

111TH CONGRESS
1ST SESSION

S. 295

To amend title XVIII of the Social Security Act to improve the quality and efficiency of the Medicare program through measurement of readmission rates and resource use and to develop a pilot program to provide episodic payments to organized groups of multispecialty and multilevel providers of services and suppliers for hospitalization episodes associated with select, high cost diagnoses.

IN THE SENATE OF THE UNITED STATES

JANUARY 21, 2009

Mr. BINGAMAN introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to improve the quality and efficiency of the Medicare program through measurement of readmission rates and resource use and to develop a pilot program to provide episodic payments to organized groups of multispecialty and multilevel providers of services and suppliers for hospitalization episodes associated with select, high cost diagnoses.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Medicare Quality and
3 Payment Reform Act of 2009”.

4 **SEC. 2. FINDINGS.**

5 (a) FINDINGS RELATING TO MEDICARE REPORTING
6 OF READMISSION RATES AND RESOURCE USE AND THE
7 MEDICARE FEE-FOR-SERVICE PAYMENT SYSTEM.—Con-
8 gress makes the following findings:

9 (1) The Medicare program under title XVIII of
10 the Social Security Act (42 U.S.C. 1395 et seq.)
11 does not publically or privately report to health care
12 providers on resource use and, as a result, many
13 health care providers are unaware of their practices
14 with respect to resource use.

15 (2) In 2008, the Congressional Budget Office
16 reported that areas with higher Medicare spending
17 scored lower, on average, on a composite indicator of
18 quality of care furnished to Medicare beneficiaries.

19 (3) Feedback on resource use has been shown
20 to increase awareness among health care providers
21 and encourage positive behavioral changes.

22 (4) The Medicare program pays for all patient
23 hospitalizations based on the diagnosis, regardless of
24 whether the hospitalization is a readmission or the
25 initial episode of care.

1 (5) The Medicare Payment Advisory Commis-
2 sion reports that within 30 days of discharge from
3 a hospital, 17.6 percent of admissions are re-
4 admitted to the hospital. In 2005, the Medicare pro-
5 gram spent \$15,000,000,000 on such readmissions.

6 (6) The Commonwealth Fund Commission on a
7 High Performance Health System found that Medi-
8 care 30-day readmission rates varied from 14 per-
9 cent to 22 percent with respect to the lowest and
10 highest decile of States.

11 (b) FINDINGS RELATING TO THE BUNDLING OF
12 MEDICARE PAYMENTS TO HEALTH CARE PROVIDERS.—
13 Congress makes the following findings:

14 (1) Bundled payments incentivize health care
15 providers to determine and provide the most efficient
16 mix of services to Medicare beneficiaries with regard
17 to cost and quality.

18 (2) The Medicare Payment Advisory Commis-
19 sion reports that bundled payments around a given
20 episode of care under the Medicare program would
21 encourage collaboration among providers of services
22 and suppliers, reduce fragmentation in health care
23 delivery, and improve the accountability for cost and
24 the quality of care.

1 (3) The Medicare Participating Heart Bypass
2 Center Demonstration which was conducted during
3 the period of 1990 to 1996 found that bundled pay-
4 ments for cardiac bypass cases were successful in re-
5 ducing spending on laboratory diagnostics, pharmacy
6 services, intensive care, physician consults, and post-
7 discharge care while maintaining a high quality of
8 care. The Medicare program saved approximately 10
9 percent on bypass patients treated under the dem-
10 onstration.

11 (4) The 16th Commonwealth Fund/Modern
12 Healthcare Health Care Opinion Leaders Survey, re-
13 leased November 3, 2008, found that more than $\frac{2}{3}$
14 of respondents reported that the fee-for-service pay-
15 ment system under the Medicare program is not ef-
16 fective at encouraging high quality and efficient care
17 and more than $\frac{3}{4}$ of respondents reported preferring
18 a move toward bundled per patient payments under
19 the Medicare program. Respondents favored shared
20 accountability for resource use as a means for im-
21 proving efficiency, and at least $\frac{2}{3}$ of respondents
22 supported realigning payment incentives for pro-
23 viders of services and suppliers under the Medicare
24 program in order to improve efficiency and effective-
25 ness.

1 **SEC. 3. PAYMENT ADJUSTMENT FOR READMISSION RATES**
 2 **AND RESOURCE USE.**

3 (a) PAYMENT ADJUSTMENT.—

4 (1) IN GENERAL.—Title XVIII of the Social Se-
 5 curity Act (42 U.S.C. 1395 et seq.) is amended by
 6 adding at the end the following new section:

7 “PAYMENT ADJUSTMENT FOR READMISSION RATES AND
 8 RESOURCE USE

9 “SEC. 1899. (a) REPORTING OF READMISSION
 10 RATES AND RESOURCE USE.—

11 “(1) ANNUAL REVIEW.—Beginning not later
 12 than 1 year after the date of enactment of this sec-
 13 tion, the Secretary shall conduct an annual review of
 14 readmission rates and resource use for conditions se-
 15 lected by the Secretary under paragraph (5)—

16 “(A) with respect to subsection (d) hos-
 17 pitals and affiliated physicians (or similarly li-
 18 censed providers of services and suppliers); and

19 “(B) with respect to the program under
 20 this title.

