

Section I: Payment Reform – Options to Improve the Quality and Integrity of Medicare Payment Systems

Linking Payment Reform To Quality Outcomes – Establishment of Hospital Value-Based Program (VBP)

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Provide value-based payment to inpatient prospective payment hospitals (IPPS) beginning in FY 2012, with payment adjusted based on performance beginning in FY 2013 • Measures focus on heart attack, heart failure, pneumonia, surgical care activities, and patient perception of care, expand beginning in 2013 • Fund VBP through reducing Medicare IPPS payments to participating hospitals: 2.0 % in FY 2013; 3.0% in FY 2014; 4.0% in FY 2105; 5.0 % in FY 2016 and beyond • Reductions apply only to DRG payment, not any add-ons (e.g., DSH, GME) • Hospitals rewarded based on whichever level is higher – attainment or improvement • Bonus payments for hospitals that meet or exceed performance standards, applied to all MS-DRGs the hospital provides; based on sliding scale according to (1) no incentive in bottom quartile of performance, (2) linear sliding-scale incentive payment in the 26-75th percentile and (3) full incentive payment above 75th percentile; unused funds returned to Medicare Trust Fund • All performance data is made public; hospitals have opportunity to review and correct first • Three-year demonstration projects to test VBP models tailed toward CAHs and small hospitals that otherwise do not quality to participate in the VBP with Secretary required to submit a report 18 months after completion of the project 	<ul style="list-style-type: none"> • Rural facilities should be included in any VBP program, but in a manner that does not unduly threaten financial survival. • Among additional measures, consider clinical processes of care typically delivered in rural hospitals such as patient transfers, ED handoffs. • Retain the option of allowing for rewards based on improvement—important for rural hospitals. • Distribute all unearned withholds as local/regional quality improvement technical assistance, and provide quality improvement technical assistance to rural hospitals. • Consider applying reductions to total Medicare payment in rural and urban hospitals. • Select measures and analyze VBP with input from rural health experts, including clinicians and rural health researchers. • Coordinate VBP with programs that provide important quality improvement technical assistance to rural hospitals. • Expand quality improvement technical assistance to rural hospitals through quality improvement organizations and resources available in the Medicare Flex Program. • Although CAHs are initially excluded they should be included in VBP and other quality improvement programs as soon as there is a program ready, following the steps described in the following bullets: <ul style="list-style-type: none"> ○ A CAH VBP program is essential, and should include measurement of services commonly provided by CAHs, including outpatient care. ○ Assisting CAHs with developing and acquiring appropriately scaled quality-enhancing knowledge, skills, and health information technology should be a priority.

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Section I: Payment Reform – Options to Improve the Quality and Integrity of Medicare Payment Systems	
<i>Linking Payment Reform To Quality Outcomes – Physician Quality Reporting Initiative (PQRI) Improvements and Requirement</i>	
Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Three additional CMS improvements to the program: 1) establish an appeals process; 2) provide more timely feedback during the course of the performance period; 3) calculate incentive payments without regard to existing geographic adjustments • Considering two options for continuing program beyond 2010: 1) bonuses through 2011 and 2012 and penalties on those who did not participate 2012 and 2013 and penalties thereafter; 2) incentives only for 2011 	<ul style="list-style-type: none"> • Calculating physician payments without regard to geographic adjustment will make this more meaningful to rural providers. • Timely feedback will benefit rural providers who may learn from this program despite not having resources to participate in vendor-driven efforts. • Opportunities for technical assistance and funding assistance to implement new information systems in small rural practices need time to have an impact prior to any use of penalties.
<i>Primary Care – Primary Care and General Surgery Bonus</i>	
Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Providers who furnish at least 60% of their services in specified settings would receive a bonus of at least 5% for office visits (codes 99201-99215), nursing home visits (99304-99340) and home visits (99341-99350) • Bonus applies to all patients (new and established) for five years (1-1-2010 through 12-1-2014) • Cost of bonuses offset by across-the-board reduction in payments for services under all other codes 	<ul style="list-style-type: none"> • The proposed level of bonuses for primary care will be only marginally beneficial for rural providers, and therefore insufficient to effect change in physician distribution. • Geographic differences in physician payment could be addressed through changes in the work expense component of the geographic practice cost index. • Benefit of payment increases for office and other visits may be partially offset within rural primary care practices by reductions in other codes those physicians also use because their practices are more likely to engage in procedures than are their urban counterparts.
<i>Primary Care – Payment for Transitional Care Activities</i>	
Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Reimburse physicians for certain care management activities performed by nurse care managers (or other qualified non-physician professionals) • Medicare pay a “modest supplemental fee” to primary care practice for each patient discharged from hospital after major chronic disease, receives at least only currently evaluation and management service or a newly covered care management service within 30 days after discharge and is not readmitted for the same DRG within 60 days after initial discharge 	<ul style="list-style-type: none"> • This could be especially beneficial to small practices, often found in rural areas, as it may enable rural primary care practices to hire nurse care managers.

