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Health Care Delivery System Reform Provisions in the Baucus Bill: A Substantive Set of Provisions

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In addition to the many hotly contested insurance and access-related provisions in the *America's Healthy Future Act of 2009*, the chairman's mark from Senate Finance Committee Chairman Max Baucus (D-Mont.), released Sept. 16 (18 HLR 1205, 9/17/09), there is in the bill a section that addresses in a substantive way reform of the health care delivery system with a focus on quality. There has been some concern among many participants in and expert observers of the health care system that the major focus on access and coverage in the evolving legislation, while understandable, has lessened attention to the important need to build on the advances in evidence-based medicine over the last decade to create mechanisms and incentives to improve the quality and cost efficiency of health care in the United States. Many believe that the broader adoption of evidence-based measures, clinical integration, care coordination, standardization and related ''quality'' concepts is the key to improving health system performance, obtaining better health outcomes and managing costs in the long run.

Much of the underlying thinking in Title III of the bill, entitled ''Improving the Quality and Efficiency of Health Care,'' draws from the Institute of Medicine's seminal publication in 2001 of *Crossing the Quality Chasm*. Especially in Subtitle A, ''Transforming the Health Care Delivery System'' (pages 75 to 110), one can see the impact of the IOM's definition of quality as six aims: care that is safe, effective, efficient, patient-centered, equitable and timely. Given the fairly broad consensus regarding these concepts in the health policy community, they may have a reasonable chance of surviving in any final bill if one is adopted.

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The following key provisions with important long-term implications for health care providers appear in Title III of the chairman's mark:

- A hospital value-based purchasing program in Medicare that moves beyond pay-for-reporting on quality measures to paying for hospitals' actual performance on those measures;
- Revisions to expand and extend quality reporting for physicians and other non-hospital providers;
- A charge to the secretary of HHS to establish a national quality improvement strategy, which would, among other things, address improvements in patient safety, health outcomes, disparities, effectiveness, efficiency and patient-centeredness;
- Recognition of Accountable Care Organizations, which, beginning in 2012, would be allowed to qualify for incentive bonus payments; among other requirements, an ACO would have to have a formal legal structure to allow it to receive bonuses and distribute them to participating providers;
- Formation at CMS of an Innovation Center that would be required to test and evaluate patient-centered delivery and payment models;
- The establishment of a bundled payment pilot program involving multiple providers to cover costs across the continuum of care and entire episodes of care; if the pilot is successful, it would be made a permanent part of the Medicare program;

- Beginning in 2013, reductions in Medicare payments to hospitals with preventable readmissions above a threshold based on appropriate evidence-based measures;
- Extension of the current gainsharing demonstration.

Below is a closer look at Title III, Subpart A, and an initial assessment of its implications.

1. Pay-for-Performance. The proposed value-based purchasing program (VBP) would provide value-based incentive payments to acute care IPPS hospitals that meet certain quality performance standards beginning in 2012. The first year of the program would be a data collection year. In 2013, hospital payments would be adjusted based on performance under the VBP program. Hospitals that meet or exceed performance standards would receive incentive payments. Funding for these payments would be generated through reducing Medicare IPPS payments to all hospitals, but all such reductions would be returned to hospitals through incentive payments in the same year. Individual hospital performance on each measure would be publicly reported, and there would be an appeals process (related to performance score calculation and the resulting value-based incentive payment).

Key Implications:

- Quality performance would affect financial performance in a direct way;
- This Medicare program, if adopted, might accelerate similar pay-for-performance programs in the private sector;
- The program would further highlight hospital board fiduciary responsibility as it relates to quality;
- There would be a host of new legal issues that would arise in connection with performance standards, measurement, other uses of publicly-available poor performance data, the appeals process, and others.

