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MEMORANDUM FOR SECRETARY HILLARY RODHAM CLINTON

From: Miguel
Date: March 12, 2010
Re: Health Care Update & Blue Dog Analysis

This memorandum provides a brief status update on the Congressional debate over health care reform.

As discussed below, the House is in the midst of charting the course forward on health care reform.

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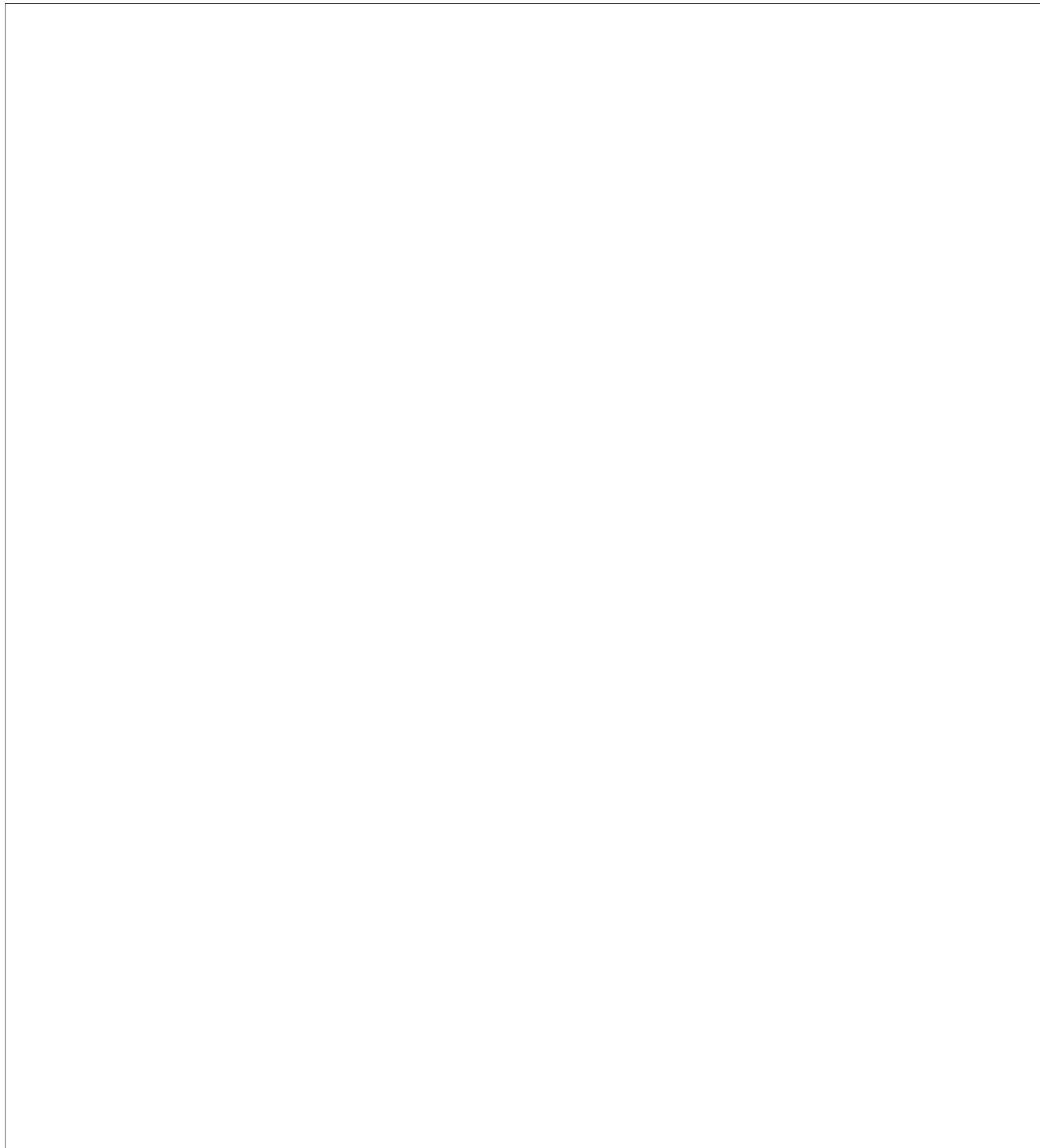
On May 12, 2009, the Blue Dog Coalition released their principles for health care reform. In addition to providing a brief summary of the current state of play on health care, this memorandum also outlines those principles and demonstrates how the President's health reform proposal meets the Coalition's goals. Talking points for use in a conversation with and other Blue Dog Coalition members are part of this analysis.