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

Chronic Care Management – CMS Chronic Care Management Innovation Center

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Establish a Chronic Care Management Innovation Center (CMIC) in CMS “for the purpose of testing and disseminating payment innovations that foster patient-centered care coordination for high-cost, chronically ill Medicare beneficiaries” • Initial testing on models meeting these criteria: 1) places the patient including family and informal caregivers, at center of team; 2) focuses on in-person contact with beneficiaries; 3) close relationship between care coordinators and primary care physicians; and 4) team-based approach to interventions • Examples include Advanced Patient-Centered Medical Homes, Transitional care teams, patient/physician shared decision-making aids 	<ul style="list-style-type: none"> • Innovations in chronic care management should include ways of adapting approaches to low patient volume environments. • Require that a fixed percentage of the CMIC budget be devoted to test models originating in rural primary care practices.

Hospital Readmissions and Bundling

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Starting in 2010 CMS directed to begin evaluating national and hospital-specific data on readmission rates of IPPS hospitals related to 8 conditions with highest volume and highest rates of readmission; list to be updated as appropriate • Exclude readmissions deemed by Secretary not to be potentially preventable • Starting in FY 2013 hospitals with readmissions above 75th percentile for selected conditions subject to payment withhold on MS-DRG-by-MS-DRG basis • Beginning in FY 2015, acute IPPS hospital services and post-acute care within 30 days of discharge paid through bundled payment; includes home health, skilled nursing facility, rehabilitation hospitals, and long-term care hospital services • Phase in with next 30% in FY 2017, final 50% in FY 2018 • Payments made to one entity such as hospital but CMS has authority allow other entities to receive bundled payments as long as hospital is involved 	<ul style="list-style-type: none"> • Many rural residents receive inpatient services at larger urban hospitals. Bundling through hospital payment may create disincentives for urban hospitals to use rural providers for post-acute care services, creating access burdens for patients and possibly affecting quality of care and outcomes. • Contracting issues in bundled payment schemes (and the lack of attractiveness to larger hospitals of negotiating with low-volume providers such as rural practices) may inadvertently also affect the patient base and financial status of rural providers. • Need to monitor implications for sources of patient care, both from the patient and the local provider perspective.

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Moving From Fee-for-Service to Payment for Accountable Care – Medicare Shared Savings Program (i.e. Accountable Care Organizations)

