 60 days before closure. Facilities would have to prepare a plan for closing the facility by a specified date specified by the state. The state would be required to approve it and ensure the safe transfer of residents to another facility or alternative setting that the state finds appropriate in terms of quality, services and location and takes into consideration the needs and best interests of each resident.

In the case of a facility where the Secretary terminates the facility's participation, the Secretary would be required to provide written notification to the parties above not later than the date that the Secretary determines appropriate. Facilities would not be permitted to admit new residents on or after the date on which written notification is submitted. The Secretary would continue making payments to a facility to support residents until they are relocated, as the Secretary determines appropriate.

**Demonstration projects on culture change and use of information technology in nursing homes.** The Secretary would conduct two demonstration projects for nursing homes and SNF: (1) for the development of best practices for facilities involved in culture change; and (2) for the development of best practices in facilities for the use of information technology to improve resident care. The Secretary would be required to submit a report to Congress after completion of the demonstration projects that evaluates the projects and makes recommendations for legislation and administrative actions. The demonstration projects cannot exceed three years.

**Dementia and abuse prevention training.** This change would add staff training requirements for SNF and nursing homes. The Secretary would revise initial nurse aide training, competency, and evaluation program requirements to include dementia management training and patient abuse prevention. If determined to be appropriate, the Secretary also may include dementia management training and patient abuse prevention in ongoing nurse aide training, competency, and evaluation program requirements.

**Study and report on training required for certified nurse aides and supervisory staff.** The Secretary would be directed to study and prepare a report to Congress on the content of certified nurse aide and supervisory staff training and whether the number of required training hours is adequate, and if not, what the training level should be.

# Workforce

## Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians

*Current Law*

With certain exceptions, the Balanced Budget Act of 1997 limited the number of allopathic and osteopathic residents that Medicare will reimburse a teaching hospital at the level reported in its cost report ending on or before December 31, 1996. The limit does not include dental or podiatry residents. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) authorized the redistribution of up to 75 percent of each teaching hospital's unused resident positions to hospitals seeking to increase their medical residency training programs. Any adjustments made to teaching hospitals' resident limits would be permanent. Rural teaching hospitals with less than 250 beds were exempt from the redistribution of any of their unfilled positions. Under the redistribution program, teaching hospitals were allowed to request up to an additional 25 full time equivalent (FTE) positions for direct graduate medical education (DGME) and indirect medical education (IME) payments. Hospitals were required to demonstrate the likelihood that the redistributed positions would be filled within 3 cost reporting periods beginning July 1, 2005. MMA required that the unused slots be redistributed according to specific priorities: rural hospitals, urban hospitals located in areas with a population of one million or less, specialty training programs that are the only specialty program in a state, and all other hospitals. The redistribution was effective for portions of cost reporting periods starting July 1, 2005. The redistributed resident slots have different IME and DGME payment formulas from those used to reimburse hospitals' previous residents.

*Proposed Option*

Similar to the proposal set forth in the MMA, the Committee's plan would establish a re-distribution of currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery. In this proposal, the Centers for Medicare and Medicaid Services (CMS) would calculate the number of unused resident slots over the last three fiscal years. Unused slots would be defined as the difference between total available resident slots and a hospital's actual FTE of residents. Based on this calculation, 80 percent of unused slots would be included in a pool for redistribution. Rural teaching hospitals with less than 250 beds would be exempt from the redistribution of any of their unfilled positions.

The Secretary would be authorized to increase the otherwise applicable resident limit for each qualifying hospital that submits a timely application addressing the criteria below, by such number determined by the Secretary. Seventy-five percent of new slots would be allocated toward primary care or general surgery residency training positions for at least 5 years. Teaching hospitals would be allowed to request up to 50 resident FTE positions from the pool of re-distributed slots. Programs applying to receive the slots will be prioritized based on certain criteria, which may include, but not be limited to : sponsoring institutions located in a Primary Health-Health Professional Shortage Area (HPSA), as determined by the Health Resources and Services Administration; sponsoring institutions located in rural areas; sponsoring institutions located in urban areas with a population of a million or less; sponsoring institutions located in states with a higher proportion of medical graduates relative to number of available residency slots within the state; and states with higher than average population growth. Hospitals that qualify for additional resident slots would display a demonstrated likelihood of filling the positions within the first three cost reporting periods and would be involved in an innovative delivery model.

Slots would be redistributed among teaching hospital sponsors. For a sponsoring institution to receive additional residency slots, they must maintain the level of primary care residency positions at a level that is at least equal to the average number of primary care positions over the past 3 fiscal years. However, if the primary care positions cannot be filled through the National Resident Match Program over that period of time, the hospital would be allowed to transfer the slot to a different specialty. The redistributed resident slots would be subject to the same IME and DGME payment formulas as is used to reimburse hospitals' previous residents.

## Promoting Greater Flexibility for Residency Training Programs

*Current Law*

Medicare pays teaching hospitals the costs of approved medical residency training programs through two mechanisms: an indirect medical education (IME) adjustment within the inpatient prospective payment system (IPPS) and direct graduate medical education (DGME) payments made outside of IPPS. With respect to training that occurs in hospital settings, Medicare will not include the time that residents spend in non-patient care activities, including didactic activities, when calculating IME payments. With respect to training that occurs in nonhospital settings, Medicare will not count the time that residents spend in non-patient care activities, including didactic activities, when calculating DGME or IME payments.

