Key Delivery Reform Provisions

- Center for Medicare and Medicaid Innovation
- Independent Payment Advisory Board (IPAB)
- Accountable Care Organizations (ACOs)
- Medical Homes
- Hospital Value-Based Purchasing Program
- Value-Based Payment Methods
- Pilot Program on Payment Bundling
- Reforms for Hospital Acquired Conditions and Hospital Readmissions

Center for Medicare and Medicaid Innovation

- Established within CMS to test, evaluate and expand innovative payment and service delivery models
  - Goal is to reduce Medicare, Medicaid and CHIP expenditures while improving quality of care
- Broad authority to select models but must consult with other federal agencies, health care professionals and experts before adopting programs
- Requirements for models
  - Address a defined population that has poor clinical outcomes or involve excess spending
  - Models may address a wide variety of areas
  - Secretary has authority to waive certain Medicare and Medicaid requirements as necessary to test models
- Secretary of HHS must evaluate each model
  - Authorized to expand duration and scope of successful models
- Established no later than January 1, 2011

Independent Payment Advisory Board (IPAB)

- Board established to implement proposals to reduce Medicare spending
- **How proposals are triggered**
  - CMS Actuary must project whether Medicare per capita spending exceeds a specific threshold
  - If spending exceeds thresholds, IPAB must submit recommendations to President and Secretary of HHS to achieve reductions in spending
  - President must submit proposal to Congress; IPAB's proposals would take effect unless Congress passes alternative that achieves same level of required savings
- **Requirements for proposals**
  - Proposals must: (1) result in a net reduction in Medicare program spending that is at least equal to applicable savings target; (2) not ration care, raise taxes or Part B premiums, or change Medicare eligibility, benefit, or cost-sharing; (3) prior to 2019, *not* reduce payment rates for "providers" that are scheduled to receive a reduction in their annual updates; (4) "as appropriate," reduce Medicare payments under Medicare parts C and D
- Board may also submit advisory reports (regardless of if threshold) to reform payments
- First reporting period: January 15, 2014

Accountable Care Organizations (ACOs) / Shared Savings Program

- Voluntary programs that permit provider-led organizations to share in achieved cost savings
- **Who may participate?**
  - Broad array of Medicare providers may work together to form an ACO
    - Includes physicians in group practices, networks of practices, hospital-physician joint ventures and hospitals employing physicians
    - Only PPS hospitals are eligible to participate
    - Must include primary care physicians to serve the ACO's beneficiaries
  - Also a pediatric ACO model
- **What is required of an ACO?**
  - Report on and achieve quality measures
  - ACO is accountable for the quality, cost and overall care of its beneficiaries (minimum 5,000 beneficiaries)
- **How are ACOs paid?**
  - Shared savings
  - Partial capitation
  - Secretary of HHS to determine other payment models
  - No penalties imposed on ACOs
- Established by January 1, 2012

Medical Homes / Independence at Home Medicare Demonstration Project

- Voluntary program of home-based primary care teams that provide care to high-need populations and may share in a portion of cost savings
- **Who may participate?**
  - A medical home is comprised of individual physicians, nurse practitioners, physician assistants, clinical social workers and psychologists or groups of these providers
  - Beneficiaries must
    - have two or more chronic illnesses and functional dependencies (require assistance for bathing, dressing etc.) and
    - within the past year has had a nonelective hospital admission and received acute or subacute rehabilitation services
  - Option for states to establish a Medicaid medical home and receive funding from HHS
- **What is required of a medical home?**
  - Provide continuous care and make in-home visits to beneficiaries
  - Report on and achieve quality measures established by the Secretary of HHS
- **How are medical homes paid?**
  - Shared savings
  - No penalties but Secretary must terminate programs that fail in two consecutive years to achieve quality measures
- Established by January 1, 2012

Hospital Value-Based Purchasing Program

- Basing Medicare hospital payments on achievement of performance measures that are tied to common conditions
- **Which hospitals are affected?**
  - All PPS hospitals with some exceptions such as for hospitals that do not have a sufficient number of patients with applicable conditions
- **What are the program requirements?**
  - Secretary of HHS to establish condition measures

    Initially, measures are based on five conditions: heart attack, heart failure, pneumonia, surgeries and healthcare-associated infections
  - Hospitals must achieve performance standards based on condition measures
  - Secretary of HHS to publicize hospital performance scores
- **What is the payment methodology?**
  - Increase base operating DRG payments for hospitals that achieve performance standards
  - Budget neutral program
- Program begins FY 2013

Value-Based Payment Methods

- Payment modifier to vary Medicare payments to physicians and physician groups
  - Payment is based on the quality and cost of the care delivered

- Secretary of HHS to conduct studies to incorporate quality measures into Medicare reimbursement system
  - Studies to be conducted by the Institute of Medicine (IOM) to study geographic variation in the volume and intensity of health care services and spending
  - Studies will address reimbursement for both hospitals and physicians
  - Secretary to encourage IPAB to consider the study's recommendations

Medicare Payment Bundling Program

- Pilot program that provides payment across an entire episode of care
  - Episode of care defined as the period: three days prior to admission to a hospital; the length of stay in the hospital; and 30 days following discharge from hospital. The Secretary of HHS may amend this definition if appropriate.
- **Who may participate?**
  - An "entity" comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency
  - Only certain services and conditions are eligible for bundled payments
  - Services include: (1) acute care inpatient services; (2) physician services delivered in and out of an acute care hospital setting; (3) outpatient hospital services (including emergency); (4) post-acute care services; and (5) others as determined appropriate by the Secretary of HHS.
- **What are the program requirements?**
  - Entities must submit data on quality measures established by the Secretary of HHS
  - Programs last for five years but Secretary of HHS may expand the program
- **What is the payment methodology?**
  - Secretary of HHS to develop payment methodologies
  - Payments not to exceed what would have been paid absent the pilot program
- Established by January 1, 2013

Hospital Acquired Conditions and Readmissions

These provisions use financial penalties to encourage delivery reform

Hospital Acquired Conditions (HACs)	Hospital Readmissions
❑ Provides financial penalties for conditions that patients acquire during a hospital stay	❑ Provides financial penalties for avoidable hospital readmissions
❑ Medicare - PPS hospitals in the top quartile for HACs will receive a 1% decrease in DRG payments	❑ PPS hospitals will have payments reduced by an amount equal to the base operating DRG payment and an adjustment factor
❑ Medicaid - Secretary of HHS to adopt regulations prohibiting federal payments for HACs	❑ Hospitals required to submit data to either the Secretary of HHS or to the States to determine patient readmission rates
❑ Secretary of HHS to publicize information on HAC rates ❑ Medicaid prohibition – FY 2011 ❑ Medicare reductions – FY 2014	❑ Secretary of HHS to publicize information on readmission rates ❑ Begins FY 2013

Core components of the public policy problem?

- Payment systems that do not reward healthcare providers to deliver better value
- Lack of transparency of performance
- Providers lack of a consistent methodology to improve care