I. BACKGROUND

The House is positioning for a final vote on health care reform legislation as soon as next week, though it is still unclear that they will be able to secure the 216 members needed to pass the measure.

CBO scores of the final bill are expected today (Friday, March 12th).



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II. BLUE DOG ANALYSIS AND TALKING POINTS

On May 12, 2009 the Blue Dog Coalition released their principles for health care reform. The analysis below outlines those principles and demonstrates how the health reform Proposal meets almost all of these goals.

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A. Controlling Costs

- **Blue Dog Principle:** *Comprehensive health care reform must be deficit neutral. Finding savings within the current health care system is a critical first step to achieving this goal.*

  President's Proposal: The Proposal is not only deficit neutral, but according to the Congressional Budget Office, it will reduce the deficit by roughly $100 billion by 2019 and about $1 trillion in the second decade.

- **Blue Dog Principle:** *Payment incentives should be realigned to improve the quality of patient care and reduce inefficiencies.*

  President's Proposal: The Proposal includes many significant policies that will realign payments to emphasize quality and efficiency. These include:

  - Establishing Value-Based Purchasing Programs: The Proposal establishes a value-based purchasing program for inpatient hospital services linking Medicare payments to performance measures for common, high-cost conditions such as cardiac, surgical and pneumonia care. Beginning in FY 2014, other Medicare providers including long term care hospitals, inpatient rehabilitation facilities and hospice will participate in the program. Providers who do not participate will be penalized. In addition, the Secretary of HHS is required to submit a plan to Congress on how to move skilled nursing facilities and home health agencies into a value-based purchasing payment system.

  - Addressing Geographic Inequities: The Proposal also begins to address geographic inequities by directing the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized. The new payment system will then be phased-in over a 2-year period beginning in 2015.

  - Extending and Expanding Physician Quality Reporting: The Proposal extends the Physician Quality Reporting Initiative (PQRI) program through 2014. This program provides incentives to physicians who

report Medicare quality data. Beginning in 2014, physicians who do not report their data will have their payments reduced.

- Creating a National Pilot Program on Bundling Payments: The Proposal establishes a national pilot program on payment bundling and allows the Secretary of HHS to increase the scale and scope of the program if certain cost and quality goals are met.

- Providing Physicians with Improved Feedback Information: The Proposal expands the Medicare physician resource use feedback program to provide for the development of individualized reports so physicians can compare their per capita utilization to other physicians in their area.

- Reducing Payments to Hospitals with High Rate of Hospital Acquired Infections: The Proposal reduces Medicare payments to hospitals with high rates of hospital acquired infections for certain high-cost and common conditions. In addition, the plan requires the Secretary of HHS to submit a report to Congress on the appropriateness of establishing a healthcare acquired condition policy for other Medicare providers including skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, ambulatory surgical centers and others.

- Promoting Accountable Care Organizations: The Proposal rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program.

- Reducing Payments to Hospitals for Preventable Readmissions: The Proposal reduces payments to hospitals for potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum (NQF). Under the Proposal, the Secretary of HHS has the authority to expand the policy to additional conditions in future years and directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions.

- Establishing a CMS Center for Innovation: The Proposal establishes a Center for Medicare & Medicaid Innovation within the Centers for

Medicare & Medicaid Services (CMS) at HHS. The Innovation Center will research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Innovations that are found to work could then be rapidly expanded and applied more broadly—helping to transform the health care system into one that provides better care at lower cost.

- **Blue Dog Principle:** *Public reporting of the costs and quality of care should be examined to increase transparency.*

  President's Proposal: The Proposal includes several provisions to increase transparency for both costs and quality of care. These include:

  - Allowing Private Sector Purchasers to Obtain Medicare Data to Measure Provider/Supplier Performance: The Proposal authorizes the release and use of standardized extracts of Medicare claims data to measure the performance of providers and suppliers in ways that protect patient privacy. Employers have argued for years that they need this type of data to ensure that they are driving quality and efficiency in the health plans in which their workers participate, and the Proposal finally establishes a pathway for this to occur.

