

Health System Reform INSIGHT



May 6, 2010

The Patient Protection and Affordable Care Act—health system reform legislation signed into law by President Obama on March 23—contains a number of key provisions for you and your patients. Some provisions may have an immediate impact on your practice and patients, while others will not take effect for some time.

Given the new direction for the nation's health system, the AMA has developed *Health System Reform Insight* to help you understand the new law and how it will affect you, when certain provisions are scheduled to take effect, how you can be ready when the regulations go into effect and what your patients need to know.

New Payment and Delivery Reform Models

The Patient Protection and Affordable Care Act establishes several demonstration programs to test and evaluate new Medicare health care delivery and payment models. This is in an effort to improve care coordination and quality while reducing the rate of spending growth. These models include bundled payments, accountable care organizations (ACOs or shared savings programs) and the medical home. The law also establishes a new Center for Innovation within the Centers for Medicare & Medicaid Services (CMS) that can test other care models, and it gives the secretary of Health and Human Services (HHS) the authority to expand the scope and duration of the new models, including the authority to expand them nationwide.

Participation in all of these demonstrations is strictly voluntary for Medicare providers, and physician practices must fully evaluate their capacity to join in these programs before pursuing them. Under these models, physicians will have to work collaboratively with other practices and/or with other providers, such as hospitals, and they may need to invest in tools and systems that are required to coordinate care and measure performance.

There may be distinct advantages to practices that are able to participate in these demonstrations. While these projects generally do not begin until at least 2012, it is important for interested physicians to begin evaluating their ability to participate now, since organizing a practice to join in these demonstrations may require long-term planning. Even for those who do not want to participate in these particular projects, it is important to recognize their goal to test



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[Overview of Major Provisions Relating to Coverage](#) (PDF)

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[Major Medicare Savings Under Health Reform Legislation](#) (PDF)

[Health Reform Law Raises GPCIs](#) (PDF)

[How Health System Reform Affects Patients](#) (PDF)

[How Health System Reform Impacts Physicians' Practices](#)

and refine these new models as potential federal payment and delivery reforms in the future. Further, many of these models may already be underway in the private market in some areas. Therefore, physicians should be familiar with the underlying concepts and overall approaches.

The AMA will work closely with the administration as these demonstrations are developed and implemented to ensure that physicians can fully participate, and will work to assist its physician members who are seeking to participate. The AMA also will be launching a series of educational materials and programs in the near future for physicians on the pathways to successfully participating in delivery reform models.

CMS Center for Medicare and Medicaid Innovation (Sec. 3021)

By January 1, 2011, the HHS secretary is required to establish a CMS Center for Innovation to test care models that improve quality and slow the rate of growth in Medicare costs. The secretary must publicly make an evaluation of each model, including an assessment of the quality of care provided. The secretary may limit model testing to certain geographic areas, and model designs do not initially have to ensure budget neutrality. The secretary also has discretion to develop any model that meets certain requirements, although the law suggests a number of specific models that may be tested. For example, models may include:

- Promoting broad payment and practice reforms in primary care, including patient-centered medical home models for high-need individuals and medical homes that address women's unique health care needs
- Using geriatric assessments and comprehensive care plans to coordinate care for patients with multiple chronic conditions who are unable to perform daily living activities or who have cognitive impairments
- Supporting care coordination for chronically ill individuals at high-risk of hospitalization through a health information technology-enabled provider network
- Establishing community-based health teams to support small-practice medical homes by assisting primary care providers in chronic care management, including patient self-management activities
- Assisting individuals in making informed health care decisions by compensating physicians and other providers for using patient decision-support tools to improve understanding of medical treatment options

Medicare Shared Savings Program (Sec. 3022)

By January 1, 2012, the HHS secretary is required to establish certain Medicare shared savings programs commonly known as ACOs for various providers. These providers include groups of physicians, networks of individual practices, partnerships or joint

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ventures between hospitals and physicians, hospitals employing physicians, and any other provider groups that the secretary determines is appropriate. To qualify, an ACO must agree to be accountable for the quality, cost and overall care for the Medicare fee-for-service beneficiaries assigned to it. An ACO must have at least 5,000 assigned Medicare beneficiaries and have in place, among other things, the following: (1) a formal legal structure that would allow the organization to receive and distribute payments for any shared savings; (2) a leadership and management structure that includes clinical and administrative systems; (3) defined processes to promote evidence-based medicine; and (4) processes to report on quality and cost measures. Payments will continue to be made to physicians and other ACO participants under the usual Medicare payment structure (e.g., the Medicare fee schedule). Additionally, ACOs would share among their provider participants a portion of any savings achieved in excess of a threshold benchmark. ACOs must agree to participate in the demonstration for at least three years.

National Pilot Program on Payment Bundling (Sec. 3023)

By January 1, 2013, the HHS secretary is required to establish a Medicare pilot program for integrated care. This will include episodes of care involving a hospitalization to improve the coordination, quality and efficiency of health care services, such as: (1) physician services delivered inside and outside of an acute care hospital setting; (2) other acute care inpatient services; (3) outpatient hospital services, including emergency department services; (4) post-acute care services, including home health, skilled nursing, inpatient rehabilitation, and inpatient services furnished by long-term care hospitals; and (5) other services the secretary determines are appropriate. The secretary will also establish a payment methodology, including bundled payments or bids for episodes of care. Payment will be made to the entity that is participating in the pilot program.

Independence at Home Demonstration Program (Sec. 3024)

By January 1, 2012, the HHS secretary is required to establish an independent at-home demonstration program to bring primary care services to the homes of high-cost Medicare beneficiaries with multiple chronic conditions. Health teams could be eligible for shared savings if they achieve high-quality outcomes, patient satisfaction and cost savings. The secretary will estimate an annual per capita spending target for the estimated amount that would have been spent under Parts A and B in the absence of the demonstration, with the target adjusted for certain risks. A medical home practice could receive an incentive payment based on actual savings achieved in comparison to the target.

Extension of Gainsharing Demonstration (Sec. 3027)

The existing Medicare gainsharing demonstration project is extended for almost two years. This project was established to test and

evaluate methodologies and arrangements between hospitals and physicians governing the use of inpatient hospital resources and physician work to improve the quality and efficiency of care provided to Medicare beneficiaries. Under this arrangement, the hospital provides payments to physicians that represent a share of savings attributable to collaborative efforts between the hospital and the physician.

Community Health Team Support for Patient-Centered Medical Homes (Sec. 3502)

The HHS secretary is required to provide grants or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional "health teams" to support primary care practices (including obstetrics and gynecology practices) within their local hospital service areas, and to provide capitated payments to primary care providers according to criteria established by the secretary. The health teams could, for example, collaborate with patient-centered medical homes in coordinating prevention and chronic disease management services, or develop and implement care plans that integrate preventive and health promotion services.

Additional resources

For general background information on payment and delivery reforms, read reports from the AMA Council on Medical Service about [Medicare physician payment reform](#) (PDF) and the [patient-centered medical home](#) (PDF).

Also, read more about payment and delivery reforms in the [Journal of the American Medical Association](#), in an [issue brief](#) (PDF) from The Commonwealth Fund, and in an [article](#) (PDF) from the Center for Healthcare Quality and Payment Reform.