Medicare will reimburse the direct costs of DGME for approved residency training programs without regard for the setting where the residents' activities relating to patient care are performed as long as the primary training hospital incurs all, or substantially all, of the costs for the training program in that setting. Through regulations, CMS has defined all, or substantially all costs, as 90 percent of residents'

stipends and fringe benefits and any costs associated with a supervisory physician. However, as presently administered, a hospital cannot include the time spent by residents working at a non-hospital site if it incurs, all or substantially all of the costs for only a portion of the residents in that program at the non-hospital site.

*Proposed Option*

In order to promote training in outpatient setting and to ensure the availability of residency programs in rural and underserved areas, the Committee is considering ways to provide more flexibility in laws and regulations governing graduate medical education funding in the Medicare program. Proposals being considered include counting time for certain non-patient care activities, such as didactic and scholarly activities in a nonhospital setting for purposes of calculating GME payments, removing current disincentives placed on training programs that rely on volunteer supervisory physicians to provide training in outpatient settings and providing flexibility in the operation of residency programs involving more than one teaching hospital. The Committee looks forward to continuing to receive input on these topics.

## TANF Health Professions Competitive Grants

*Current Law*

The Temporary Assistance for Needy Families (TANF) block grant provides grants to states for a wide range of benefits and services for needy children and their caretakers. States may use TANF funds for activities that seek to achieve any of TANF's statutory goals. One goal is to end the dependence of needy parents on government benefits, and one means to achieve this goal is job preparation. Thus, TANF funds may be used for education and training of low-income parents, both those who receive assistance (cash welfare) and other low-income parents. Though TANF funds may be broadly used for education and training for low-income parents, there are limits to counting education and training toward TANF work requirements for adult recipients of assistance.

In addition to block grants to the states, TANF also has categorical grants awarded on a competitive basis to states and other organizations for research and demonstration projects for responsible fatherhood and healthy marriage initiatives. These funds are in addition to block grant funds to the states which also may be used for these types of activities.

*Proposed Option*

The Secretary of Health and Human Services (HHS), in consultation with the Secretary of Labor, shall make 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 pay well and are expected to either experience labor shortages or be in high demand. .

Grants would be awarded to States, Localities, Indian Tribes and Tribal Organizations, Higher Education Institutions, Community Based Organizations, and local Workforce Investment Boards. Grantees that are not state TANF agencies would be required to consult and coordinate with state TANF agencies. Grantees who are not local Workforce Investment Boards (WIBs) would be required to consult and coordinate with both the local and state WIB.

Low-income parents would receive financial aid, child care, case management, and other supportive services. Aid would not be considered "assistance" for purposes of TANF requirements. Projects may also provide incentive payments to participants for meeting interim training goals. To assess the effectiveness of these programs, grantees will be required to report on their programs' participants and HHS will be required to make reports to Congress. The Committee is continuing to review the appropriate funding level for these grants and looks forward to input on this topic.

## Proposal on Development of a National Workforce Strategy

*Current law*

In the Department of Health and Human Services, the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) play key roles in supporting workforce development and training.

In CMS, the Medicare program provides an important funding source for graduate medical education through two distinct payments made to teaching hospitals. Medicare makes direct graduate medical education (DGME) payments to compensate teaching hospitals for costs directly related to residency programs, such as residents' stipends and benefits and the costs associated with supervisory physicians. These payments are made based on the number of residents and the hospital's proportion of Medicare inpatient caseload. Medicare also makes indirect medical education (IME) payments to compensate hospitals for costs indirectly associated with medical education, such as higher patient costs and other costs associated with teaching hospitals. These payments are based on a hospital's intern/resident to bed (IRB) ratio along with a national adjustment factor.

At HRSA, a number of health care workforce programs authorized by Title VII and Title VIII of the Public Health Service Act are administered. HRSA is also the primary federal agency that collects health care workforce data and is responsible for tracking national trends. HRSA is comprised of six bureaus: The Bureau of Primary Health Care, The Bureau of Clinician Recruitment and Service, The Bureau of Health Professions, The Maternal and Child Health Bureau, The HIV/AIDS Bureau, The Healthcare Systems Bureau. The Bureau of Clinician Recruitment and Service and The Bureau of Health Professions focus on all levels of medical education, including undergraduate education, undergraduate medical education, and graduate medical education. HRSA is also responsible for certifying communities as Health Professional Shortage Areas (HPSAs), which take into account factors such as the prevailing rate of poverty and infant mortality; the number of physicians per 1,000 residents; and travel distances to nearest available care. HPSA designations determine eligibility for a number of federal workforce programs, including the National Health Service Corps, Nursing Education Loan Repayment Program and Rural Health Clinic Certification. In addition, HRSA is supported by four health profession committees that advise the agency on various workforce issues. These committees include the National Advisory Committee on Nursing Education and Practice; Advisory Committee on Interdisciplinary and Community Based Linkages; Advisory Committee on Training in Primary Care Medicine and Dentistry; and the Council on Graduate Medical Education.

*Proposed Option*

Several studies and policy experts have called for a renewed effort to develop a comprehensive and coordinated national strategy to address workforce shortages and encourage training in key focus areas that support delivery system reform goals, such as improving care coordination, health provider use of health information technology and increasing access to primary care services.

Some recommendations have called for the establishment of a national health workforce commission that would be tasked with advising Congress and the Secretary on health care workforce policy and recommendations. Others have promoted, at minimum, a need to provide additional resources to support the workforce-related activities of CMS and HRSA and to encourage increased collaboration among these agencies. As part of this, Secretary should be directed to work with external stakeholders to develop and set forth a national workforce strategy that will set the nation on a path toward recruiting, training and retaining a health workforce that meets our nation's current and future health care needs.