2. Physician, home health agency and skilled nursing facility value-based purchasing and rehabilitation facility, long term acute care hospital, hospice, and cancer hospital quality reporting. The chairman's mark includes a host of provisions that strengthen and expand current quality reporting initiatives for all of the above-listed providers. A great many more quality measures would be selected and adopted for the various care settings, and incentive payments would be extended and expanded (and reductions potentially put in place in future years) for physicians, HHAs and SNFs. There is an additional provision for measuring hospital-acquired conditions (HACs), reporting the results and in the future reducing payments to hospitals with high HAC rates.

Key Implications:

- Increased/improved reporting;
- More compliance obligations;
- Reimbursement impacts, good and bad.

3. National Strategy to Improve Health Care Quality. As contemplated in the mark, this strategy would be comprehensive and far-reaching in developing priorities to improve overall population health, improve patient safety, reduce preventable hospital admissions and readmissions, reduce health care disparities, address gaps in quality and efficiency, improve payment policy to emphasize quality and efficiency and enhance the use of data to improve care and population health. In developing the strategy, the secretary of HHS is instructed to work with a broad array of stakeholders from the public and private sectors, and the President would convene an interagency working group to make recommendations to the secretary. The secretary would update the national strategy not less than triennially, with the first report due December 31, 2010.

Key Implications:

- The structure for a regular, comprehensive public-private strategic planning process and dialogue with a focus on quality and population health is put in place;
- Such a process is likely to trigger regular and repeated change and potentially significant innovation;
- Additional legal issues, transactions, regulatory compliance and other matters likely will result.

4. Accountable Care Organizations. ACOs eligible for bonuses beginning in 2012 are defined as group practices, networks of practices, joint ventures between hospitals and practitioners, hospitals employing practitioners, among others the secretary determines appropriate. Practitioner is defined as including physicians, nurse practitioners, physician assistants, clinical nurse specialists and others. To qualify as an ACO, an organization would have to meet at least the following criteria: (1) agree to become accountable for the overall care their Medicare fee-for-service beneficiaries; (2) agree to a minimum three-year participation; (3) have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers; (4) include the primary care physicians for at least 5,000 Medicare fee-for-service beneficiaries; (5) provide CMS with information regarding primary care and specialist physicians participating in the ACO as the secretary deems appropriate; (6) have arrangements in place with a core group of specialist physicians; (7) have in place a leadership and management structure, including with regard to clinical and administrative systems; (8) define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care; and (9) demonstrate to the secretary that it meets patient-centeredness criteria determined by the secretary, such as use of patient and caregiver assessments or the use of individualized care plans. The mark includes additional requirements related to the measures to be used to determine incentive payments to ACOs, requirements related to data collection and reporting and the formula related to total per beneficiary spending that would be the basis for possible shared savings payments to the ACO.

Key Implications:

- Numerous organizational structurings, restructurings and transactions related to forming qualifying ACOs or revising existing organizations;
- Major legal issues, notwithstanding this potential new law, in light of current antitrust, Stark, anti-kickback, CMP and other laws;
- New and evolving application process for recognition as an ACO;
- Development of similar private market arrangements between payers and providers;
- Lots of new contracts;
- New management jobs and Board positions, with concomitant responsibilities;

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- Compliance requirements for ACOs under the new qualification and payment rules;
- Penalties for noncompliance.

5. Innovation Center. This new office within CMS would be authorized to test, evaluate and expand different payment structures and methodologies that would aim to foster patient-centered care, improve quality and slow the rate of Medicare cost growth. The secretary's authority is broad here to implement and evaluate new approaches, expand those determined to be working, consult with outside experts and invest new funds in the effort. Over 10 years, $10 billion is appropriated to fund the effort. There is significant detail in what the Center is to test and what criteria to use, again all reflecting current thinking about quality, cost efficiency and evidence-based medicine—medical homes, risk-based comprehensive payment models, health IT-enabled networks, medication therapy management, home-based primary care and chronic care management, etc.

Key Implications:

- Possible widespread ultimate adoption of these kinds of models and approaches in the Medicare program;
- An ongoing public-private dialogue on best practices;
- Accelerated innovation and development in the private sector as a result of the Federal effort;
- Transactional, governance, regulatory, compliance and other legal consequences, many unforeseen today, including new legislation to implement successful models.

