ISSUE BRIEF

CAMPAIGN FOR
Better Care

THE CAMPAIGN FOR BETTER CARE AND PAYMENT SYSTEM REFORMS: WHAT CONSUMER AND PATIENT ADVOCATES NEED TO KNOW NOW THAT HEALTH CARE REFORM HAS PASSED

INTRODUCTION

After more than a year of congressional debate, President Obama signed health care reform into law in March. The Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Affordability Reconciliation Act, not only extends health care coverage to millions of uninsured Americans, it also includes a number of initiatives intended to accelerate changes to the way health care is delivered and paid for.

Today, our payment system pays based on services delivered rather than outcomes achieved. That's because the health care delivery system is organized to respond to these incentives. As a result, care coordination and patient-centered care that decreases the need for services and supports good clinical outcomes fails to be rewarded.

The newly enacted health care reform legislation adopts a different framework for payment and health care delivery by embracing innovation and creating tools to test and evaluate new ways to produce the best outcomes for patients. This approach focuses on moving health care payment and delivery away from service-based structures and toward quality and outcomes.

The adoption of these initiatives in health care reform was motivated both by the need to improve quality as well as by the need to change the trajectory of rising health care costs.

The Campaign for Better Care applauds policymakers' recognition that payment and delivery systems need to be reformed to produce better care for patients. However, advocates need to remain vigilant about how reforms will be implemented.

New models of care and payment reforms should be implemented carefully and evaluated in a rigorous way. Providers must be held accountable for the quality of care delivered so that reforms do not prioritize cost savings over patients' needs and preferences.

This issue brief details several of the payment and delivery system initiatives adopted in health care reform and discusses how the Campaign for Better care can shape implementation of these initiatives to ensure that the needs of patients and families come first.

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The Campaign for Better Care is led by the National Partnership for Women & Families, Community Catalyst, and the National Health Law Program and funded by The Atlantic Philanthropies.

REFORM MODELS

CENTER FOR MEDICARE AND MEDICAID INNOVATION

PPACA creates a new Center for Medicare and Medicaid Innovation that will be operational by the beginning of 2011 and will be housed within the federal Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS). The Innovation Center is charged with identifying and testing new and innovative health care payment and delivery system models. When a new model is found to reduce spending without reducing the quality of care or is found to improve quality without increasing spending, the Secretary of Health and Human Services can expand it to a broader population (including nationwide expansion) if the CMS Chief Actuary certifies that the expansion would further reduce program spending. The legislation provides $10 billion over nine years to support the Center's activities.

MEDICAL HOME

A Medicare medical home demonstration project, authorized by Congress in 2006, has been on-hold pending the outcome of the federal health care reform debate. The goal of the 2006 project was to test providing targeted, accessible, continuous and coordinated care to Medicare beneficiaries with chronic illnesses who require regular medical monitoring and treatment. Health care reform revives the medical home and identifies it as a potential model to be tested under the CMS Innovation Center. PPACA suggests testing both patient-centered medical homes for high-need individuals and medical homes that address women's unique health care needs.

PPACA also creates an Independence at Home demonstration project through which high risk beneficiaries who have had a recent hospital admission can receive comprehensive, coordinated, continuous and accessible care at home. Participating medical practices will consist of care teams with experience providing home-based primary care, including making home visits and being available 24 hours a day, seven days a week. Practices will report on quality measures that will be identified by the Secretary. Subject to their performance on quality measures, Independence at Home practices will be eligible for incentive payments if they are able to demonstrate Medicare savings.

Further, PPACA creates a state Medicaid option to provide health homes for enrollees with chronic conditions. When states exercise this option, Medicaid enrollees with chronic conditions can designate a health home that could be a provider or a team of health care professionals. A health home will provide services such as comprehensive care management, care coordination, comprehensive transitional care, and patient and family support services. The initial federal Medicaid match rate for health home payments will be 90 percent, before reverting to traditional match rates.

BUNDLED PAYMENT

By 2013, the Secretary will establish a 5-year Medicare pilot program to test whether bundled payments incentivize hospitals, physicians and post-acute care providers to improve care and reduce costs. A bundled payment will be a comprehensive payment for an "episode of care" that includes a hospitalization and care during the 30 days after hospital discharge. The payment method established by the Secretary will capture inpatient, physician, outpatient and post-acute services as well as services such as care coordination, medication reconciliation and transitional care. The bundled payment cannot result in any increase in Medicare spending. The entity that receives the bundled payment must share it

with its partners and report annually on quality measures, including measures of patients' functional status improvement, reductions in rates of avoidable hospitalizations, efficiency, patient-centeredness and patient perceptions of care.

The Secretary will conduct an independent evaluation of the pilot to assess the extent to which there are improvements in health outcomes, quality measures, and beneficiaries' access to care, as well as whether spending is reduced. After 2015, the Secretary may expand the duration and scope of the pilot program if certain conditions are met. The conditions include: 1) the Secretary determines that an expansion is expected to reduce spending without reducing quality or is expected to improve quality and reduce spending; 2) the CMS Chief Actuary certifies that the expansion would reduce spending; and, 3) the Secretary determines that the expansion would not limit coverage to individuals.