The Committee looks forward to working in cooperation with the Senate Committee on Health, Education, Labor and Pensions to further explore and develop policies in this area.

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

## Linking Payment to Quality

*Current Law*

The Medicare statute requires Medicare Advantage (MA) plans to report certain quality measures to CMS on an annual basis in order to participate in Medicare. Preferred provider organizations were allowed to submit fewer measures than HMOs, and private fee-for-service plans were exempt altogether. But the Medicare Improvements for Patients and Providers Act of 2009 (MIPPA) required that all MA plans (including private fee-for-service plans) report quality measures beginning 2010. The quality measures include HEDIS and HOS measures developed by NCQA. These measures address a range of health issues—such as how well MA plans care for patients with asthma, heart attacks and diabetes. Some measures of health outcome, such as blood sugar control for diabetics, are also included. In addition, CMS collects consumer satisfaction information from Medicare beneficiaries who are enrolled in MA plans.

In 2006, CMS began compiling these measures into 5-star ratings of MA and prescription drug plans to report overall plan performance. CMS publishes the 5-star ratings of MA plans in the *Medicare&You* Handbook and the web-based plan finder tool to give Medicare beneficiaries better information to choose among plans. CMS also uses plan ratings for oversight and monitoring purposes to ensure plan quality.

Although MA plans report quality measures and CMS' plan ratings are publicly available, the measures and the ratings are not used to provide financial incentives to MA plans to improve quality of care. This differs from the traditional Medicare program in which a number of financial incentives and penalties are used to encourage hospitals and physicians to improve health care quality. For example, under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, acute-care hospitals that do not successfully report on a series of designated quality measures will see a two-percentage-point reduction in their annual market basket update. For FY2010, hospitals will have to report on 42 measures including clinical processes linked to better quality and coordination of care for patients with chronic disease, and various patient safety indicators.

*Proposed Option*

Under any proposed payment option, some portion of payment to MA plans should be tied to performance on quality measures. As previously mentioned, current law already requires MA plans to

report on certain quality measures on an annual basis in order to participate in the Medicare program. These measures are recognized by the NCQA, a national, independent accrediting body. CMS compiles performance on these measures, along with consumer satisfaction data, into a 5-star ranking system. This widely available ranking system could be used to determine a portion of MA payments so that higher ranked MA plans receive an increase compared to lower ranked plans.

## Developing a More Efficient Payment Structure

*Current Law*

Section 1853 of the Medicare statute requires the Secretary to calculate benchmark payment rates each year for MA plans for each county of the country (and the territories). Payments to MA plans are determined annually by the Secretary by comparing MA plan bids to the statutory benchmark rates. MA plans submit bids representing their estimated costs for providing the benefits that are covered under Medicare Parts A and B. The bid amount includes their estimated total costs of delivering benefits, as well as profit and administrative costs, sales and marketing and care management activities. (MA plans also submit separate bids to cover the benefits under Part D.) The statutory benchmarks are updated each year by CMS's projection of per capita growth in Medicare spending.

If a MA plan bid is equal to or above the benchmark, its payment is the benchmark, and it must charge an enrollee premium equal to the difference between the bid and the benchmark. If a MA plan bid is below the statutory benchmarks, its payment is its bid. In addition, MA plans that bid below the MA benchmarks are paid 75 percent of the difference between their bids and the benchmarks. Thus, the total payment to an MA plan that bids below the statutory benchmark is equal to its bid plus 75 percent of the difference between its bid and the benchmark rate.

Beginning in 2011, certain MA plans will also be eligible for incentive payments if their physicians and hospitals are meaningful users of electronic health records (EHRs). The Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act (ARRA), authorized Medicare incentive payments and penalties to encourage physicians and hospitals to adopt and use EHRs. The same EHR incentive payments and penalties also apply to certain eligible physicians affiliated with MA organizations that function as an HMO, and to hospitals that are under common corporate governance with a qualifying MA organization and serve enrollees in an MA plan offered by the organization.

*Proposed Options*

The Committee will consider modifying current MA benchmarks in order to encourage MA plans to provide Medicare covered benefits more efficiently and to promote improvements in quality of care. The goal should be to allow high quality, efficient MA plans to participate in Medicare in a cost effective manner.

The Committee will explore several approaches to modifying the MA benchmark formula. The options will have different distributional impacts on Medicare spending and beneficiary access to plans. Examples of options are described more fully below.

## Approach 1: Modify Current Benchmarks

**Blend Benchmark Rates.** The Committee could consider an option, presented at a recent MedPAC meeting, to blend local and national fee-for-service spending rather than move the benchmarks to 100 percent of local fee-for-service. In this option, beginning in 2012, the Secretary would set MA benchmarks as a blend of the local (county-level) per capita spending in traditional Medicare (75 percent) and the national average per capita spending in traditional Medicare (25 percent). This option would be phased-in over three years. All other components of MA payment, bidding and extra benefits would be maintained as under current law.

This option would lower MA benchmarks in each county and, according to analyses conducted by MedPAC, also move them closer to the costs that plans bid to provide Medicare benefits. The impact of this option would vary significantly by geographic area. In areas where local fee-for-service spending is low, the blended benchmarks would be slightly higher than local fee-for-service but in many cases fall below where plans are able to bid. This means MA plans in low spending areas would have to reduce their costs in order to keep their bids below the blended benchmarks. In areas where local fee-for-service spending is high, blended benchmarks will be lower than local fee-for-service but benchmarks would still remain above where plans are able to bid today. This means that MA plans in high spending areas would not have to lower their costs to ensure their bids are below the blended benchmarks. As result of this option, MA benchmarks would more closely reflect local patterns of fee-for-service spending and utilization of care than they do today.

