Southeastern Actuaries Conference
Medicare Advantage Update
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Agenda

- Part C and D Reporting Requirements
- 2010 Medication Therapy Management Requirements
- Model of Care
- Impact of Proposed Health Care Reform

Part C and D Reporting Requirements

CMS Part C & D Reporting Requirements

Background

- In 2006, CMS initiated the collection of Part D Reporting Requirement data.
- CMS introduced Part C Reporting requirements beginning January 1, 2009.
- Medicare Advantage Organizations ***must*** have effective procedures to develop, compile, evaluate and report to CMS.
- MA Plans must report on 28 measures in 2009 moving to 31 in 2010
- Beginning in 2010, Part C and Part D Plan reported data will be audited (8 measures)

CMS Part C Reporting Requirements

2009 Reporting Measures (13)

Measure	Reporting Frequency	First Due date
1. Benefit Utilization	Annually	August 31, 2010
2. Procedure Frequency	Annually	May 31, 2010
3. Serious Reportable Adverse Events	Annually	May 31, 2010
4. Provider network Adequacy	Annually	February 28, 2010
5. Grievances	Quarterly	May 31, 2009
6. Organization Determinations/ Reconsiderations	Quarterly	May 31, 2009
7. Employer Group Plan Sponsors	Semi-annually	August 31, 2009
8. PFFS Plan Enrollment Verification Calls	Annually	February 28, 2010
9. PFFS Provider Payment Dispute Resolution Process	Annually	February 28, 2010
10. Agent Compensation	Annually	February 28, 2010
11. Agent Training/Testing	Annually	February 28, 2010
12. Plan Oversight of Agents	Quarterly	May 31, 2009
13. SNPs Care Management	Annually	May 31, 2010

CMS Part D Reporting Requirements

2010 Data Elements Summary (18)

Measures	Reporting Frequency
1. Retail, Home Infusion and LTC Pharmacy Access	One Quarter Annually
2. Access to Extended Day Supplies at Retail Pharmacies	Collected Annually
3. Vaccines	Semi-annually Annually
4. MTMP	Semi-annually/Annually
5. Generic Drug Utilization	Quarterly
6. Grievances	Quarterly
7. Pharmacy Support of Electronic Prescribing	Quarterly
8. Employer/Union-Sponsored Group Health Plan Sponsors	Semi-annually
9. Coverage Determinations and Exceptions	Quarterly
10. Appeals	Quarterly
12. Pharmaceutical Manufacturer Rebates, Discounts, other price concessions	Annually
13. LTC Utilization	Semi-annually/Annually
14. FWA Compliance Programs	Semi-annually Annually
15. Drug Benefit Analyses	Quarterly
16. Enrollment	Quarterly
17. Plan Oversight of Agents	Quarterly
18. Agent training and testing	Annually

Data Validation Process

- MAO completes the Organizational Assessment Instrument (OAI)
- Data Validation Contractor (DVC) conducts onsite visit to MAO
  - Interviews with staff
  - Policy and Procedure review
  - Review sample data and data files
  - Validation standard review
- DVC conducts offsite data evaluation and review
- DVC prepares final assessment report for MAO
- DVC submits data validation results to CMS

Data Validation Timeline

- Industry Comment Period – Ended September 30
- CMS Pilot Testing – September 2009 to March 2010
- Industry Launch – Spring 2010
- Data Validation Timeframe – March 2010 through June 2010

2010 Medication Therapy Management Requirements

MTM Program - Purpose

- MTM programs aim to improve therapeutic outcomes
  - promote appropriate use of medications
  - reduce the risk of adverse events, including adverse drug interactions

Under 423.153(d), a Part D sponsor must have established a MTM program that:

- Ensures optimum therapeutic outcomes for targeted beneficiaries through improved medication use
- Reduces the risk of adverse events
- Is developed in cooperation with licensed and practicing pharmacists and physicians
- Describes the resources and time required to implement the program if using outside personnel and establishes the fees for pharmacists or others
- May be furnished by pharmacists or other qualified providers
- May distinguish between services in ambulatory and institutional settings
- Is coordinated with any care management plan established for a targeted individual under a chronic care improvement program (CCIP)

Per the revised in requirements in the 2010 Call Letter, all Part D sponsors must establish a MTMP that:

- Enrolls targeted beneficiaries using an opt-out method of enrollment only
- Targets beneficiaries for enrollment at least quarterly during each year
- Targets beneficiaries who:
  - Have multiple chronic diseases
  - Are taking multiple Part D drugs
  - Are likely to incur annual costs of at least $3000 for all covered Part D drugs
- Offers interventions to the participating beneficiary and his/her prescriber.
- Measures and analyzes MTMP outcomes and reports details to CMS through our Part D reporting requirements.