21 “(2) REPORTING.—

22 “(A) TO HOSPITALS AND AFFILIATED PHY-
 23 SICIANS.—Beginning not later than 1 year after
 24 the date of enactment of this section, taking
 25 into consideration the results of the annual re-
 26 view under paragraph (1), the Secretary shall

1 provide confidential reports to subsection (d)
2 hospitals and to affiliated physicians (or simi-
3 larly licensed providers of services and sup-
4 pliers) that measure the readmission rates and
5 resource use for conditions selected by the Sec-
6 retary under paragraph (5).

7 “(B) TO THE PUBLIC.—Beginning not
8 later than 3 years after such date of enactment,
9 taking into consideration the results of such an-
10 nual review, the Secretary shall make available
11 to the public an annual report that measures
12 the readmission rates and resource use under
13 this title for conditions selected by the Sec-
14 retary under paragraph (5). Such annual re-
15 ports shall, to the extent practicable, be inte-
16 grated into public reporting of data submitted
17 under section 1886(b)(3)(B)(viii) with respect
18 to subsection (d) hospitals and data submitted
19 under section 1848(m) with respect to eligible
20 professionals.

21 “(3) DEFINITION OF READMISSION.—The Sec-
22 retary shall define readmission for purposes of this
23 section. Such definition shall—

1 “(A) include a time frame of at least 30
2 days between the initial admission and the ap-
3 plicable readmission;

4 “(B) capture readmissions to any hospital
5 (as defined in section 1861(e)) or any critical
6 access hospital (as defined in section
7 1861(mm)(1)) and not be limited to readmis-
8 sions to the subsection (d) hospital of the initial
9 admission; and

10 “(C) ensure that the diagnosis for both the
11 initial admission and the applicable readmission
12 are related.

13 “(4) PENALTIES FOR NON-REPORTING.—The
14 Secretary shall establish procedures for the collection
15 of data necessary to carry out this subsection. Such
16 procedures shall—

17 “(A) subject to subparagraph (B), provide
18 for the imposition of penalties for subsection
19 (d) hospitals and affiliated physicians (or simi-
20 larly licensed providers of services and sup-
21 pliers) that do not submit such data; and

22 “(B) include a hardship exceptions process
23 for affiliated physicians (and similarly licensed
24 providers of services and suppliers) who do not
25 have the resources to participate (except that

1 such process may not apply to more than 20
2 percent of affiliated physicians (or similarly li-
3 censed providers of services and suppliers)).

4 “(5) SELECTION OF CONDITIONS.—

5 “(A) INITIAL SELECTION.—The Secretary
6 shall select conditions for the reporting of read-
7 mission rates and resource use under this sub-
8 section—

9 “(i) that have a high volume under
10 this title; or

11 “(ii) that have high readmission rates
12 under this title.

13 “(B) UPDATING CONDITIONS SELECTED.—

14 Not less frequently than every 3 years, the Sec-
15 retary shall review and update as appropriate
16 the conditions selected under subparagraph (A).

17 “(6) TIME PERIOD OF MEASUREMENT.—The
18 Secretary shall, as appropriate and subject to the re-
19 quirements of this subsection, determine an appro-
20 priate time period for the measurement of readmis-
21 sion rates and resource use for purposes of this sec-
22 tion.

23 “(7) RISK ADJUSTMENT OF DATA.—The Sec-
24 retary shall make appropriate adjustments to any
25 data used in analyzing or reporting readmission

1 rates and resource use under this section, including
2 any data used to conduct the annual review under
3 paragraph (1), in the preparation of reports under
4 subparagraph (A) or (B) of paragraph (2), or in the
5 determination of whether a subsection (d) hospital
6 or an affiliated physician (or a similarly licensed
7 provider of services or supplier) has met the bench-
8 marks established under subsection (b)(1)(A)(i) to
9 take into account variations in health status and
10 other patient characteristics.

11 “(8) INCORPORATION INTO QUALITY REPORT-
12 ING INITIATIVES.—The Secretary shall, to the extent
13 practicable, incorporate readmission rates and re-
14 source use measurements into quality reporting ini-
15 tiatives for other Medicare payment systems, includ-
16 ing such initiatives with respect to skilled nursing
17 facilities and home health agencies.