**Benchmark Reduction and Gradual Phase-Down.** The Committee could also consider the option of a gradual reduction to Medicare Advantage (MA) benchmarks through a combination of across-the-board reductions and phase-downs to a target ratio for counties in which rates most exceed local fee-for-service (FFS) expenditures. The goal of this option would be to reduce MA county rates in a manner that recognizes the wide geographic variation in local fee-for-service costs across the country and mitigates any negative impact on beneficiary premiums and benefits. Under this option, in 2011, all geographic areas would be subject to a one percent across-the-board reduction in their annual growth update. Starting in 2012, rates in counties with high MA-to-FFS expenditure ratios (above 120 percent) would be reduced by phasing down ratio levels so that, by 2014, the MA-to-FFS expenditure ratio in these counties would equal 120 percent. These are areas where underlying Medicare fee-for-service expenditures are generally lower than the national average and include many rural counties and some urban areas. Counties with ratios between 101-120 percent, which are generally more urban areas, would have rates reduced by applying a 2 percent reduction in their annual growth rates in 2012, 2013, and 2014. Areas with ratios at 100 percent of FFS, which include counties with high fee-for service expenditures, would receive 1 percent growth rate reductions during this same time period. Finally, MA plans that do not utilize certain practices, including health information technology (HIT), pay-for-performance, and emphasizing primary care and wellness, would receive an additional 2 percent reduction in plan payments between 2011 and 2014.

## Approach 2: Set Benchmarks Based on Plan Bids

**Competitive Bidding Based on Policy in the President's Budget.** The Committee could also consider a competitive bidding option in which the Secretary would not set benchmark rates per statute. MA benchmarks would be established by MA plan bids for Parts A and B benefits. This method is similar to the way private plans are currently paid under Part D. Under this option, beginning in 2012, MA benchmarks would be set as the enrollment-weighted average of MA plan bids in each county or geographic area. All MA plans would be paid the new benchmark. MA plans bidding below the new

benchmark would keep 100 percent of the difference between their bid and the benchmark to provide extra benefits, reduce cost sharing, and reduce premiums to their enrollees. As under current law, MA plans that bid above the benchmark would be paid the benchmark and required to charge a supplemental premium to their enrollees. The new benchmarks would be capped at the current MA benchmarks so that new benchmarks could not exceed current levels. This provision would be phased-in over three years.

According to CBO, this option would reduce the amounts paid for enrollees in Medicare Advantage to the levels determined by the MA plan bids. This option might also encourage MA plans to compete more strongly on the basis of price and quality, rather than on the level of extra benefits as they do today. The new benchmarks would be independent from local fee-for-service spending and thus allowed to fall above or below current fee-for-service rates. However, MA plan bids in all parts of the country would be expected to compress tightly around the local area averages. This would mean plans would have few extra benefits to make available at no charge to beneficiaries. MA plans would still be allowed to offer extra benefits relative to traditional Medicare, but they may have to charge premiums.

**Competitive Bidding with Bonus Payments.** The Committee could also modify competitive bidding to include a phase-in and reward plans that meet certain standards. This approach could establish benchmarks based on MA plan bids for the Parts A and B benefits, as described above. However, beginning in 2012, MA benchmarks would be set as the enrollment-weighted average of MA plan bids in each county or geographic area. The new benchmark would be phased in over 3 years beginning in 2012. In 2012, 67 percent of the benchmark would be based on current law, and 33 percent would be based on plan bids. In 2013, 33 percent of the benchmark would be based on current law, and 67 percent would be based on plan bids. In 2014, the benchmark would be based entirely on MA plan bids for each county.

In addition, competitive bidding would be coupled with financial incentives for plans to implement evidence-based chronic care management programs (as described below) and achieve quality improvement targets mentioned earlier. The added payments would be designed to mitigate pressure on MA plans to compress their bids by reducing activities that improve quality or manage the care of their enrollees. The administrative costs for managing chronic care and improving quality would continue to be included in plan bids. The added payments would be used to offer extra benefits to Medicare beneficiaries who enroll in their plans (as described below).

## Pay for Chronic Care Management

*Current Law*

Current payments to MA plans are risk-adjusted. CMS uses characteristics, such as age, sex, disability status and prior health history to estimate the relative risk of each beneficiary enrolled in a plan. MA plans are paid their base amount (their bids plus 75 percent of any difference between their bids and the benchmarks) adjusted by their enrolled beneficiaries' risk scores. If MA plans enroll beneficiaries with higher costs, they receive an additional payment that gives them more resources to manage the higher costs of treating sicker enrollees. If MA plans enroll beneficiaries with lower costs, their base amount is adjusted downward to reflect the lower cost of covering healthier beneficiaries.

Other than risk adjusting payments, the statute does not contain explicit financial incentives for MA to manage or coordinate care for high cost, chronically ill Medicare beneficiaries.

*Proposed Option*

In addition to maintaining the current risk-adjusted payment model, the Committee could consider proposals to pay plans a bonus for chronic care management along with competitive bidding. Plans would be eligible for added payments if they manage chronic care in an effective manner. The bonus payments would be designed to mitigate pressure on MA plans to compress their bids by reducing activities of managing and coordinating care. Bonus payments would be available to MA plans that have evidence-based programs to manage the care of chronically ill beneficiaries. The amount available would be based on plan activities and performance targets, as specified below.