  - Establishing Medical Reimbursement Data Centers: The Proposal authorizes the establishment of medical reimbursement data centers to develop fee schedules and other database tools that reflect market rates for medical services in various geographic areas. These Centers will also make health care cost information readily available to the public on the internet.

  - Requiring Hospitals to Publish a List of Standard Charges: The Proposal requires hospitals to annually publish a list of the hospital's standard charges for items and services provided, including diagnosis related groups (DRGs), the standard unit that hospitals use to bill Medicare and other payors for inpatient services.

- **Blue Dog Principle:** *Medicare, Medicaid and CHIP program integrity should be strengthened by reducing waste, fraud and abuse.*

President's Proposal: The Proposal includes an unprecedented number of fraud and abuse policies:

- Medicare, Medicaid, and CHIP Program Integrity Provisions: The Secretary will establish procedures to screen high-risk providers and suppliers enrolling in Medicare, Medicaid, and CHIP. Providers and suppliers enrolling or re-enrolling will be subject to new requirements including a compliance program, disclosure of current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked. The Secretary is authorized to deny enrollment in these programs if these affiliations pose an undue risk.

- Enhanced Medicare and Medicaid Program Integrity Provisions: New penalties will exclude individuals who order or prescribe an item or service, make false Statements on applications or contracts to participate in a Federal health care program, or who know of an overpayment and do not return the overpayment. Each violation would be subject to a fine of up to $50,000. The Secretary may suspend payments to a provider or supplier pending a fraud investigation. Health Care Fraud and Abuse Control (HCFAC) funding will be increased by $10 million each year for fiscal years 2011 through 2020. The Secretary will establish a national health care fraud and abuse data collection program for reporting adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB). The Secretary will have the authority to disenroll a Medicare enrolled physician or supplier who fails to maintain and provide access to written orders or requests for payment for durable medical equipment (DME), certification for home health services, or referrals for other items and services. The HHS Secretary will expand the number of areas to be included in round two of the DME competitive bidding program from 79 of the largest metropolitan statistical areas (MSAs) to 100 of the largest MSAs, and to use competitively bid prices in all areas by 2016.

- Additional Medicaid Program Integrity Provisions: States will be required to terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or

another State's Medicaid program. Medicaid agencies will be required to exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments; (2) is suspended, excluded, or terminated from participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation. Agents, clearinghouses, or other payees that submit claims on behalf of health care providers must register with the State and the Secretary. States and Medicaid managed care entities must submit data elements for program integrity, oversight, and administration. States must not make any payments for items or services to any financial institution or entity located outside of the United States.

- In addition, the President's Proposal incorporates a number of additional proposals that are either part of the Administration's FY 2011 Budget Proposal or were included in Republican plans. These include:

  - *Comprehensive Sanctions Database.* The Proposal establishes a comprehensive Medicare and Medicaid sanctions database, overseen by the HHS Inspector General. This database will provide a central storage location, allowing for law enforcement access to information related to past sanctions on health care providers, suppliers and related entities. (Source: H.R. 3400, "Empowering Patients First Act" (Republican Study Committee Proposal))

  - *Registration and Background Checks of Billing Agencies and Individuals.* In an effort to decrease dishonest billing practices in the Medicare program, the Proposal will assist in reducing the number of individuals and agencies with a history of fraudulent activities participating in Federal health care programs. It ensures that entities that Proposal for Medicare on behalf of providers are in good standing. It also strengthens the Secretary's ability to exclude from Medicare individuals who knowingly submit false or fraudulent claims. (Source: H.R. 3970, "Medical Rights & Reform Act")

  - *Expanded Access to the Healthcare Integrity and Protection Data Bank.* Increasing access to the health care integrity data bank will improve coordination and information sharing in anti-fraud efforts. The Proposal broadens access to the data bank to quality control and

peer review organizations and private plans that are involved in furnishing items or services reimbursed by Federal health care program. It includes criminal penalties for misuse. (Source: H.R. 3970, "Medical Rights & Reform Act")