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Groups of provider have opportunity to qualify for sharing cost savings they achieve in Medicare starting in 2012 • To qualify as an organization: 1) agree to minimum 2 year participation, 2) have formal legal structure that allows organization to receive/distribute bonuses to participating providers, 3) include primary care providers of at least 5,000 Medicare beneficiaries; 4) provide CMS with list of primary care and specialist physicians participating in the organization; 5) have contracts with a core group of specialist physicians; 6) have management and leadership structure in place for joint decision making; 7) define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care • Spending baseline for ACO determined on organizational level using most recent 3 years of total beneficiary spending • Under consideration: 3 year performance period, flat-dollar per beneficiary spending target to the ACO based on expected national growth rate; adjusting and/or capping rate of savings; applying a FFS for withhold to earn back; allow Secretary to transition ACO payments from FFS to fully- or partially-capitated payment structures; targeted relief from legal or regulatory impediments to provider cooperation 	<ul style="list-style-type: none"> • There should be opportunity for rural providers to participate in this program, even where there are no current examples of ACOs. • Operational definition of “formal legal structure” will be important for rural provider networks formed without unified governance but with signed agreements among providers (such as single signature capability). • Definition of specialist physicians participating in the organization is also important; for rural based organizations it may be problematic to include a wide range of specialties, although it could perhaps be done based on the percentage of patient care services covered by the group, e.g., ACO viable if responsible for 80% or more of all care received by the patient population served.

Moving From Fee-for-Service to Payment for Accountable Care – Extension and Expansion of the Medicare Health Care Quality Demonstration Program

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Permanently Section 646 of MMA, demonstration program for physician groups, integrated health care delivery systems or regional coalitions to implement alternative payment systems, waiving provisions of the Stark, anti-kickback and civil monetary penalties; must include multi-payer projects 	<ul style="list-style-type: none"> • Set aside for high risk/high potential for success (in terms of measureable differences) projects in sparsely populated rural areas (use rural-urban commuting area [RUCA] codes to determine).

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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

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Exploring expanding eligibility for HER Medicare incentive payments to include nurse practitioners and physician assistants under certain conditions such as those who practice in settings outside of physician office • explore providing additional IT incentives to other providers such as post-acute services that were not included in ARRA; especially if additional incentives within Medicare would help support care coordination and quality improvement goals and activities described elsewhere in this document 	<ul style="list-style-type: none"> • Health information technology incentives for physician assistants and nurse practitioners will support technology implementation in rural health clinics and other rural practices. • To be inclusive with post-acute services, policy makers may want to include human service providers as well as health care professionals/providers.

Health IT - Improving Quality Measurement

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Measures applicable to all age groups and focus at minimum on <ul style="list-style-type: none"> ○ patient outcomes and functional status ○ coordination of care across episodes of care and care transitions ○ meaningful use of HIT ○ efficiency and equity of health services and health disparities ○ patient experience and satisfaction 	<ul style="list-style-type: none"> • Measures related to coordination of care across episodes of care and care transitions will be especially meaningful in rural places.

Comparative Effectiveness Research

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Exploring having private, non-profit corporation to generate and synthesize evidence on what works in health care; could contract with AHRQ, NIH • Establish independent expert committee to develop methods and standards for comparative effectiveness research • Establish expert advisory panels to be certain research and findings are relevant to decision-makers at point of service; public comment and input integral • Consider potential differences between patient subgroups and their responses to different health care strategies when design each study • Fund annually by mix of public and private sector funds 	<ul style="list-style-type: none"> • Evidence of what works in health care should encompass what works in rural practices with limited resources. • Relevance to decision makers at point of service should include relevance specific to rural practice environments.

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

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • 80% of unused slots over last 2 years included in a pool for redistribution, but rural teaching hospitals with less than 250 beds would be exempt from the redistribution of unfilled positions • 75% of new slots allocated toward primary care or general surgery residency training positions for at least 5 years • Program priorities based on criteria including but not limited to location in a primary health HPSA, location in a rural area, or location in urban areas with population of one million or less • Slots would be redistributed among teaching hospital sponsors that maintain level of primary care residency positions at a level at least equal to number of primary care positions over past 3 years 	<ul style="list-style-type: none"> • Policies to address rural physician shortages should be supported by increases in primary care and general surgery residency slots and additional financial incentives to enter those career paths. • Assuming effective policies generating interest in primary care careers, the strategies for reallocating unused residency slots as outlined in this proposal appropriately target areas of high priority need.