18 “(b) PAYMENT ADJUSTMENT FOR READMISSION
19 RATES AND RESOURCE USE.—

20 “(1) IN GENERAL.—

21 “(A) BENCHMARKS.—

22 “(i) IN GENERAL.—The Secretary
23 shall establish benchmarks for measuring
24 the readmission rates and resource use of
25 subsection (d) hospitals and affiliated phy-

1 sicians (or similarly licensed providers of
2 services and suppliers) under this section.

3 “(ii) REPORT TO CONGRESS ON
4 METHODOLOGIES USED TO ESTABLISH
5 BENCHMARKS.—Not later than 2 years
6 after the date of enactment of this section,
7 the Secretary shall submit to Congress a
8 report on the methodologies used to estab-
9 lish the benchmarks under clause (i).

10 “(iii) RISK ADJUSTMENT OF DATA.—
11 In determining whether a subsection (d)
12 hospital has met the benchmarks estab-
13 lished under clause (i) for purposes of the
14 payment adjustment under this subsection,
15 the Secretary shall provide for risk adjust-
16 ment of data in accordance with subsection
17 (a)(7).

18 “(B) PAYMENT ADJUSTMENT.—Not later
19 than 3 years after the date of enactment of this
20 section, in the case of a subsection (d) hospital
21 that the Secretary determines does not meet 1
22 or more of the benchmarks established under
23 subparagraph (A)(i) during the time period of
24 measurement, the Secretary shall reduce the
25 base operating DRG payment amount (as de-

1 fined in subparagraph (C)) for the subsection
 2 (d) hospital for each discharge occurring in the
 3 succeeding fiscal year by—

4 “(i) 1 percent or an amount that the
 5 Secretary determines is proportionate to
 6 the number of readmissions of the sub-
 7 section (d) hospital which exceed the appli-
 8 cable benchmark established under sub-
 9 paragraph (A)(i), whichever is greater; or

10 “(ii) in the case where the Secretary
 11 updates the amount of the payment adjust-
 12 ment under paragraph (3), such updated
 13 amount.

14 “(C) BASE OPERATING DRG PAYMENT
 15 AMOUNT DEFINED.—

16 “(i) IN GENERAL.—Except as pro-
 17 vided in clause (ii), in this subsection, the
 18 term ‘base operating DRG payment
 19 amount’ means, with respect to a sub-
 20 section (d) hospital for a fiscal year—

21 “(I) the payment amount that
 22 would otherwise be made under sec-
 23 tion 1886(d) for a discharge if this
 24 subsection did not apply; reduced by

1 “(II) any portion of such pay-
2 ment amount that is attributable to
3 payments under paragraphs (5)(A),
4 (5)(B), (5)(F), and (12) of such sec-
5 tion 1886(d).

6 “(ii) SPECIAL RULES FOR CERTAIN
7 HOSPITALS.—

8 “(I) SOLE COMMUNITY HOS-
9 PITALS.—In the case of a sole com-
10 munity hospital, in applying clause
11 (i)(I), the payment amount that would
12 otherwise be made under subsection
13 (d) for a discharge if this subsection
14 did not apply shall be determined
15 without regard to subparagraphs (I)
16 and (L) of subsection (b)(3) of section
17 1886 and subparagraph (D) of sub-
18 section (d)(5) of such section.

19 “(II) HOSPITALS PAID UNDER
20 SECTION 1814.—In the case of a hos-
21 pital that is paid under section
22 1814(b)(3), the term ‘base operating
23 DRG payment amount’ means the
24 payment amount under such section.

1 “(2) SHARED ACCOUNTABILITY.—The Sec-
2 retary shall examine ways to create shared account-
3 ability with providers of services and suppliers asso-
4 ciated with episodes of care, including how any pen-
5 alty could be distributed among such providers of
6 services and suppliers as appropriate and how to
7 avoid inappropriate gainsharing by such providers of
8 services and suppliers.

9 “(3) ANNUAL UPDATE.—The Secretary shall
10 annually update the benchmarks established under
11 paragraph (1)(A)(i) and the payment adjustment
12 under paragraph (1)(B) to further incentivize im-
13 provements in readmission rates and resource use.

14 “(4) INCORPORATION OF NEW MEASURES.—In
15 the case where the Secretary updates the conditions
16 selected under subsection (a)(5)(B), any new condi-
17 tion selected shall not be considered in determining
18 whether a subsection (d) hospital has met the bench-
19 marks established under paragraph (1)(A)(i) for
20 purposes of the payment adjustment under para-
21 graph (1)(B) during the period beginning on the
22 date of the selection and ending 1 year after such
23 date.”.

24 (2) CONFORMING AMENDMENT.—Section
25 1886(d)(1)(A) of the Social Security Act (42 U.S.C.