Plans that conduct certain activities or meet or exceed specified performance targets would be eligible for bonus payments. There are many ways to design bonus payments for chronic care. One way would be to make an additional payment of 3 to 5 percent of Medicare's national average (fee-for-service) monthly per capita cost. For example, plans could earn 1 to 2 percent for conducting certain care management activities—like having a medical home, gain sharing with their primary care providers. Plans could earn another 1 or 2 percent for meeting or exceeding quality improvement targets. While bonus payments would not be available until the new benchmarks are fully phased in, the following is an example from 2009 to illustrate the proposed bonus payments. In 2009, the national average monthly Medicare cost was $741. If this option were implemented in 2009, MA plans would be eligible to receive an additional $22 to $37 per enrollee per month. This would be a flat amount available across all areas of the country and would not depend on a plan's bid, the benchmark or service area. It would depend solely on how the plan performed.

## Simplify Extra Benefits

*Current Law*

The Medicare statute requires that MA plans use the amount of any difference between their bids and benchmarks to offer extra benefits relative to those covered under Medicare Parts A and B. The amount and type of extra benefits that can be offered by MA plans varies widely by geographic area. Plans have flexibility when determining the extra benefits, reduced cost sharing or reduced premiums to be offered along with the basic A/B benefit package. Plans can use the difference to cover benefits not available under traditional Medicare (such as eyeglasses), reduced cost sharing relative to traditional Medicare (such as $10 copays for physician visits), reduce Part B premiums, or reduce Part D premiums and cost sharing. Plans are allowed to cover the entire amount of the Part B premium ($96.40 in 2009). Only plans in certain areas of the country can buy down the entire Part B premium because the benchmarks in those areas are high. Plans cannot offer enrollees further cash rebates. These extra benefits are paid for entirely by the Medicare program at no additional cost to Medicare beneficiaries that enroll in MA plans.

*Proposed Option*

The Committee could also consider reducing the amount of variation in the amount and type of extra benefits offered by MA plans and funded by Medicare payments (i.e., at no charge to beneficiaries). Moreover, the ability to offer extra benefits could be linked to plan performance and not solely dependent on how high the MA benchmarks are set. Currently, plans in areas with high benchmarks can offer $200-$300 per month in extra benefits. Plans in areas with low benchmarks can offer $0-$10 per month in extra benefits. In addition, MA plans have wide discretion in how they allocate extra benefits. The Committee could explore ways of simplifying the amount and type of extra benefits that can be offered by MA plans.

One option is to require MA plans that can offer extra benefits with their bonus payments to do so in the following priority: (1) set a maximum limit on beneficiary out-of-pocket copayments, (2) reduce Parts A/B cost sharing, and (3) add new benefits, like eyeglasses, dental coverage, and gym memberships. Plans could also be disallowed from buying down the Part B or D premiums. Plans could also be limited in making cost sharing for Part A/B covered benefits higher than those under traditional Medicare. In other words, plans could not offer worse cost sharing than traditional Medicare. Plans could still be allowed to impose some cost sharing where there is none under traditional Medicare, such as for home health, or some laboratory services.

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

## Provider Screening

*Current Law*

The Social Security Act provides the Secretary of Health and Human Services (HHS) with general authority to prescribe regulations for the efficient administration of the Medicare program. Under this authority, the Centers for Medicare & Medicaid Services (CMS) has implemented regulations requiring providers and suppliers to submit information to enroll in the Medicare program and receive billing privileges. As part of the enrollment process, providers and suppliers are required to submit information necessary to verify identity and state licensure. CMS reserves the right to perform on-site inspections of a provider or supplier to verify compliance. If enrollment requirements are not met, CMS may revoke Medicare billing privileges. Providers and suppliers must resubmit and recertify the accuracy of their enrollment information every five years. CMS may deny a provider's or supplier's enrollment in Medicare or revoke a provider's billing privileges for the following reasons: non-compliance with enrollment requirements, exclusion from participation in federal health care programs, conviction of a felony, or the submission of false or misleading information on the enrollment application.

CMS manual instructions require that Medicare contractors query the following databases prior to approving an application for enrollment in Medicare: Qualifier.net, the Medicare Exclusions Database (List of Excluded Individuals/Entities or LEIE), and the Government Services Administration (GSA) debarment list. In a 2003 program transmittal, CMS mandated that contractors stop querying the Healthcare Integrity and Protection Data Bank (HIPDB) (discussed subsequently) when providers enroll in the program because, the transmittal stated, the HIPDB is not cost effective and duplicates other efforts.

*Proposed Option*

Medicare program applications for all providers and suppliers would be evaluated before billing privileges would be granted. The Secretary 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. Provider and supplier application fees would be imposed to cover the costs of screening. Applicants would be required to disclose previous affiliations with enrolled entities that have uncollected Medicare or Medicaid debt. A provisional participation agreement of six to 12 months would be granted during which some new providers and suppliers would be subject to enhanced oversight, such as prepayment review and payment limitations.

The Secretary would be authorized to require surety bonds of up to $500,000 (commensurate with the size of the business) and to impose moratoria on the enrollment of new providers as determined to be necessary to prevent or combat fraud. The Secretary could deny participation outright on the basis of undue risk caused by affiliations. Permissive exclusions and/or civil monetary penalties would be established for false statements on provider or supplier enrollment applications.