- *Liability of Medicare Administrative Contractors for Claims Submitted by Excluded Providers.* In attacking fraud, it is critical to ensure the contractors that are paying claims are doing their utmost to ensure excluded providers do not receive Medicare payments. Therefore, the Proposal holds Medicare Administrative Contractors accountable for Federal payment for individuals or entities excluded from the Federal programs or items or services for which payment is denied. (Source: H.R. 3970, "Medical Rights & Reform Act")

- *Community Mental Health Centers.* The Proposal ensures that individuals have access to comprehensive mental health services in the community setting, but strengthens standards for facilities that seek reimbursement as community mental health centers by ensuring these facilities are not taking advantage of Medicare patients or the taxpayers. (Source: H.R. 3970, "Medical Rights & Reform Act")

- *Limiting Debt Discharge in Bankruptcies of Fraudulent Health Care Providers or Suppliers.* The Proposal will assist in recovering overpayments made to providers and suppliers and return such funds to the Medicare Trust Fund. It prevents fraudulent health care providers from discharging through bankruptcy amounts due to the Secretary from overpayments. (Source: H.R. 3970, "Medical Rights & Reform Act")

- *Use of Technology for Real-Time Data Review.* The Proposal speeds access to claims data to identify potentially fraudulent payments more quickly. It establishes a system for using technology to provide real-time data analysis of claim and payments under public programs to identify and stop waste, fraud and abuse. (Source: Roskam Amendment offered in House Ways & Means Committee markup)

- *Illegal Distribution of a Medicare or Medicaid Beneficiary Identification or Billing Privileges.* Fraudulent billing costs taxpayers millions of dollars each year. Individuals looking to gain access to a beneficiary's personal information approach Medicare and Medicaid

beneficiaries with false incentives. Many beneficiaries unwittingly give over this personal information without ever receiving promised services. The Proposal adds strong sanctions, including jail time, for individuals who purchase, sell or distribute Medicare beneficiary identification numbers or billing privileges under Medicare or Medicaid – if done knowingly, intentionally, and with intent to defraud. (Source: H.R. 3970, "Medical Rights & Reform Act")

- *Study of Universal Product Numbers Claims Forms for Selected Items and Services Under the Medicare Program.* The Proposal requires HHS to study and issue a report to Congress that examines the costs and benefits of assigning universal product numbers (UPNs) to selected items and services reimbursed under Medicare. The report must examine whether UPNs could help improve the efficient operation of Medicare and its ability to detect fraud and abuse. (Source: H.R. 3970, "Medical Rights & Reform Act", Roskam Amendment offered in House Ways & Means Committee markup)

- *Medicaid Prescription Drug Profiling.* The Proposal requires States to monitor and remediate high-risk billing activity, not limited to prescription drug classes involving a high volume of claims, to improve Medicaid integrity and beneficiary quality of care. States may choose one or more drug classes and must develop or review and update their care Proposal to reduce utilization and remediate any preventable episodes of care where possible. Requiring States to monitor high-risk billing activity to identify prescribing and utilization patterns that may indicate abuse or excessive prescription drug utilization will assist in improving Medicaid program integrity and save taxpayer dollars. (Source: President's FY 2011 Budget)

- *Medicare Advantage Risk Adjustment Errors.* The Proposal requires in statute that the HHS Secretary extrapolate the error rate found in the risk adjustment data validation (RADV) audits to the entire Medicare Advantage (MA) contract payment for a given year when recouping overpayments. Extrapolating risk score errors in MA Proposals is consistent with the methodology used in the Medicare fee-for-service program and enables Medicare to recover risk adjustment overpayments. MA plans have an incentive to report more sever beneficiary diagnoses than are justified because they receive

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higher payments for higher risk scores. (Source: President's FY 2011 Budget)

- *Modify Certain Medicare Medical Review Limitations.* The Medicare Modernization Act of 2003 placed certain limitations on the type of review that could be conducted by Medicare Administrative Contractors prior to the payment of Medicare Part A and B claims. The Proposal modifies these statutory provisions that currently limit random medical review and place statutory limitations on the application of Medicare prepayment review. Modifying certain medical review limitations will give Medicare contractors better and more efficient access to medical records and claims, which helps to reduce waste, fraud and abuse. (Source: President's FY 2011 Budget)