Model of Care

CMS is very specific of the Model of Care Goals

- Improve **access** to medical, mental health, and social services
- Improve access to **affordable** care
- Improve coordination of care through an identified point of contact
- Improve **transition of care** across healthcare settings and providers
- Improve access to **preventive** health services
- Assure appropriate **utilization of services**
- Assure **cost-effective** service delivery
- Improve **beneficiary health outcomes:**
  - Reduce hospitalizations and SNF placements
  - Improve self-management and independence
  - Improve mobility and functional status
  - Improve pain management
  - Improve quality of life as self-reported
  - Improve satisfaction with health status and health service

Written care plan management is required for all SNP Members

- Goals should address
  - MOC goals are written as measurable outcomes
  - How the MAO will know that MOC goals are met
  - What actions the MAO will take if MOC goals are not met

Individualized Care Plan - Goals and objectives are written as measurable

- ID most vulnerable beneficiaries' special needs
- Address the needs of the most vulnerable through add-on benefits and services
- Involve beneficiaries and/or caregivers whenever feasible
- Be reviewed and revised when health status changes, in addition to annually and initially
- Specific services and benefits to be provided should be included
- Specific indicators that will be measured to determine if goal is met
- Show that actions are taken if goal is not met

Impact of Proposed Health Care Reform

Role of Public Programs
Dual-Eligible Benefit Coordination

- Chairman's Mark
  - Establishes Federal Coordinated Health Care Office (CHCO)
    - Established by March 1, 2010
    - Reports directly to the Administrator of CMS

Purpose:

- Integrate benefits under Medicare and Medicaid program.
- Improve coordination between Federal and state governments to ensure beneficiaries get full access to the items and services to which they are entitled.

Goals:

- Provide dual-eligible beneficiaries full access to their benefits.
- Simplify the processes for access to benefits and services.
- Improve the quality of health care and long-term care services.
- Increase beneficiary understanding and satisfaction.
- Eliminate regulatory conflicts between the two programs.
- Improve care continuity.
- Eliminate cost-shifting between the two programs and related health care providers.
- Improve the quality of performance of providers and services under the two programs.

Promoting Disease Prevention and Wellness

- Beginning in 2011, Medicare beneficiaries would have access to a comprehensive health risk assessment (HRA)
  - Detect chronic diseases, modifiable risk factors and urgent health needs
  - Completed prior to or as part of welcome visit
  - Medicare would pay for assessment and personalized prevention plan
  - Personalized prevention plan would include:
    - Schedule of preventive services
    - Strategy to address risk factors
    - List of all medications currently prescribed
    - List of all providers involved in the patient’s care
    - Referral to interventions for modifiable risk factors, such as nutrition and smoking
- Removing Barriers to Preventive Services
  - Remove cost sharing for preventive services covered by Medicare
- Evidence-Based Coverage for Preventive Services
  - Provide funding for CMS to improve provider education and patient awareness

Promoting Disease Prevention and Wellness

- Study on Beneficiary Access to Immunizations
  - Evaluate impact on access of covering adult immunizations under Part D
- Incentives for Healthy Lifestyles
  - Appropriate $100M over five years
  - Provide incentives to beneficiaries who successfully participate in healthy lifestyle programs
  - Programs target:
    - Risk factors
    - High blood pressure
    - High cholesterol
    - Tobacco use
    - Overweight or obesity
    - Diabetes and falls
  - Establish a system to monitor participation and validate changes in health risk and outcomes
  - Prior to establishing incentive, will review evidence concerning healthy lifestyle programs