## Data Base Creation and Data Matching

*Current Law*

Under the Social Security Act, the Secretary of HHS is required to establish a Medicare Integrity Program (MIP) and to contract with organizations to provide a range of services to facilitate the identification of fraud, waste, and abuse in the Medicare program. MIP activities can include cost report auditing, recovery of improper payments, provider education, and data matching between Medicare and other public programs, including state Medicaid programs through the Medicare-Medicaid data matching program. In addition, CMS is required to share data with the Internal Revenue Service (IRS) and the Social Security Administration (SSA). The CMS/IRS/SSA data matching program is used to determine if beneficiaries or their spouses have other health insurance that should pay some or all of Medicare beneficiaries' health care claims.

Medicaid laws require Medicaid program integrity and related fraud and abuse activities at the state level. Medicaid program integrity activities include auditing, identifying federal overpayments, education and training, referring cases of suspected fraud and abuse to Medicaid Fraud Control Units, disclosure of ownership and control information, and development and maintenance of Medicaid Management Information Systems (MMIS computer systems) capable of supporting a full range of fraud and abuse activities, as well as coordination with the Medicare program. States also must operate eligibility determination systems that support data matching through the Public Assistance Reporting Information System (PARIS). Using PARIS, states are able to identify individuals who are receiving benefits under public programs in neighboring states. Additionally, the Secretary is required to establish a Medicaid Integrity Program (MIP) and contract with vendors to provide services to identify fraud, waste, and abuse. States are required to have false claims statutes that are consistent with the federal False Claims Act.

The Social Security Act also requires the Secretary to develop and maintain a national health care fraud and abuse data collection program for the reporting of adverse actions taken against health care providers or suppliers. The HHS Office of the Inspector General (OIG) issues regulations implementing the Healthcare Integrity and Protection Data Bank (HIPDB). The statute requires the following types of health care related adverse actions be reported to the HIPDB: civil judgments; federal or state criminal convictions; actions taken by federal or state licensing agencies; and provider exclusions from Medicare and Medicaid. Only final adverse actions are reportable to the HIPDB. Administrative fines, citations, corrective action plans, and other personnel actions are not reportable except under certain circumstances. Settlements, in which a finding of liability has not been established, are also not reportable. Both federal and state government agencies as well as health plans are required to report to the HIPDB. Health plans that fail to report are subject to a civil monetary penalty of $25,000. The Secretary is required to publish a report identifying government agencies that fail to report to the HIPDB. HIPDB cannot duplicate the reporting requirements established for the National Practitioner Data Bank.

Title IV of the Health Care Quality Improvement Act of 1986, as amended, established the National Practitioner Data Bank (NPDB). The NPDB collects and releases data related to the professional competence of physicians, dentists, and certain health care practitioners. The types of information

included in the NPDB are medical malpractice payments, certain adverse licensure actions, adverse clinical privileging actions, adverse professional society membership actions, and exclusions from Medicare and Medicaid. The statute defines the entities eligible to report and query the databank. Malpractice payers that fail to report are subject to a civil monetary penalty. Section 1921 of the Social Security Act expanded the scope of reporting requirements for the NPDB to encompass additional adverse licensure actions and actions taken by state licensing and certification agencies, peer review organizations, and private accreditation organizations. Section 1921 also required that actions taken against all health care practitioners be included in the databank. States are required to have a system for reporting adverse actions to the NPDB. A final rule implementing section 1921 has not yet been promulgated.

With respect to existing quality data reporting requirements, the Social Security Act and CMS regulations require multiple facilities to publicly report on certain quality of care measures, including hospitals, home health agencies, nursing homes, and dialysis facilities. Moreover, most states mandate a variety of professionals to report known or suspected cases of elder abuse; however, state laws vary as to who is a mandated reporter and who is encouraged to report incidents of elder/adult abuse.

The Federal Food Drug and Cosmetic Act (FFDCA) requires user facilities (*e.g.*, hospitals and nursing homes) to report specified adverse events involving medical devices to the HHS Secretary. The FFDCA also requires manufacturers of products such as prescription drug and biological products, medical devices, nonprescription drugs, and dietary supplements to report certain adverse events to the Secretary. The National Childhood Vaccine Injury Act requires voluntary adverse reports to be collected from the public, and mandatory reports from manufacturers and some others. The FDA generally collects voluntary reports via Medwatch and mandatory reports in accordance with product-specific regulations. The agency has also launched the Sentinel Initiative with the goal of creating a national, integrated, electronic system for monitoring medical product safety.

*Proposed Option*

A new comprehensive "One PI" database would be required of CMS, including specific benchmarks and implementation deadlines. The One PI database would expand existing program integrity data sources and expand data sharing and matching across federal and state Medicaid claims and payment data, including HHS, SSA, the Departments of Veterans Affairs (VA), Defense (DOD), and Justice (DOJ), and the Federal Employees Health Benefit Program (FEHBP). The One PI database would enable existing and new data sources to be integrated, such as: (1) quality-of-care under fee for service, managed care, and waivers; (2) Medicaid encounter data; (3) health plan performance; (4) ownership, control, and business relationships; (5) survey and certification; (6) resident/patient neglect or abuse; (7) adverse actions; (8) site visits; (9) penalties and settlements; and (10) data on results from other program monitoring.