- *Establish a CMS-IRS Data Match to Identify Fraudulent Providers.* The Proposal authorizes the Centers for Medicare & Medicaid Services (CMS) to work collaboratively with the Internal Revenue Service (IRS) to determine which providers have not filed Federal tax returns to help identify potentially fraudulent providers sooner. The data match will primarily target certain high-risk provider types in high-vulnerability areas. This proposal also enables both IRS and Medicare to recoup any monies owed to the Federal government through this program. By requiring the Internal Revenue Service (IRS) to disclose to CMS those entities that have evaded filing taxes and matching the data against provider billing data, this proposal will enable CMS to better detect fraudulent providers billing the Medicare program. (Source: President's FY 2011 Budget)

- *Undercover Health Professionals to Weed out Fraud and Abuse.* The Proposal includes a provision to allow medical professionals to conduct random undercover investigations of health care providers that receive reimbursements from Medicare, Medicaid, and other Federal programs. (Source: Senator Coburn Amendment #87 during HELP Committee Mark Up)

B. Increasing Value

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- **Blue Dog Principle:** *The role of primary care providers should be strengthened and prioritized. Patient care should be coordinated across settings and focus on the entire course of a patient's illness.*

✓ **President's Proposal:** The Proposal includes a number of provisions to strengthen the role of primary care providers and encourage the coordination of care across different settings. These include:

  - <u>Promoting Accountable Care Organizations:</u> The Proposal rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program.

  - <u>Supporting Primary Care Teams:</u> The Proposal includes a new demonstration program for chronically ill Medicare beneficiaries will test payment incentives and integrated service delivery models relying on physician and nurse practitioner-directed home-based primary care teams.

  - <u>Creating a Primary Care Extension Program:</u> The Proposal creates a primary care extension program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health.

  - <u>Supporting Patient-Centered Medical Homes:</u> The Proposal creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care.

  - <u>Expanding Access to Primary Care Services and General Surgery Services:</u> The Proposal provides primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10 percent Medicare payment bonus for five years.

- **Blue Dog Principle:** *Financial incentives should be implemented to encourage beneficiaries to follow recommended prevention and wellness services.*

  President's Proposal: The Proposal includes several provisions to incentivize individuals and Medicare beneficiaries to follow recommended prevention and wellness services.

  - The Proposal expands proven employer-wellness programs by allowing employers to vary premiums by up to 30 percent for employee participation in certain health promotion and disease prevention programs.

  - Under the Proposal, Medicare beneficiaries will not have to pay coinsurance (including co-pays and deductibles) for preventive services delivered in all settings.

  - The Proposal provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services, including a comprehensive health risk assessment, such as:

    - A five- to ten-year screening schedule;
    - A list of identified risk factors and conditions and a strategy to address them;
    - Health advice and referral to education and preventive counseling; and
    - Community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition.

- **Blue Dog Principle:** *Additional investment should be made to research cures and improve treatments for health conditions.*

  President's Proposal: The Proposal authorizes the Cures Acceleration Network, within the National Institutes of Health (NIH), to award grants and contracts to develop cures and treatments of diseases. In addition, the Proposal includes a two-year temporary credit subject to an overall cap of $1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases.

C. Improving Access

- **Blue Dog Principle:** *Individual and small businesses should be provided with a targeted tax credit to use toward the cost of health care coverage.*

  President's Proposal:
  - Individuals and families: The Proposal provides refundable tax credits for Americans with incomes up to 400 percent of poverty (up to about $88,000/year for a family of four) to purchase coverage through the Exchange. The credit will be calculated on a sliding scale beginning at 2 percent of income for those at 100 percent of poverty and phasing out at 9.5 percent of income between 300-400 percent of poverty.

  - Small businesses: The Proposal provides $40 billion in tax credits to help small businesses purchase coverage for their employees. Under the provision, small businesses with fewer than 26 workers and average annual wages of less than $50,000 with a sliding scale tax credit of up to 50 percent of the employer contribution toward the total premium cost. Tax-exempt small businesses meeting similar requirements are also eligible for tax credits.

