

Medical Homes and Accountable Care Organizations in Health Care Reform

January 2010

House Bill – HR 3962 – “Affordable Health Care for America Act”
Senate Bill – S 3590 – “Patient Protection and Affordable Care Act”

Medical Homes – House	Medical Homes - Senate
<p>Medicare</p> <p>The Secretary shall establish a medical home pilot program for the purpose of evaluating the feasibility of reimbursing qualified patient centered medical homes for furnishing medical home services in FFS. The medical home pilot program will focus on high need beneficiaries (upper 50th percentile of risk).</p> <p>Medical home services include direct and ongoing access to a primary care provider and principal care provider for first contact, continuous and comprehensive care and coordination of care for all stages of life.</p> <p>The pilot will test two models: an independent patient centered medical home model and a community based medical home model. The independent model will start within six months of enactment, while the community based model will start within two years of enactment. The pilot will operate for five years.</p> <p>Payment for independent medical homes will be a prospective risk adjusted fee for medical home services not currently covered under Medicare FFS, e.g. care coordination, managing chronic illness. Payment for community based medical homes includes two monthly payments – a payment to the community based organization and a payment to the primary care practice.</p> <p>Eligible beneficiaries include FFS beneficiaries that are enrolled in Part B and eligible for Part A and are not enrolled in a MA or PACE plan.</p> <p>The medical home can be led by a primary care physician or nurse practitioner. A physician assistant may also participate.</p>	<p>Medicare</p> <p>Creates a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce costs and enhance quality and improve coordination of care.</p> <p>Testing of models in Phase I is focused on models where there is evidence that there are deficits in care leading to poor clinical outcomes or potentially avoidable costs. Seventeen specific models are listed, many of which incorporate the elements of the medical home.</p> <p>One of the models is promoting broad payment and practice reform in primary care including patient centered medical home models for high-need individuals, medical homes that address women’s unique health care needs, and models that transition primary care practices away from FFS toward comprehensive payment or salary based payment.</p> <p>Another model is contracting directly with groups of providers to promote innovative care delivery models, such as through risk based comprehensive payment or salary based payment.</p> <p>Another model utilizes geriatric assessments and comprehensive care plans to coordinate care of patients with chronic conditions including an inability to perform 2 ADLs (including through interdisciplinary teams).</p>

The program shall include urban, rural and underserved areas.

The bill authorizes \$6 m from the SMI Trust Fund each fiscal year 2010 -2014 and \$2.5 m in 2010-12 for administrative costs of operating the pilot program and authorizes \$200 m for medical home payments to independent medical homes between 2010 and 2014 and \$125 m for community based medical homes each fiscal year 2012-16. If the evaluation finds the pilot program successful and the actuary certifies that the pilot program is budget neutral, the Secretary may issue regulations to establish medical homes on a permanent basis.

This section repeals the medical home demos in TRHCA and MIPPA. (§1302)

Medicaid

- Authorizes a similar 5 year pilot project for high risk Medicaid beneficiaries (medically fragile children and high risk pregnant women).
- States must apply to HHS.
- Increases the federal match for administrative costs to 90% for the first two years and 75% for the next 3 years (capped at \$1.235 b over 5 years). (§1722)

Since this authority is under the demonstration section of the statute, waivers are available. Phase I projects do not need to be budget neutral.

Phase II allows the Secretary to expand the duration and scope of programs successfully evaluated in Phase II through rulemaking.

The program applies to Medicare, Medicaid, duals and CHIP.