The existing provider databases (HIPDB, NPDB, and LEIE) would be expanded and consolidated with a national patient abuse/neglect registry into a centralized sanctions data system. This data system would include information on providers in Medicare and all state Medicaid programs, including provider ownership and business relationships, history of adverse actions, results of site visits or other monitoring by any program. Additional reporting of facility-specific quality-of-care data would be required. Data on the fraud settlements that occur during the year would be reported to the consolidated database. State licensure boards and federal and state law enforcement agencies would be able to access the data. The Medicare and Medicaid programs would be required to verify any applicant's status in the provider database prior to issuing provider/supplier numbers.

The One PI database would be accompanied by additional authority for appropriate agencies (such as OIG and DOJ) to use these data, including secondary data sources, to identify and investigate potential fraud and abuse, including by coordination of benefits, workers' compensation, auto insurance, and private health/life insurance. New civil penalties would be authorized for instances of intentional fraud and abuse, as well as new sanctions to be imposed on entities that failed to submit necessary data. Failure to report Medicaid encounter data would result in a reduction of federal financial participation available under title XIX of the Social Security Act.

CMS and OIG would be authorized to access all supporting documentation needed to validate Medicare claims and/or payments, including beneficiary medical records of prescribing physicians for prescription drugs paid for through Medicare Part D.

## Provider Compliance and Penalties

*Current Law*

**Conditions of Participation and Coverage.** The Social Security Act mandates the establishment of minimum health and safety standards that providers (hospitals, hospices, nursing homes, and home health agencies) and suppliers participating in the Medicare and Medicaid programs must meet in order to receive payment. Generally, state agencies, under contract with CMS, survey providers and certain suppliers to determine compliance with the conditions or standards set forth in the statute and regulations. Alternatively, a provider can be deemed to meet these requirements if it has been accredited by an approved national accreditation body which has demonstrated that its inspection program ensures that all applicable conditions are met or exceeded. CMS has the authority to conduct a survey of an accredited provider or supplier to validate its organization's accreditation process. These surveys are conducted on a representative sample basis, or in response to substantial allegations of noncompliance. The remedies available to CMS when a provider is found noncompliant with Medicare's health and safety standards include revoking the provider's participation agreement, denying payment, requiring a corrective action plan, and imposing certain penalties.

**Program Sanctions.** Under Medicare's peer review or Quality Improvement Organization (QIO) program, the Secretary has the authority to impose sanctions on providers participating in Medicare for noncompliance. Health care providers that receive Medicare payment are required to provide services that are both medically necessary and economically efficient. Medicare providers and suppliers are also required to provide services that meet professionally recognized standards of care. If a QIO finds that a provider has failed in a substantial number of cases to meet these requirements, or has committed a gross violation of care, the Secretary may exclude the provider from participating in federal health care programs. The Secretary may also impose a fine of up to $10,000 for each instance of medically improper or unnecessary care.

**Payment Suspension.** CMS and its contractors have the authority to withhold payment in whole or in part if there is reliable evidence of an overpayment or fraud. CMS regulations stipulate the procedures CMS and its contractors must follow when deciding to suspend payment.

**Deterrence/Civil and Criminal Penalties.** OIG is authorized to impose civil penalties on any person, including an organization, agency, or other entity, that knowingly presents or causes to be presented to a federal or state employee or agent certain false or fraudulent claims. A penalty of not more than $15,000 may be assessed against individuals that knowingly give false or misleading information to influence the decision when to discharge such person or another individual from a hospital. Entities that are excluded from Medicare or Medicaid but retain an ownership or control interest in a participating entity may be

civilly fined not more than $10,000 per day. Civil monetary penalties (CMPs) of not more than $50,000 may be levied against individuals that knowingly and willfully make false statements or receive kickbacks in connection with reimbursement from a federal health program. An individual or entity excluded from a federal health care program that submits a claim for reimbursement to a program, or causes such a claim to be submitted, may be subject to a civil monetary penalty of up to $10,000 for each item or service furnished during the period that the person or entity was excluded. The individual or entity may also be subject to treble damages for the amount claimed for each item or service. The Secretary may issue subpoenas and require the attendance and testimony of witnesses and the production of any other evidence at an investigational inquiry. The Secretary may also delegate this authority to OIG for purposes of any investigation under the civil monetary penalties statute.

The False Claims Act provides penalties for submitting a false claim for payment or approval to an officer or employee of the federal government. Violations may be punished with a civil monetary penalty between $5,000 and $10,000, plus treble damages.

The Emergency Medical Treatment and Active Labor Act (EMTALA) imposes a duty on Medicare participating hospitals with an emergency department to provide an initial screening examination, and any necessary stabilizing treatment, to individuals that come to the emergency department and request assistance. Violations of EMTALA by hospitals may be punished with a civil monetary penalty of not more than $50,000 ($25,000 in the case of hospitals with fewer than 100 beds). Violations by physicians may be punished with a civil monetary penalty of not more than $50,000.

Under the Health Insurance Portability and Accountability Act (HIPAA), it is illegal for anyone to willfully prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a "federal health care offense." Section 241 of HIPAA defines "federal health care offense" as a number of criminal acts related to health care under the federal criminal code.

**Program Exclusions.** OIG has the authority to exclude health care providers from participation in federal health care programs. Exclusions from federal health programs are mandatory under certain circumstances and permissive in others. Exclusion is mandatory for those convicted of certain offenses, including (1) a criminal offense relating to the delivery of an item or service under Medicare, Medicaid, or a state health care program; (2) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service; or (3) a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. OIG has "permissive" authority to exclude an entity or an individual from a federal health program under numerous circumstances, including conviction of certain misdemeanors relating to fraud, theft, embezzlement, breach of fiduciary duty or other financial misconduct; a conviction based on an interference with or obstruction of an investigation into a criminal offense; and revocation or suspension of a health care practitioner's license for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

Generally, in the case of a mandatory exclusion, the minimum period of exclusion cannot be less than five years. However, upon the request of the administrator of a federal health care program who determines that the exclusion would impose a hardship on individuals entitled to benefits under Medicare Part A or enrolled under Medicare Part B (or both), the Secretary may waive the exclusion under certain circumstances with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.