Improving the Quality and Efficiency of Health Care
Medicare Advantage

- Medicare Advantage Payment
  - The calculation of MA benchmarks would be based on actual plan costs as reflected in plan bids, rather than statutorily set rates
    - Encourages plans to compete on the basis of price and quality, rather than on the level of extra benefits offered to enrollees
    - Provides cost savings
  - Transition plan for MA local benchmarks:
    - 2011: Per capita growth percentage decreased by 3%
    - 2012: Blended 33% enrollment weighted plan bids / 67% current law MA benchmarks
    - 2013: Blended 67% enrollment weighted plan bids / 33% current law MA benchmarks
    - 2014: 100% of the enrollment weighted average of the 2013 plan bids, increased by national MA growth percentage for 2014
    - 2015: Enrollment weighted average of all MA bids in each payment area
  - Regional plan benchmark would continue to be calculated the same
    - Statutory portion would be based on the new MA benchmarks, though

Improving the Quality and Efficiency of Health Care
Medicare Advantage

- Medicare Advantage Payment
  - Plan Rebate:
    - 2011, 2012, and 2013 local and regional MA plans will still receive 75% of the difference between their bid and the benchmark rates as a rebate payment
    - Beginning in 2014, MA plans would receive 100% of the difference between their bids and the new benchmarks if their bid is below the new benchmark
      - As is now, if a plan's bid is equal to or above the new benchmark rates they must charge an enrollee premium equal to the difference
  - Bidding Rules
    - Beginning in 2012, establish bidding rules to protect the integrity and fairness of the bidding process
    - Bids not meeting actuarial standards or abiding by the rules established will be denied
    - Plan actuaries who certified these bids will be reported to the ABCD

Improving the Quality and Efficiency of Health Care
Medicare Advantage

- Medicare Advantage Payment
  - Payment Areas
    - Beginning in 2012, establish new MA payment areas for urban areas
    - In urban areas, payment areas will be based on MSAs, as determined by the OMB
      - Divide MSAs that cover more than one state
      - Allow for adjustments to reflect patterns of actual health care use
    - Beginning in 2015, one or more rural counties in a state would be combined into a single service area
    - In 2012, bidding service areas and payment areas will be the same
    - Plans must bid and serve the entire payment area
      - Limited exception to payment area requirements for plans can be made if:
        - » There are historical licensing agreements that preclude the offering of benefits throughout the entire payment area
        - » There are historical limitations in a plan’s structural capacity to offer benefits throughout an entire payment area

Improving the Quality and Efficiency of Health Care
Medicare Advantage

- Medicare Advantage Payment
  - Bonus Payments
    - Beginning in 2014
    - Based on care coordination and management activities by MA plans
    - ½% of the USPCC is available for each of the following criteria that a plan meets:
      1. Care management programs that target individuals with one or more chronic conditions, identify gaps in care, and facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.
      2. Programs that focus on patient education and self-management of health conditions, including interventions that help manage chronic conditions, reduce declines in health status and foster patient/provider collaboration.
      3. Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and re-admissions.
      4. Patient safety programs, including provisions for hospital-based patient safety programs in their contracts with hospitals.

Improving the Quality and Efficiency of Health Care

Medicare Advantage

- Medicare Advantage Payment (continued)

  5. Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements or pay-for-performance programs.
  6. Medication therapy management programs that focus on poly-pharmacy and medication reconciliation, periodic review of drug regimens, and integration of medical and pharmacy care for chronically-ill, high-cost beneficiaries.
  7. Health information technology programs, including electronic health records, clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.
  8. Programs that address identify and ameliorate health care disparities among principal at-risk subpopulations.

  – 2nd bonus payment based on prior achievement or improvement in plan quality performance
    - Could receive 2% or 4% of USPCC depending on how well they rank above an average score.
    - Accommodations will be made for new and low-enrollment plans, so they may receive up to 2% based on certain criteria. In the third year, new plans will be evaluated in the same manner as other plans with comparable enrollment.

  – Plans must use 100% of these bonus payments to offer additional benefits to enrollees

Improving the Quality and Efficiency of Health Care
Medicare Advantage

- Medicare Advantage Payment
  - Grandfathering
    - Plans allowed to grandfather extra benefits to current enrollees
    - Grandfather begins in 2012
    - Beginning in 2013, extra benefits will be reduced by 5% each year
    - Must submit a separate bid for enrollees with grandfathered benefits
    - Performance bonuses not available for grandfathered plans
  - Transitional Benefits
    - Provides for transitional benefits for enrollees who would experience a significant reduction in additional benefits due to competitive bids
  - CMS Actuary Certification
    - If the Chief Actuary of CMS certifies that beneficiaries would lose Medicare-covered benefits when the provisions of the Chairman's Mark are implemented, the Mark would strike the provisions related to competitive benchmarks and bonus payments
    - This determination must be made three months after the enactment of this legislation