6. Bundled Payments. The secretary would be required to develop, test and evaluate alternative payment methodologies through a national, voluntary pilot program that is designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting in 2013. If evaluations find that the pilot program achieves the goals of improving patient outcomes, reducing costs and improving efficiency, then the secretary would be required to submit an implementation plan to Congress on making the pilot a permanent part of the Medicare program. In so doing, the secretary would be required to determine which Medicare statutory provisions and related regulations would be appropriate to waive in order to conduct the pilot program. This includes waiving the anti-kickback and civil monetary penalty statute after consultation with the Inspector General. The secretary is instructed to select eight conditions to be included in the pilot. The pilot program's bundled payment would be made to a Medicare provider or other entity comprised of multiple providers to cover the costs of acute care inpatient and outpatient hospital services, physician services and post-acute care. The comprehensive bundled payment would include costs of any re-hospitalizations that occur during the covered period. The bundled payment for each of the eight selected conditions would be based on the average hospital, physician, and post-acute care payments made over the hospitalization period per patient.

Any Medicare provider, including hospitals, physician groups, or post-acute entities interested in assuming responsibility for the bundled payments would be able to apply to participate in the pilot program. Any entity assuming responsibility for the bundled Medicare payments would be required to have an arrangement with an acute hospital for initiation of bundled services. All services provided under the bundle would be required to be provided or directed by Medicare participating providers. Eligible entities would receive the bundled payments for each patient served, regardless of whether patient receives certain levels of physician or post acute care. If the secretary finds that the pilot program results in significant improvements in quality and outcomes and reductions in cost, then the secretary would be required to submit an implementation plan to Congress in FY 2016 with recommendations regarding making the pilot a permanent part of the Medicare program in FY 2018.

Key Implications:

- Potentially, this pilot could transform the Medicare payment system;
- Significant new organizational structures and relationships among providers likely would result in response if payment changes are broadly adopted;
- There would be many new implementing regulations and probably follow-up legislation;
- Again, concomitant changes in private payment systems would be likely;
- Ultimately, by the end of the next decade, both the payment system and the delivery system in the United States might look very different.

7. Reducing Avoidable Hospital Readmissions. Starting in FY 2013, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is re-hospitalized with a preventable readmission within seven days and by ten percent if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days. Preventable readmissions would be defined as all readmissions that could have been reasonably prevented, as determined by the secretary. According to a methodology that would be determined by the secretary, which may include using condition-specific measures endorsed by the National Quality Forum, CMS would calculate a national preventable readmissions benchmark by conditions. Hospitals with readmissions above the 75th percentile (based on 30-day rates) for selected conditions would be subject to readmissions payment policy related to the selected conditions.

Key Implications:

- Lowered reimbursement for some hospitals;
- Additional reporting and compliance requirements.

8. Extension of Gainsharing Demonstration. The authority to conduct the gainsharing demonstration would be extended until September 30, 2011. The date of the quality improvement and achieved savings report would be extended from December 1, 2008 to March 31, 2011. An additional $1.6 million would be appropriated in FY 2010. All appropriations would be available for expenditure through FY 2014.

Key Implications:

- Extension of shared savings efforts;
- Demonstration projects protected from CMP restrictions.

The other bills on health care reform previously released in the House and Senate also address some of these quality, cost efficiency and care coordination ideas. However, Baucus' bill appears to be the most comprehensive treatment to date, and may suggest that

a final bill, if passed, will seek to expedite the adoption of evidence-based medicine best practices and related concepts in improving health care quality. In that event, additional legislation, new regulations and much private sector activity likely would follow. Stay tuned.

The text of Baucus's Sept. 16 chairman's mark is available at http://finance.senate.gov/sitepages/leg/LEG%202009/091609%20Americas_Healthy_Future_Act.pdf.

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