PPACA also creates a Medicaid bundled payment demonstration project to operate from 2012 through 2016 in up to eight states. The project will focus on creating bundled payments for an "episode of care" that includes a hospitalization and concurrent physician services provided during a hospitalization. States must ensure that payments are adjusted for severity of illness, and participating hospitals are required to have a discharge planning process that ensures the appropriate placement of Medicaid enrollees post-discharge.

ACCOUNTABLE CARE ORGANIZATIONS

Starting in 2012, the Secretary of Health and Human Services will create a Medicare shared savings program, which will establish Accountable Care Organizations (ACOs). An ACO will be some combination of physicians, hospitals and other providers working together to manage, coordinate and be accountable for at least 5,000 Medicare beneficiaries' care. To the extent that an ACO meets quality performance standards and achieves a savings target to be developed by the Secretary, the ACO is eligible to share in the savings it generates for the Medicare program. The Secretary is required to increase the quality standards over time. ACOs can be structured in a variety of ways, including operating at partial financial risk. The Secretary may sanction or terminate an ACO if she determines that it is intentionally avoiding sicker patients.

REDUCED PAYMENT FOR HOSPITAL READMISSIONS

Beginning October 1, 2012, the Secretary will reduce Medicare payments to hospitals with excess readmissions for high volume or high expenditure conditions or procedures. The initiative will first focus on three conditions: heart failure, AMI and pneumonia, and will exclude planned readmissions or transfers. In fiscal year 2015, the program will expand to include four additional conditions identified by the Medicare Payment Advisory Commission (COPD, CABG, PTCA (a type of angioplasty), and 'other vascular') as well as additional conditions determined by the Secretary. The Secretary will make hospital readmission rates for Medicare patients, as well as for all patients, publicly available on the CMS Hospital Compare Web site. The Congressional Budget Office estimates that this payment penalty provision will save more than $7 billion over ten years.

INDEPENDENT PAYMENT ADVISORY BOARD

An independent, 15-member Payment Advisory Board will be established for the purpose of reducing the rate of growth of Medicare spending. Under certain circumstances in which Medicare spending exceeds targets, the Board will be required to recommend changes to the Medicare program to reduce the rate of spending growth. The Secretary will be required to implement the Board's recommendations

unless Congress blocks them through legislation. Congress would be able to consider an alternative proposal on a fast-track basis. The circumstances that would trigger the Board's recommendations depend on the CMS Chief Actuary's determination, beginning in 2013 and annually thereafter, as to whether projections of Medicare per capita growth exceed a targeted growth rate pegged initially to the consumer price index and the consumer price index for medical expenditures. The Board could not recommend raising beneficiary premiums or cost sharing or otherwise restrict benefits, and certain classes of providers are protected from cuts for the first 10 years. The Board also would submit to Congress and the President non-binding advisory recommendations to slow the rate of growth of national health expenditures.

In addition to health services researchers, physicians and other providers, the Board will include representatives of consumers and the elderly. A consumer advisory council also will be established to advise the Board on the impact of payment policies on consumers. It will include 10 consumer representatives and will meet at least twice per year. The Congressional Budget Office estimates that this provision will save $15.5 billion over 10 years.

VALUE-BASED PURCHASING

A Medicare hospital value-based purchasing program will be established beginning in fiscal year 2013. It will award incentive payments to hospitals based on their performance on quality standards to be established by the Secretary. The standards will recognize both performance and improvement by hospitals. In fiscal year 2013, the Secretary will ensure that the quality measures on which performance is assessed address five specific conditions (AMI, heart failure, pneumonia, surgeries measured by the Surgical Care Improvement Project, and health care-associated infections) as well as the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAPS). For fiscal year 2014 and beyond, the Secretary will include efficiency measures, including measures of Medicare spending per beneficiary. The program will be funded by withholding a portion of all hospitals' payments starting with 1 percent in 2013 and phasing up to 2 percent by 2017.

REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES

Health care reform creates new Health Insurance Exchanges that will function as purchasing pools that will facilitate the purchase of insurance by individuals and small businesses seeking affordable coverage. As part of the implementation of the Exchanges, the Secretary will develop guidelines, including reporting requirements, to allow health plans participating in the Exchanges to implement payment structures that provide increased reimbursement or other incentives to improve health outcomes. These payment structures will encourage activities such as: 1) care coordination, chronic disease management, medication and care compliance initiatives (including use of the medical home model) and effective case management; 2) comprehensive programs to reduce hospital readmissions; 3) programs to improve patient safety and reduce medical errors; and 4) wellness and health promotion activities.