Improving the Quality and Efficiency of Health Care
Medicare Advantage

- Benefit Protection and Simplification
  - Prohibits MA plans from charging cost sharing greater than under original Medicare for certain services such as chemotherapy treatment, renal dialysis and skilled nursing care
  - Reserves the right to identify additional services for which this provision applies
  - Modifies how plans can use their rebates and bonuses beginning in 2012:
    - Use most significant share to meaningfully reduce Part A, B and D cost sharing
      - No more reducing or eliminating the Part B premium
      - Out of pocket maximums would apply to all Part A and B benefits
    - Use next share to add preventive and wellness benefits
    - Use remainder to add non-covered benefits
  - Simplify information to beneficiaries by classifying plans according to the share that rebates, bonuses and supplemental premiums are of each plan's bid
    - A plan's marketing materials must reflect this category

Improving the Quality and Efficiency of Health Care

Medicare Advantage

- Simplification of Annual Beneficiary Election Periods
  - Beginning in 2011, annual enrollment period dates for MA and Part D will be 10/15 – 12/7
  - Beginning in 2011, annual open enrollment period (1/1 – 3/31) for MA plans will be eliminated
  - Beginning in 2011, new 45-day period (1/1 – 2/15) in which beneficiaries who enroll in MA or PDP plans during the AEP could disenroll and return to FFS

Improving the Quality and Efficiency of Health Care

Medicare Advantage

- Extension for Specialized MA Plans for Special Need Individuals
  - Extend SNP authority through 12/31/2013
  - Require all dual-eligible SNPs to have established contracts with state Medicaid programs by 1/1/2013
  - Changes related to payments, rebates and bonuses mentioned above apply to SNPs as well
  - SNP bids will be used in the determination of the MA benchmarks from 2012-2013
  - As under current guidelines, dual-eligible SNPs would not be allowed to charge premiums if their bids exceed the new benchmarks
  - Provide authority for a frailty adjustment for fully-integrated dual-eligible SNPs
  - New enrollees would be assigned a risk score that reflects the known underlying risk profile and chronic health status of each enrollee
  - Beginning in 2012, SNP plans must be certified by the NCQA in order to serve the targeted populations

Improving the Quality and Efficiency of Health Care
Medicare Advantage

- Extension of Reasonable Cost Contracts
  - Cost contracts may continue operating regardless of any other MA plans serving the area for three years, from 1/1/2010 to 1/1/2013
- MA Private Fee-for-Service Plans
  - Allows employer-based PFFS plans a waiver from the network requirements
  - For plans not sponsored by employers, a network area would be defined as an area served by two or more MA organizations
- Medigap
  - Requests that the NAIC create new plans for C and F that include normal cost sharing
    - Encourages the use of appropriate Part B physician services
    - Available in 2015

Improving Medicare for Patients and Providers

- Medicare Part D Improvements
  - Improving Coverage in the Part D Coverage Gap
    - Discount program for beneficiaries who have drug spending that falls into the coverage gap
    - Provides for 50% discount on brand-name drugs available during the entire coverage gap
    - Only for beneficiaries enrolled in Part D who do not qualify for the low-income subsidy and are not enrolled in an ER sponsored plan
    - 100% of the negotiated price of discounted drugs count toward TrOOP
    - If a manufacturer does not participate in the discount program, their drugs will not be covered under Part D
  - Improving the Determination of Part D Low-Income Benchmarks
    - Effective in 2011, MA rebates and bonus payments will be excluded from the MA-PDP premium amount when calculating the regional LIS benchmark amount
  - Voluntary De Minimus Policy for Low-Income Subsidy Plans
    - Plans that bid a nominal amount above the regional LIS benchmark amount can chose to absorb the cost of the difference between their bid and the LIS benchmark in order to qualify as an LIS-eligible plan

Improving Medicare for Patients and Providers

- Medicare Part D Improvements
  - Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance
    - Beginning in 2011, the surviving spouse of an LIS-eligible couple undergo a redetermination of his or her eligibility status no earlier than one year from the next scheduled redetermination
  - Facilitation of Reassignments of Beneficiaries in Low-Income Subsidy Plans
    - Plans whose LIS members are reassigned must submit utilization data to the beneficiary's new plan within thirty days of notification of the reassignment
  - Funding Outreach and Education of Low-Income Programs
    - Provides $45M for outreach and education activities related to low-income assistance programs
  - Strengthening Formularies with Respect to Certain Categories or Classes of Drugs
    - Provides authority to determine classes of clinical concern
    - These classes of clinical concern will be protected on plan formularies