Section 1128 of the Social Security Act provides that any individual or entity that is excluded (or directed to be excluded) from participation in a federal health care program is entitled to reasonable notice and opportunity for a hearing by the Secretary, as well as judicial review of the Secretary's final decision after

such hearing. This section also provides that an exclusion is effective at such time and upon such reasonable notice to the public and to the individual or entity excluded, as may be specified in regulations. However, unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under Medicare or under a state health care program for—(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or (ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion, until the passage of 30 days after the effective date of the exclusion. Further, unless the Secretary determines that the health or safety of individuals receiving services warrants the exclusion taking effect earlier, any individual or entity that is the subject of an adverse determination based on certain false claims, kickbacks, and other prohibited activities is entitled to a hearing by an administrative law judge before any exclusion based upon the determination takes effect.

*Proposed Option*

As a condition of participation, Medicare and Medicaid providers would be required to implement compliance programs. Intermediate sanctions and program safeguards would be established to provide greater flexibility to CMS and law enforcement to address problems. Payments could be suspended during an investigation.

The CMP law would be amended in several instances to increase monetary penalties and extend use of CMPs. A CMP would be established for each instance of a hospital's failure to report an adverse action affecting the clinical privileges of a physician. The CMP law (at section 1128A(a)(5) relating to beneficiary inducements), would be amended to tailor the prohibition to address harmful conduct and relieve the burden on certain charitable and other innocuous programs currently covered by the broad reach of the statute. The imposition of a CMP would be authorized on an excluded person who orders or prescribes (rather than directly furnishes) items or services reimbursed by federal health care programs.

Penalties for submitting false claims and for violations of EMTALA would be increased. Criminal offenses of the Social Security Act (section 1128B) would be defined as "federal health care offenses." The testimonial subpoena authority would be extended to program exclusion investigations.

Section 1128(c)(3)(B) would be amended to clarify that hardship waivers of an OIG exclusion can be based on hardship imposed on beneficiaries of any federal health care program.

## Program Integrity Funding and Reporting Requirements

*Current Law*

Medicare program integrity and anti-fraud activities are funded through the Health Care Fraud and Abuse Control (HCFAC) and, as mentioned earlier, MIP. HCFAC and MIP were both established by HIPAA, which sought to increase and stabilize federal funding for health care anti-fraud activities. Specifically, HCFAC funds are directed to the enforcement and prosecution of health care fraud, whereas MIP funding supports the program integrity activities undertaken by CMS contractors.

The purpose of the HCFAC program, which is jointly administered by HHS and DOJ, is to coordinate federal, state, and local law enforcement efforts directed at controlling health care fraud and abuse. To fund the program, HIPAA established within the Hospital Insurance (HI) Trust Fund (Part A) an expenditure account called the HCFAC account. All monies collected from health care investigations and enforcement efforts are to be deposited into the HI Trust fund. The HCFAC account funds anti-fraud

activities conducted by HHS, the HHS OIG, DOJ, and the Federal Bureau of Investigation (FBI). MIP authorizes the Secretary to contract with private entities to conduct the following six activities: (1) medical review; (2) audits of cost reports; (3) Medicare Secondary Payer determinations; (4) provider education; (5) developing and updating a list of items of DME that are subject to prior authorization; and, as mentioned earlier, (6) the Medicare-Medicaid Data Match Program.

Funding for HCFAC increased from $176 million in FY1998 to $376 million in FY2008. The Tax Relief and Health Care Act of 2006 (TRHCA) extended and increased the mandatory annual appropriation for HCFAC to 2010. Funding for MIP increased from $440 million in FY1998 to $820 million in FY2006. The Deficit Reduction Act of 2005 (DRA) increased funding for the MIP program by $112 million for FY2006 to implement program integrity and oversight activities for the prescription drug benefit. TRHCA, however, did not increase funding for MIP, so the annual appropriation for MIP remains at $720 million. Between fiscal years 1998 and 2008, total funding for program integrity and health care fraud activities increased from an estimated $0.7 billion to $1.1 billion.

Every year, HHS and the DOJ are required to release a joint annual report to Congress on HCFAC results and accomplishments. These reports include numbers and examples of enforcement actions, program accomplishments, and amounts deposited into the HI Trust Fund resulting from health care fraud enforcement activities. Congress did not require that HHS and DOJ include expenditures or results for the MIP program in these reports.

Established by the DRA, the Medicaid Integrity Program (MIP) is modeled after Medicare's MIP program. MIP provides HHS with dedicated resources to promote Medicaid integrity, to contract with entities to reduce fraud, waste, and abuse, and to add 100 full-time equivalent MIP staff. Annual MIP reports to Congress on program accomplishments and use of funds are required. In addition, the Secretary is required to develop comprehensive five-year plans for Medicaid program integrity.

*Proposed Option*

HCFAC funding would be increased to allow HHS and DOJ to engage in more of the integrity activities allowed in that program.

With respect to both MIPs, annual reporting requirements would be enhanced and harmonized by expanding the program evaluation requirements for the Medicare Integrity Program. This would allow for more meaningful assessment of the Medicare and Medicaid Integrity Programs.