SHARED DECISION-MAKING PROGRAM

PPACA authorizes a new grant program under the Public Health Service Act to improve patients' understanding of their medical treatment options. The program will support efforts to develop and disseminate tools giving patients and caregivers information about the pros and cons of their treatment options. Shared decision-making programs will focus, in particular, on preference sensitive care, meaning medical care for which the clinical evidence does not clearly support one treatment option and,

instead, the treatment decision depends on the patient's preferences. The bill also supports the creation of patient decision aids, which are educational tools to help patients and caregivers communicate their beliefs and preferences regarding treatment options and to decide with their health care provider what treatments are best for the patient. To implement this program, funding will need to be secured through the annual federal appropriations process.

WHAT THE CAMPAIGN FOR BETTER CARE WANTS CONSUMER ADVOCATES TO KNOW AND DO TO MAKE PAYMENT AND DELIVERY SYSTEM REFORM WORK FOR PATIENTS

ENSURE A STRONG PATIENT VOICE IN PAYMENT AND DELIVERY SYSTEM REFORM

Consumers, patients and their caregivers want a seat at the table to inform the design, implementation and evaluation of the new models of patient care and payment systems envisioned in PPACA.

For patients to have a voice:

- CMS should establish a multi-stakeholder Advisory Council to the Center for Medicare and Medicaid Innovation that includes strong consumer representation. The future direction of care delivery and payment systems needs to be informed by the beneficiaries who depend on these programs. Consumer input into the selection of which models CMS will test, the establishment of quality benchmarks and the evaluation of quality outcomes will be essential to ensuring that the Innovation Center promotes and protects patients' interests while it identifies ways to reduce program costs.

- The Independent Payment Advisory Board must have strong consumer members, and there must be a clear process for making the Board's Consumer Advisory Council an active part of the Board's work rather than simply a pro forma entity. The Board has new and unprecedented authority over the direction of future Medicare spending. The impact of its decision-making on patients must be at the top of the Board's agenda and strong consumer advocacy can make that happen.

BUILD PATIENT-CENTERED POLICY AND PRACTICE INTO NEW MODELS OF CARE DELIVERY

Support patient-centered policy and practice that includes:

- Understanding patients and caregivers' needs and preferences
- Prioritizing care coordination and management
- Measuring clinical outcomes and supporting continuous quality improvement
- Assessing patient and caregiver experience of care and supporting patient engagement in decision-making
- Ensuring accountability and transparency

As CMS develops the criteria it will use to assess whether providers and facilities qualify to participate in new payment models such as ACOs and medical homes, consumers need to advocate for building patient-centered criteria into the assessment. For example, a patient-centered ACO should have processes in place to understand patients and caregivers' needs and preferences. These processes could include using individualized care plans and patient decision aids like shared decision-making tools.

Further, patient-centered criteria must be part of the monitoring, oversight and evaluation used to determine the impact of the various payment reform models CMS will be exploring. Advocates need to focus on patient-centered criteria as a way to hold CMS accountable for valuing patients' needs and preferences as Medicare examines new ways to organize and pay for care.

PROTECT PATIENTS FROM UNINTENDED CONSEQUENCES OF CHANGING PROVIDER INCENTIVES

New payment models like bundled payments and ACO shared savings have the potential to significantly change the dynamics among providers. Hospitals, physicians and, in some instances, post-acute providers will have an incentive to work together to maximize efficiencies and, as a consequence, maximize their own financial gain.

While bundled payments and ACO shared savings may align providers' interests and encourage them to work more closely together, it also may create competition and disputes over how payments should be divided. Further, ACOs, bundled payment and other models like hospital readmission penalties may create perverse incentives for providers to reduce or avoid providing care to complex patients who could be less profitable under these models.

To protect patients as provider incentives change, consumer advocates need to closely monitor and track:

- How bundled payments for episodes of care are set to ensure that they reflect the cost of the care and services that beneficiaries need
- How robust the quality standards for ACOs and bundled payments are and how well CMS balances quality and cost-savings in evaluating these models
- How well CMS has adopted patient-centered policy and practice criteria for approving and evaluating new payment and delivery models
- How risk adjustment mechanisms are established and implemented to best align payment with patients' health status and ensure that providers don't avoid complex or high-risk patients
- How race, ethnicity, language and gender data are being collected, reported and used to identify and reduce health disparities
- What processes are created to inform beneficiaries about the financial incentives of their providers
- What appeals mechanisms beneficiaries have if they suspect that their care is being impacted by providers' financial incentives
- How CMS is monitoring the implementation of new payment models to protect patients from providers who may be purposefully avoiding high-risk patients

CONCLUSION

The new health care reform law creates a framework for advancing patient-centered care through changes in how care is paid for and delivered. The law offers numerous opportunities to begin to move health care payment and delivery systems toward improving quality and patient-centered care. The next phase of this effort will be critical to determining whether or not these goals can be realized. Implementation of health care reform will require the input and voices of consumer and patient advocates to ensure that these reforms remain focused not only on addressing rising health care costs, but also on improving outcomes for patients and their families.