Improving Medicare for Patients and Providers

- Medicare Part D Improvements
  - Reducing the Part D Premium Subsidy for High-Income Beneficiaries
    - Applies to beneficiaries with adjusted gross income of $85,000 (individual) and $170,000 (couple) in 2009
    - Instead of setting the Medicare premium subsidy at 74.5% of total Part D premiums, the subsidy would vary based on annual income
  - Simplifying Part D Plan Information
    - Beginning in 2011, establishing two or more categories of prescription drug plans, based on ranges of the actuarial values
    - Develop standardized nomenclature, definitions and language to describe and present the benefits on Plan Finder
  - Limitation on Removal or Change of Coverage of Covered Part D Drugs Under a Formulary Under a PDP or MA-PD
    - Cannot remove a covered drug from plan formulary
    - Cannot apply a cost or utilization management tool that limits coverage of such a drug
    - Cannot increase cost sharing of such a drug other than the date on which Part D sponsors begin marketing their plans

Improving Medicare for Patients and Providers

- Medicare Part D Improvements
  - Medicare Part D Copayment Equity – cost sharing for beneficiaries under a home or community based service would be equal to those receiving institutional care, beginning 1/1/2011
  - AIDS Drug Assistance Programs and Indian Health Service – count toward annual out of pocket threshold, beginning 1/1/2011
  - Generic "First Fill" – plan sponsors allowed to waive copayments for first fills of generic drugs
  - Long-Term Care Pharmacy – provisions to reduce waste associated with 30-day fills for residents in long-term care facilities
  - Pharmacy Benefit Manager Transparency – PBMs provide information to HHS and plans regarding prescription utilization and costs
  - Office of the Inspector General – must report annually on the inclusion of drugs commonly used by dual-eligibles on Part D plan formularies
  - HHS Ongoing Study on Coverage for Dual-Eligibles – report on retroactive coverage for full benefit dual eligibles who enroll in a plan under Part D

Examples of Bid Payments

Transition to Competitive Bidding – Determination of Benchmarks

- 2011: CMS National Growth Rate minus 3%
- 2012: $2/3^{rds}$ current law benchmark + $1/3^{rd}$ current year competitive bids for basic Medicare A/B
- 2013: $1/3^{rd}$ current law benchmark + $2/3^{rds}$ current year competitive bids for basic Medicare A/B
- 2014: 2013 enrollment weighted competitive average bid for basic Medicare A/B adjusted for 2014 National Growth Rate
- The above would be calculated at the MSA level for urban areas and county level for rural areas.
- For RPPO, the statutory portion would be based on the new MA benchmarks instead of statutory rates.

Examples - Assumptions

- CMS National Growth Rate = 0%
- MA Claim Trend = 0%
- MA Risk Score = 1.0
- Coding Intensity adjustment = 0%
- A/B Cost = average bid amount
- The above is to show the impact without addressing the effect of CMS growth rates, MA claim trends and changes in risk scores, including coding intensity adjustments.

Example – Dade County, FL

Year	Benchmark	A/B Cost	Rebate	Supp Bens	RxPrem	MberPrem
2010	$1,230	$870	$270	$170	$100	$ 0
2011	$1,193	$870	$242	$142	$100	$ 0
2012	$1,085	$870	$ 161	$61	$100	$ 0
2013	$ 978	$870	$ 81	$ 0	$100	$ 19
2014	$ 870	$870	$ 0	$ 0	$100	$100

- **The current rebate approach applies through 2013.**
- **The above example assumes that MA benefits are reduced first, and that rebates are applied to the Rx premium to the extent available.**
- **As the rebate continues to decline, it ultimately leads to a member premium, assuming no reduction in Rx benefits.**
- **2012 BM = (2 * 1193 + 870) / 3**
- **2013 BM = (1193 + 2 * 870) / 3**

Example - Roosevelt County, MT

Year	Benchmark	A/B Cost	Rebate	RxPrem	MberPrem
2010	$ 740	$720	$15	$ 25	$50
2011	$ 718	$720	$0	$ 25	$67
2012	$ 718	$720	$0	$ 25	$67
2013	$ 718	$720	$0	$ 25	$67
2014	$ 718	$720	$0	$ 25	$67

- This example, assumes the benchmark can not exceed the benchmark that would apply under existing law, thus it remains constant. Chairman's Mark not clear.
- Value of supplemental benefits = $50 – $25 + $15 = $40. Supplemental benefits are assumed to be kept constant.
- 2011+ member premium = $720 – $718 + $40 + $25.