1 1395ww(d)(1)(A)), in the matter preceding clause
2 (i), is amended by striking “section 1813” and in-
3 sserting “sections 1813 and 1899”.

4 (b) VOLUNTARY PILOT PROGRAM FOR BUNDLED
5 PAYMENTS FOR EPISODES OF TREATMENT.—

6 (1) INITIAL IMPLEMENTATION.—

7 (A) IN GENERAL.—The Secretary of
8 Health and Human Services (in this subsection
9 referred to as the “Secretary”) shall establish a
10 pilot program to provide episodic payments to
11 hospitals and other organizing entities for items
12 and services associated with hospitalization epi-
13 sodes of Medicare beneficiaries with respect to
14 1 or more conditions selected under subpara-
15 graph (B).

16 (B) SELECTION.—The Secretary shall ini-
17 tially implement the pilot program for hos-
18 pitalization episodes with respect to conditions
19 that have a high volume, high readmission rate,
20 or high rate of post-acute care under the Medi-
21 care program under title XVIII of the Social
22 Security Act (42 U.S.C. 1395 et seq.) (as deter-
23 mined by the Secretary).

24 (C) PAYMENTS.—

1 (i) IN GENERAL.—Under the pilot
2 program, episodic payments shall—

3 (I) be risk adjusted; and

4 (II) cover all costs under parts A
5 and B of the Medicare program asso-
6 ciated with a hospitalization episode
7 with respect to the selected condition,
8 which includes the period beginning
9 on the date of hospitalization and
10 ending 30 days after the date of dis-
11 charge.

12 (ii) COMPATIBILITY OF PAYMENT
13 MECHANISMS.—The Secretary shall, to the
14 extent feasible, ensure that the payment
15 mechanism under the pilot program func-
16 tions with payment mechanisms under the
17 original Medicare fee for service program
18 under parts A and B of title XVIII of the
19 Social Security Act and under the Medi-
20 care Advantage program under part C of
21 such title.

22 (iii) PROCESS.—Under the pilot pro-
23 gram, episodic payments shall be made to
24 a hospital or other organizing entity par-
25 ticipating in the pilot program. The par-

1 participating hospitals and other organizing
2 entities shall make payments to other pro-
3 viders of services and suppliers who fur-
4 nished items or services associated with the
5 hospitalization episode (in an amount ne-
6 gotiated between the participating hospital
7 and the provider of services or supplier).

8 (iv) SAVINGS.—The Secretary shall
9 establish procedures to ensure that the
10 Secretary, participating hospitals or other
11 organizing entities, providers of services,
12 and suppliers share any savings associated
13 with higher efficiency care furnished under
14 the pilot program.

15 (D) INCLUSION OF VARIETY OF PROVIDERS
16 OF SERVICES AND SUPPLIERS.—In selecting
17 providers of services and suppliers to partici-
18 pate in the pilot program, the Secretary shall
19 establish criteria to ensure the inclusion of a
20 variety of providers of services and suppliers,
21 including providers of services and suppliers
22 that serve a wide range of Medicare bene-
23 ficiaries, including Medicare beneficiaries lo-
24 cated in rural and urban areas and low-income
25 Medicare beneficiaries.

1 (E) DURATION.—The Secretary shall con-
2 duct the pilot program under this paragraph for
3 a 5-year period.

4 (F) IMPLEMENTATION.—The Secretary
5 shall implement the pilot program not later
6 than 2 years after the date of enactment of this
7 Act.

8 (G) DEFINITION OF ORGANIZING ENTI-
9 TY.—In this subsection, the term “organizing
10 entity” means an entity responsible for the or-
11 ganization and administration of the furnishing
12 of items and services associated with a hos-
13 pitalization episode of a Medicare beneficiary
14 with respect to 1 or more conditions selected
15 under subparagraph (B).

16 (2) EXPANDED IMPLEMENTATION.—

17 (A) ESTABLISHMENT OF THRESHOLDS
18 FOR EXPANSION.—The Secretary shall, prior to
19 the implementation of the pilot program under
20 paragraph (1), establish clear thresholds for use
21 in determining whether implementation of the
22 pilot program should be expanded under sub-
23 paragraph (B).

24 (B) EXPANDED IMPLEMENTATION.—If the
25 Secretary determines the thresholds established

1 under subparagraph (A) are met, the Secretary
2 may expand implementation of the pilot pro-
3 gram to additional providers of services, sup-
4 pliers, and episodes of treatment not covered
5 under the pilot program as conducted under
6 paragraph (1), which may include the imple-
7 mentation of the pilot program on a national
8 basis.

9 (3) AUTHORIZATION OF APPROPRIATIONS.—
10 There are authorized to be appropriated such sums
11 as may be necessary to carry out this subsection.

○