Workforce - Promoting Greater Flexibility for Residency Training Programs

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • To consider Committee proposals to include counting time for non-patient care activities (didactic and scholarly activities in nonhospital setting) for purposes of calculating GME payments, remove disincentives placed on training programs that rely on volunteer supervisory physicians for training in outpatient settings and providing flexibility in operation of residency programs involving more than one teaching hospital 	<ul style="list-style-type: none"> • These are helpful provisions for rural areas.

Workforce - Proposal on Development of a National Workforce Strategy

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Recommendations from studies and experts include a national health workforce commission, additional resources to support workforce-related activities of CMS and HRSA and encourage collaboration among these agencies • Secretary should be directed to work with external stakeholders on a national workforce strategy to meet current and future health care needs 	<ul style="list-style-type: none"> • Funding should support a national workforce commission and state or regional commissions charged to assess provider supply/distribution and recommend policies to address specialty and geographic shortages. • Legislation should support new outpatient practice models that optimize the training, experience, and licensure of all rural health care professionals.

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

Linking Payment to Quality

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Payment to MA plans should be tied to performance on quality measures 	<ul style="list-style-type: none"> • Must include all forms of MA plans, including Private Fee-For-Service plans.

Developing a More Efficient Payment Structure

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Consider current MA benchmarks to encourage plans to provide Medicare covered benefits more efficiently and promote improvement in quality of care; explore approach to modifying MA benchmark formula, following bullets • Option: blend local and national FFS spending, 75/25, phased in over 3 years • Option: gradually reduce benchmarks through combination of across-the-board reductions and phase-downs to a target ratio of counties in which rates most exceed local FFS expenditures • Option: beginning in 2012 benchmarks set as enrollment-weighted average of MA plan bids in each county or geographic area and all plans paid the new benchmark • Option: competitive bidding with bonus payments linked to quality improvement targets 	<ul style="list-style-type: none"> • Rural residents are less likely to enroll in MA plans, especially those from remote rural areas; more balance between the support given to the MA and traditional Medicare fee-for-service programs would benefit rural beneficiaries. • The option to blend to local and national FFS rates would seem in theory to raise many rates in rural areas because spending is below the national average, however benchmark rates would fall below current rates in many if not most rural areas due to historical payment changes. Thus this change would lead to significant payment reductions in rural areas, potentially leading to reductions in benefits and drops in the number of plans available. • The option to make these changes more gradual would be more beneficial to rural areas and would soften the blow, but ultimately would lead to the same effect. • The option to set benchmarks based on current plan bids would have the effect of benchmark rates bunching around FFS rates, which would tend to lead to reductions in payment in most rural areas, leading to reductions in benefits and plan offerings. • The option of competitive bidding would lead to less connection to FFS payment, but competitive bids would still likely be tied initially and eventually to FFS payment in the local area, thus leading initially to cuts in benefit offerings and enrollment cuts in rural areas. • Changes to the calculation of payment to MA plans should include analysis of changing the geographic area used as the basis for rate setting, moving from county boundaries to more rational service areas to smooth wide variation in payments.

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Pay for Chronic Care Management

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Could consider proposals to pay plans a bonus for chronic care management along with competitive bidding 	<ul style="list-style-type: none"> • Making bonus payment a flat payment and not depending on current payment would be geographically neutral providing the full benefit in rural areas.

Simplify Extra Benefits

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> • Could consider reducing amount of variation in amount and type of extra benefits offered by MA plans and funded by Medicare payments • Could link ability to offer extra benefits to plan performance and not solely dependent on how high MA benchmarks are set • Option: require MA plans that can offer extra benefits to use these priorities: 1) set maximum limit on beneficiary out-of-pocket copayments; 2) reduce Parts A/B cost sharing; 3) add new benefits 	<ul style="list-style-type: none"> • Any specification of extra benefits should require that those benefits be available at the same out-of-pocket cost to all beneficiaries enrolled in the plan, regardless of where they live or receive care. • While the provisions make sense to target the extra benefits to beneficiaries, another option is to suggest the extra payments should go back to taxpayers.