Payments Under Competitive Bidding

- Example assumptions:
  - Three plans in marketplace, each with equal number of enrollees
  - Plan bids: A = $900; B = $850; C = $800
  - Current law benchmark = $1,000
  - Competitive bidding benchmark = $850 (weighted average of plan bids)

	Payment to Plan		Rebate		Member Premium	
	Current = Plan Bid + Rebate	Compe-titive Bidding	Current = .75 * (BM – Plan Bid	Compe-titive Bidding	Current	Compe-titive Bidding
Plan A	$975	$850	$75	n/a	n/a	$50
Plan B	$962.50	$850	$112.50	n/a	n/a	$0
Plan C	$950	$850	$150	$50	n/a	n/a

Other Issues - MA

- The SFC Chairman's Mark provides for offsetting the SGR adjustment for 2010 only. The SGR adjustment will continue to negatively impact benchmarks after 2010.
- There is a provision that if a plan's A/B cost is less than 75% of the benchmark for 2011, the associated rebate can be carried forward through 2019, but with an annual 5% amortization. No details are provided as to how to prepare a bid.
- The introduction of a competitive element will significantly change the bid submission process for 2012 and later bids. The Mark does not contain any guidance as to how this would be implemented.

Changes to Provider Payments and other items

Improving the Quality and Efficiency of Health Care
Linking Payment to Quality Outcomes in the Medicare Program

- Hospital Value-Based Purchasing (VBP)
  - Establish a VBP that pays for actual performance on quality measures
  - Make value-based incentive payments to acute care IPPS hospitals beginning FY2012
  - Adjust hospital payments based on performance under the VBP beginning FY2013
  - Measures would focus on same areas of the current quality measures:
    - Heart attack
    - Heart failure
    - Pneumonia
    - Surgical care activities
    - Patient perception of care
  - Funding for VBP incentive payments would be generated through reducing Medicare IPPS payments to hospitals and would be phased in as follows:
    - 1.00% in FY2013
    - 1.25% in FY2014
    - 1.50% in FY2015
    - 1.75% in FY2016
    - 2.00% in FY2017
  - DSH, IME, low-volume and outlier payments would not be impaired by payment reductions

Improving the Quality and Efficiency of Health Care

Linking Payment to Quality Outcomes in the Medicare Program

- Physician Value-Based Purchasing
  - Physician Quality Reporting Initiative (PQRI)
    - Currently:
      - Physician quality reporting system
      - Successful reporting yields a bonus payment of 2% of allowable charges
      - Program ends in 2010
    - Proposed:
      - Incentive payments extended beyond 2010
      - CMS to provide timely feedback to providers and establish an appeals process for providers who participate in the PQRI
      - Beginning in 2011, CMS will make incentive payments to physicians who participate in a new PQRI set of criteria
      - CMS will also issue penalties to eligible professionals who failed to participate in the program
        - » 1.50% in 2013
        - » 2.00% in 2014 and beyond

Improving the Quality and Efficiency of Health Care
Linking Payment to Quality Outcomes in the Medicare Program

- Physician Value-Based Purchasing (continued)
  - Expansion of Physician Feedback Program
    - Currently:
      - MEDPAC and GAO recommended providing physicians with feedback on resources used
      - Expectation is physicians can study their practice patterns to determine if they use resources more than peers or what evidence-based research recommends
      - MIPPA established a feedback program, which will provide physicians confidential reports that measure the resources involved in furnishing care to Medicare beneficiaries
    - Proposed
      - Beginning in 2012, CMS will provide reports to physicians that compare their resource use with that of other physicians or groups of physicians caring for patients with similar conditions
      - Beginning in 2014, payment would be reduced by five percent if an aggregation of the physician’s resource use is at or above the 90th percentile of nation utilization

Improving the Quality and Efficiency of Health Care
Linking Payment to Quality Outcomes in the Medicare Program