Funding of \$5 m is available for 2010 and 10 m for FY 2011 – 2019, including funds for evaluations. (§3021)

Accountable Care Organizations - House	Accountable Care Organizations - Senate
<p>Medicare</p> <p>The Secretary shall conduct a three to five year ACO pilot program beginning January 2012. ACOs are groups of physicians or other physician organization models that include a sufficient number of primary care physicians and are accountable for the cost and outcomes of care for assigned FFS beneficiaries. ACOs may also include an affiliated hospital or other Medicare providers or suppliers of service.</p> <p>The pilots will include Part A and B services (Part D optional) and will test different payment incentive models including a performance target model (target or growth rate) and partial capitation model (e.g. physician services or Part B services) to reduce growth in costs and improve health outcomes. ACOs that meet or exceed annual quality and performance targets for a year receive incentive payments.</p> <p>Eligible beneficiaries include FFS beneficiaries that are enrolled in Part B and eligible for Part A and are not enrolled in a MA or PACE plan.</p> <p>The ACOs will utilize patient-centered processes of care, including patient and caregiver involvement, and planning and monitoring of care management plans. ACOs will report on annual quality measures that the Secretary specifies e.g. PQRI, ERx and EHR and/or alternative measures.</p> <p>The pilot will include urban, rural and underserved areas. If the pilot is successful, the Secretary may implement the ACO program on a permanent basis through regulations on as large a geographic scale as practical, provided it is determined budget neutral.</p> <p>The Secretary may give preference to ACOs who are participating with other payers and limit the risk of small ACOs.</p> <p>Administrative funds of \$25 million each year FY 2010 – FY 2014 and \$20 million for 2015. No duplicate funds may be made to physicians participating in other pilot programs. (§1301)</p>	<p>Medicare</p> <p>Establishes a Medicare Shared Savings Program no later than January 2012 that promotes accountability for patient populations and coordinates and redesigns provision of services under Medicare FFS Parts A and B.</p> <p>Allows providers to organize as ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. ACOs can include group practices, networks of individual practices of ACO professionals, partnerships or employment arrangements between hospitals and ACOs professionals.</p> <p>The ACO must have adequate participation of primary care physicians to serve at least 5,000 beneficiaries who are assigned to the ACO by the Secretary.</p> <p>To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries and enter into 3 year agreements with the Secretary. The ACO must report on quality and costs specified by the Secretary such as clinical processes and outcomes, patient and caregiver experience and utilization rates as well as other measures which may include transitions across care settings and existing criteria such as PRQI.</p> <p>The annual Shared Savings shall be the percent difference between the risk adjusted per capita expenditure under the ACO and a benchmark for the ACO set by the Secretary. (§3022)</p>

Independence at Home Demonstration Program	
<p>Medicare Similar to Senate provision but provides that the Secretary may set an aggregate target spending level for all qualifying practices or different targets for different groups or single practices. (§1312)</p>	<p>Medicare The Secretary shall test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home based primary care teams designed to reduce expenditures and improve health outcomes. The model is accountable for coordinated care for high risk populations at home and coordinated across all treatment settings resulting in reduce hospitalizations, readmissions, ER visits, improved outcomes, improved efficiency and costs.</p> <p>The independence at home medical practice includes physicians and nurse practitioners who provide care as part of a team and provide in home visits, are available 24/7; is organized for providing physicians services; furnishes care to at least 200 beneficiaries during the year; uses electronic health information systems and remote monitoring.</p> <p>The entity shall report on quality measures specified by the Secretary which may be for the group.</p> <p>The practice may receive an incentive payment if the expenditures for a year are 5 percent less than the estimated per capita spending target set by the Secretary that includes a risk corridor. The incentive payment is a portion of these savings.</p> <p>Eligible beneficiaries include FFS beneficiaries entitled to part A and enrolled in Part B, with 2 or more chronic conditions who had a non-elective hospital admission, received acute or sub-acute rehab services and has 2 or more functional dependencies requiring the assistance of another person.</p> <p>Priority shall be given to practices located in high cost areas, have experience with chronic care services to beneficiaries who live at home and use electronic medical records or other technology. The maximum number of beneficiaries that may participate in the demonstration is 10,000.</p> <p>Administrative funding of \$5 m each year is authorized for FY 2010 to 2015. Effective January 1, 2012. Agreements are for a 3 year period. (§3024)</p>