

Senate Finance Committee-September 16, 2009

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

The Secretary would be directed to complete and submit to Congress Medicare value-based purchasing implementation plans for HHAs and SNFs by 2011 and 2012, respectively. There is currently a CMS demonstration program for SNFs under way.

National Pilot Program on Payment Bundling

The Secretary would be required to develop a pilot study to evaluate alternative payment methodologies to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting in 2013, with the potential of making the pilot a permanent part of Medicare, if successful.

Any Medicare provider, including hospitals, physician groups, or post-acute entities interested in assuming responsibility for the bundled payment would be able to apply to participate in the pilot program.

Permitting Physician Assistants to Order Post-Hospital Extended Care Services

The bill would allow a physician assistant who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes.

This provision would apply to items and services furnished on or after January 1, 2010.

MedPAC Study on Adequacy of Medicare Payments for Health Care Providers Serving Rural Areas

The Chairman's Mark would require MedPAC to review payment adequacy for rural health care providers serving the Medicare program and provide a report to Congress by January 1, 2011.

MedPAC would analyze beneficiaries' access to care in rural communities, adequacy of Medicare payments to rural providers and quality of care. MedPAC would also provide recommendations on appropriate modifications to the rural payment adjustments.

Improving Coverage in the Part D Coverage Gap

Beginning July 1, 2010, eligible beneficiaries would automatically receive a 50% discount off the negotiated price for brand-name prescription drugs that are covered under Part D and covered by their plan's formulary or are treated as being on plan formularies through exceptions and appeals processes, that fall in the donut hole.

The 50% discount would be available during the entire coverage gap—that is, at the point when total prescription costs of a beneficiary exceeds the initial coverage limit (\$2,700 in 2009) and reaches the catastrophic coverage limit (\$6,153 in 2009) each year.

The discount program would apply to Medicare beneficiaries who enroll in Part D, do not qualify for the low-income subsidy, are not enrolled in an employee-sponsored retiree drug plan, and do not have annual income that exceeds the Part B income thresholds (\$85,000 for singles and \$170,000 for couples in 2009).

The bill would also allow 100% of the negotiated price of discounted drugs (excluding dispensing fees) to count toward the annual out-of-pocket threshold that is used to define the coverage gap each year, so that the size of the coverage gap would not widen and beneficiaries with high prescription drug costs would not be held back from reaching the catastrophic benefit as a result of the discount program.

Reducing the Part D Premium Subsidy for High-Income Beneficiaries

Beneficiary premiums under Part D would be subject to income thresholds or means testing.

The bill would reduce, beginning in 2011, the Medicare premium subsidy amount for beneficiaries whose income exceeded the thresholds used under Part B (\$85,000 for an individual and \$170,000 per couple) in 2009. Instead of setting the Medicare premium subsidy at 74.5% of total Part D premiums, the bill would decrease the Medicare premium subsidy as follows: 35% for incomes between \$80,000 and \$100,000, 50% for incomes between \$100,000 and \$150,000, 65% for incomes between \$150,000 and \$200,000, and 80% for income greater than \$200,000. Income thresholds for couples filing jointly are twice these dollar amounts.

Limitation on Removal or Change of Coverage of Covered Part D Drugs Under a Formulary Under a Prescription Drug Plan or a MA-PD

The Chairman's Mark would not allow Part D sponsors, beginning in 2011, to remove a covered drug from a plan formulary, apply a cost or utilization management tool that imposes a restriction or limitation on the coverage of such a drug (such as through the application of a preferred status, usage restriction, step therapy, prior authorization, or quantity limitation), or increase the cost sharing of such a drug (such as through the placement of a drug on a tier that would result in higher cost sharing for a beneficiary) other than the date on which Part D sponsors may begin marketing their plans with respect to the immediately succeeding plan year. Exceptions apply to new generic drugs or change in safety issues.

Part D sponsors would be required to provide each enrollee a notice of any change in the formulary or other restrictions or limitations on coverage of a drug for the upcoming plan year.

Home Health Payment Changes;

Updating Home Health Payments through Rebasing

Starting in CY2013, the Secretary would be directed to rebase payments to reflect the number and mix of HH services, level of intensity of services, and the average cost of providing care.

The Secretary would be directed to phase in the new reimbursement system. By CY2016, 100 percent of the payments would be rebased.

MedPAC would be directed to report to Congress in CY2014 and CY2016 on the implementation of the new system, with particular emphasis on how rebasing changes impact: access to care for beneficiaries, quality outcomes, supply of HH providers; and any differential financial impacts on rural, urban, non-profit and for-profit providers.

Provider-Specific Cap on Home Health Outlier Payments

Starting in CY2011, there would be an annual cap of 10% of revenues that a HH agency may be reimbursed in a given year from outlier payments.

Reinstatement of Rural Home Health Payment Adjustment

Between CY2010 to CY2015, there would be a 3% add-on payment for HH providers serving rural areas.

Plan to Reform Medicare Hospital Wage Index

By December 31, 2011, the Secretary would be required to provide a plan to Congress on how to comprehensively reform the Medicare wage index system.

This plan would take into account the goals set forth in the MedPAC June 2007 report including establishing a new hospital compensation index system that uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved.

Market Basket Cuts

The provision would reduce market basket updates for home health providers by 1% in 2011 and 2012.

No mention on SNF market basket.

Productivity

The provision would provide for updates based on the MB or CPI minus full productivity estimates for all Parts A and B providers who are subject to a MB or CPI update.

For SNFs, it would begin 2012.

For Home Health, it would begin 2015.

Medicare Commission

The Chairman's Mark would establish an independent Medicare Commission (separate entity than MedPac) that would develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries.

The Commission would be tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts compared to the trajectory of Medicare spending under current law.

Nursing Home Transparency

The Chairman's Mark would make 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.

Required Disclosure of Ownership

Accountability Requirements.

Require SNFs and nursing homes to develop and implement compliance and ethics programs to be followed by their employees and agents.

Nursing Home Compare Website

Require the Secretary to include additional information on the Medicare *Nursing Home Compare* website (standardized staffing data, links to state internet websites with various information, a standardized complaint form, a summary of information on enforcement action against the facility, and a summary of facility expenditures for direct care staffing based on data submitted.

Reporting of Expenditures

Requires 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 publicly available.

Civil Monetary Penalties

Allow facilities to participate in an independent informal dispute resolution process that would produce a written record and occur within 30 days of imposition of the penalty. With monetary amounts of the CMP collected and placed in 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, except for cases of immediate jeopardy level, and 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 be eligible for a reduction.

The Secretary would be authorized to use a portion of collected CMPs to fund activities that benefit residents.

Demonstration Projects on Culture Change and use of Information Technology in Nursing Homes.

Require the Secretary to conduct two demonstration projects for nursing homes and SNF for the development of best practices for facilities involved in culture change and information technology to improve resident care.

American Association of Homes and Services for the Aging (AAHSA)