- Physician Value-Based Purchasing (continued)
  - IP Rehabilitation Facility, Long Term Acute Care Hospital and Hospice Quality Reporting
    - Currently
      - IRFs, LTCHs and hospices are not required to report quality data to CMS
      - IRFs do submit a clinician’s comprehensive assessment of each patient upon admission and at discharge
    - Proposed
      - Establishes quality reporting programs for IRFs, LTCHs and hospices
      - Failure to report quality measures would result in reduction of annual market basket update by 2.00%

Improving the Quality and Efficiency of Health Care

Linking Payment to Quality Outcomes in the Medicare Program

- Physician Value-Based Purchasing (continued)
  - IPPS Exempt Cancer Hospital Quality Reporting
    - Currently:
      - Eleven cancer hospitals are exempt from the Medicare IPPS
      - Paid on reasonable cost basis
      - Also are held harmless under the OPPS
    - Proposed
      - Establish quality reporting programs for IPPS-exempt cancer hospitals
      - By FY2013, quality measures would be selected
      - In FY2014, would implement mandatory quality measure reporting
  - Home Health Agency and Skilled Nursing Facility Value-based Purchasing Implementation Plan
    - Currently:
      - HHAs are required to submit data for a set of quality measures
      - Received a 2.00% reduction in Medicare annual update for failure to submit
    - Proposed:
      - Develop value-based purchasing implementation plans for HHAs and SNFs by 2011 and 2012, respectively

Improving the Quality and Efficiency of Health Care

Linking Payment to Quality Outcomes in the Medicare Program

- Physician Value-Based Purchasing (continued)
  - Reducing Hospital Acquired Conditions
    - Currently:
      - Hospitals will not receive additional Medicare payment for complications that were acquired during a patient's hospital stay
      - Beginning FY2008, CMS required hospitals to report whether certain conditions for Medicare patients were present at admission
      - Starting FY2009, IPPS hospitals will not receive additional payment for secondary diagnoses resulting from hospital acquired conditions
    - Proposed:
      - Apply a new payment adjustment to hospitals ranked in the top quartile of national, risk-adjusted HAC rates
      - CMS would calculate national and hospital-specific data on the HAC rates

Improving Medicare for Patients and Providers

- Ensuring Beneficiary Access to Physician Care and Other Services
  - Addresses:
    - Sustainable Growth Rate – Annual update to Medicare fee schedule would be 0.5% increase in 2010. The conversion factor for 2011 and subsequent years would be computed as if the 2010 increase had never applied.
    - Extension of Floor on Medicare Work Geographic Adjustment
    - Mis-valued Relative Value Units
    - Therapy Caps
    - Extension of Treatment of Certain Physician Pathology Services under Medicare
    - Extension of Increased Payments for Ambulance Services under Medicare
    - Extension of Long-Term Care Hospital Provisions
    - Extension of Payment Adjustment for Medicare Mental Health Services
    - Permitting Physician Assistants to Order Post-Hospital Extended Care Services
    - Recognizing Attending Physician Assistants as Attending Physicians to Serve Hospice
    - Medicare Diabetes Self-Management Training
    - Medicare Improvement Fund
    - Medicare Part B Special Enrollment Period for Disabled TRICARE Beneficiaries

Improving Medicare for Patients and Providers

- Rural Protections
  - Extend Medicare Rural Hospital Flexibility Program
  - Extend Hospital Outpatient Department Hold Harmless for Small Rural Hospitals
  - Extend and Expand Hospital Outpatient Department Hold Harmless for Sole Community Hospitals
  - Extend Reasonable Cost Reimbursement for Lab Services in Small Rural Hospitals
  - Extend Rural Community Hospital Demonstration Program
  - Extend Medicare Dependent Hospital Program
  - Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals

Resources

- The America's Health Future Act and related sites
  - Senate Finance
  - http://finance.senate.gov/sitepages/Americas_Healthy_Future_Act.html
- Senate HELP Committee Affordable Health Choices Act (S. 1679)
  - Senate HELP
  - http://help.senate.gov/
- H.R. 3962 – Affordable Health Care for America Act
  - Ways and Means
  - http://docs.house.gov/rules/health/111_ahcaa.pdf
- Side by side comparison of major health care reform proposals
  - Kaiser Family Foundation
  - http://www.kff.org/healthreform/sidebyside.cfm