- **Blue Dog Principle:** *Payments to rural health care providers and community health centers should be modernized in order to meet the unique challenges that these entities face.*

  President's Proposal: The Proposal extends a number of important provisions to maintain access to essential services for beneficiaries in rural areas.
  - Community health centers: The Proposal invests an unprecedented $11 billion in community health centers, recognizing the critical role they play in providing quality care in underserved areas. About 1,250 centers provide care to 20 million people, with an emphasis on preventive and primary care.

- Physician payments in rural areas: The Proposal extends the floor on geographic adjustments to Medicare physician payments in rural areas to more appropriately reflect practice costs.

- Outpatient protections: The Proposal extends the outpatient hospital "hold harmless" provision, allowing small rural hospitals and sole community hospitals to receive this adjustment through FY2010.

- Rural Community Hospital Demonstration: The Proposal extends the Rural Community Hospital Demonstration Program for five years and expands eligible sites to additional States and hospitals.

- **Blue Dog Principle:** *Loan assistance and forgiveness programs should be improved to increase the number of physicians, nurses and other health care professionals in rural and underserved areas.*

  President's Proposal: The Proposal creates, expands, and improves several health care workforce programs. These include:

  - National Health Service Corps: The Proposal reauthorizes and appropriates funding for to the National Health Service Corps, which provides scholarships and loan repayment for clinicians who provide medical, dental, and mental health care in urban and rural Health Professional Shortage Areas (HPSAs) throughout the country. The Proposal also increases the loan repayment benefits for each Corps member.

  - Health Professions Education and Training in Primary Care, Pediatrics, and Dentistry: The Proposal establishes a primary care training and capacity building program, and it enhances faculty development in primary care and physician assistant programs. The Proposal eases current criteria for schools and students to qualify for loans, establishes a grant program to help eligible entities recruit students most likely to practice medicine in underserved rural communities, and supports dental education and training. The Proposal also establishes a loan repayment program for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents who work in underserved areas or with underserved populations.

- Nursing Education and Training: The Proposal awards grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention, increases nurse student loan amounts, and addresses nurse faculty shortages by making nurse faculty eligible for loan repayment and scholarship programs and reauthorizing the nurse faculty loan program.

- Public Health Workforce: The Proposal establishes a Public Health Workforce Recruitment and Retention Program Corps to address public health workforce shortages, provides funding to support training of the public health workforce and preventive medicine physicians, establishes a Ready Reserve Corps within the Commissioned Corps for service in times of national emergency, supports fellowship training in public health, and authorizes grants to promote the community health workforce.

- **Blue Dog Principle:** *Access to telemedicine programs should be promoted and expanded.*

  President's Proposal: The new CMS Center for Innovation has broad authority to search, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. The Proposal specifically directs the Center for Innovation to consider testing telehealth expansions.

- **Blue Dog Principle:** *The ability of insurance companies to deny coverage to individuals with pre-existing conditions should be eliminated.*

  President's Proposal: The Proposal prohibits denials of coverage based on pre-existing conditions for children within months of passage. Starting in 2014, the Proposal prohibits all denials of coverage based on pre-existing conditions.

- **Blue Dog Principle:** *Access to long-term care services should be improved. Patients should be provided with the option of home-or community-based care, along with increased efforts to educate the public about end of life care and long-term care insurance.*

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President's Proposal: The Proposal includes several provisions to improve access to long-term care services, including home and community-based care.

- CLASS Act for voluntary long-term care insurance: The Proposal creates a voluntary long-term care insurance program, which will provide a cash benefit to help seniors and people with disabilities obtain services and supports that will enable them to remain in their homes and communities. The Proposal will include a number of improvements that ensure that the program is financially and actuarially sound.

- "Community First Choice" Option for People with Disabilities: A new optional Medicaid benefit will be created through which States may offer community-based attendant services and supports to Medicaid beneficiaries (<150% of poverty) with disabilities who would otherwise require care in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

- Additional Long-Term Care Options: A number of new State options would be created including: allowing States to provide home- and community-based services (HCBS) and full Medicaid benefits to people with long-term care needs; extending the "Money Follows the Person" rebalancing demonstration; protecting recipients of home- and community-based services against spousal impoverishment; and increases funding for State Aging and Disability Resource Centers. The Proposal also removes barriers to providing HCBS by giving States the option to provide more types of HCBS through a State plan amendment to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment.

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