



## KEY PROVIDER ISSUES IN HEALTH CARE REFORM

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### DEMONSTRATION AND PILOT PROGRAMS IN REFORM

One of the goals of health care reform is to "bend the cost curve": to change the provision or organization of health care in a way that increases its value and decreases spending. The law contains a mix of small, limited-scope demonstration projects (demos) and larger pilot projects which may allow providers and physicians to participate in some new payment systems, or to be reimbursed differently for preventive or coordinated services. Some of these pilots and demos are intended to incorporate private sector innovations in Medicare or to allow Medicare to partner with private sector programs.

#### Beginning in 2010

**Medicaid Global Payments Demonstration Project (SEC. 2705)** This demo is limited to five states and scheduled to end in 2012. Large, safety net hospital systems participating in Medicaid would be permitted to alter their provider payment system from a fee-for-service structure to a capitated, global payment structure.

**Rural Community Hospital Demonstration Program (SEC. 3123)** The law extends the current demo—which provides critical-access-hospital-type reimbursement to smaller rural hospitals—for an additional five years, expands the maximum number of participating hospitals to 30 and expands eligible sites to 20 states with low population densities.

#### Beginning in 2011

**Community-Based Care Transitions Program (SEC. 3026)** This pilot establishes a program in which eligible hospitals in partnership with community-based organizations provide patient-centered, evidence-based care transition services to Medicare beneficiaries at the highest risk of preventable re-hospitalization. Generally, a "high-risk" beneficiary has multiple diagnoses, cognitive impairment, depression, or a history of multiple readmissions. The pilot is five years long, though the Secretary has the discretion to extend it.

**Independence At Home (SEC. 3024)** Creates chronic care coordination teams to bring primary care services to the highest cost Medicare beneficiaries with multiple chronic conditions. Teams of health care professionals, including physician assistants and nurse practitioners, caring for patients with

*For information, visit [www.strategichealthcare.net](http://www.strategichealthcare.net), or contact Marian Lowe, Partner, Strategic Health Care, at 202-266-2606 or at [marian.lowe@shcare.net](mailto:marian.lowe@shcare.net).*

multiple chronic conditions in their residences would be eligible for shared-savings if they achieve quality outcomes, patient satisfaction and cost savings. The demo is limited to 10,000 beneficiaries; contracts are limited to three years.

The law establishes the **Center for Medicare and Medicaid Innovation (CMI)**. The Center will be an umbrella for many experiments in new payment systems or care organizations (Please see more details on the CMI at the end of this paper).

### **Beginning in 2012**

**Accountable Care Organizations (ACOs) (SEC. 1899)** This pilot will allow organizations to manage and coordinate Part A and B Medicare services for at least 5,000 beneficiaries and share in the savings they generate for the Medicare program. To qualify as an ACO, the organization must

- have adequate participation of primary care physicians and specialists,
- define processes to promote evidence-based medicine,
- report on quality and cost measures, and
- coordinate care

ACOs can include partnerships or joint ventures of hospitals and physicians, physicians employed by hospitals, networks of individual practices, group practices, or other arrangements of providers and suppliers. Participating entities will continue to be paid individually for Medicare services; they will jointly share and distribute any savings if they achieve quality outcomes, patient satisfaction, and cost savings. The manager's amendment provided additional flexibility to the Secretary of HHS to implement innovative payment models for participating Accountable Care Organizations, including a Partial Capitation Model or other payment models currently used by the private sector.

There is a smaller demonstration to establish pediatric ACOs in Medicaid. These ACOs will share in the federal and state savings. The demo will end Dec. 31, 2016.

**Hospital Value-Based Purchasing (VBP) Demonstration Project (SEC. 3001)** The law will establish a three-year demonstration project to test payment systems which link financial rewards and penalties to performance on quality measures for critical access hospitals and small hospitals. CAHs and small hospitals, however, are exempted from the VBP program. For larger, inpatient hospitals the project will begin in FY2013, since they generally do not have an adequate number of patients per year to reliably measure and risk-adjust quality for the current quality measures.

**Medicaid bundled payments (SEC. 2704)** This 8-state demo will evaluate the use of bundled payments for the provision of integrated care for Medicaid beneficiaries. A single payment for each patient's episode of care would include hospitalization and the concurrent physician services provided during a

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hospitalization. States can target this demo by diagnoses, categories of beneficiaries, or regions of the state.

**Medicaid Emergency Psychiatric Care Demonstration Project (SEC. 2707)** This demo is limited to three year's duration and is scheduled to end in 2015. It will expand the number of emergency inpatient psychiatric care beds available in communities. Allows states to cover patients in non-governmental freestanding psychiatric hospitals and receive federal Medicaid matching payments. The evaluation will assess whether the demo improves timely access to emergency psychiatric care, reduces the burden on overcrowded emergency rooms, and improves the efficiency and cost-effectiveness of inpatient psychiatric care.

**Graduate Nurse Training Demonstration Program (SEC.5509)** Up to 5 eligible hospitals, partnered with accredited schools of nursing, would receive Medicare reimbursement for the educational and clinical instruction costs attributable to increasing the number of advanced practice nurses they train. At least half of the nurse training would occur outside the hospital.

#### Beginning in 2013

**Medicare bundled payments (SEC. 1866D)** Under this pilot, a single payment would be made for all of the inpatient, outpatient, physician, and post-acute costs for an episode of chronic or acute care. It would include ten prevalent, high-cost diagnoses. The Secretary may expand and extend the pilot beyond 2016 if it is successful at reducing costs and maintaining quality and access.

#### Beginning in 2016

**Test Value Based Purchasing in IRF, LTACH, hospice, cancer hospitals, and inpatient psychiatric facilities (SEC. 3401)** These pilots could be extended if the Secretary finds they improve care and do not increase spending.

#### No start date provided

**Medicare Hospice Concurrent Care Demonstration (SEC. 3140)** Allows patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time. Participation is limited to 15 hospice programs and a three-year duration.

#### More details on the Innovation Center (SEC. 3021)

The CMI within CMS will test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures, payment reform models, and methodologies to foster patient-centered care, improve quality, and slow Medicare costs growth.

Preferred models also improve the coordination, quality and efficiency of health care services. Models include:

1. Promoting broad payment and practice reform in primary care;

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2. Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models;
3. Promoting care coordination between providers of services and suppliers that transition health care providers away from fee-for-service and toward salary-based payment;
4. Supporting care coordination for chronically-ill Medicare beneficiaries at high risk of hospitalization;
5. Varying payment to physicians who order advanced diagnostic imaging services;
6. Utilizing medication therapy management services;
7. Establishing community-based health teams to support small-practice medical homes;
8. Funding physician, nurse practitioner, or physician assistant-led home based primary care programs with demonstrated experience in serving high-cost Medicare beneficiaries with multiple chronic illnesses and functional disabilities;
9. Assisting Medicare beneficiaries in making informed health care choices;
10. Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State;
11. Allowing States to test and evaluate all-payer payment reform;
12. Aligning national, evidence-based guidelines of cancer care with payment incentives;
13. Improving post-acute care through continuing care hospitals;
14. Funding home health providers who offer chronic care management services to Medicare beneficiaries in cooperation with interdisciplinary teams;
15. Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions.

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