Summary of Key CBC Priorities in Health Care Reform Law

The health care reform bill signed into law by President Obama represents a major step forward for the Campaign for Better Care, with numerous key provisions that reflect the Campaign’s goals of improving the health care system for vulnerable older adults and people with chronic conditions. The new law lays a strong foundation for the Campaign’s work going forward.

The following summary highlights these new provisions.

**CHANGES IN PAYMENT AND DELIVERY OF CARE**

There are numerous ways the new law promotes innovation in payment and delivery that could dramatically improve the quality and coordination of care for vulnerable older adults and those with chronic illnesses. The Campaign worked vigorously to shape these provisions to ensure that they lay the groundwork for our efforts to improve the quality and coordination of care.

**Center for Medicare and Medicaid Innovation**

- Establishes a Center for Medicare and Medicaid Innovation, within CMS, to test, evaluate, and rapidly expand different Medicare and Medicaid payment models once they are shown to foster more patient-centered care and better care coordination, as well as slow cost growth.

**Medical Home**

- Provides grants to establish community-health teams, to support the development of patient-centered medical homes. Under this approach, a team of health professionals would help local practices provide more comprehensive and coordinated medical care linked to community-based services.
- Gives states the option of providing care to Medicaid beneficiaries with chronic conditions through a “health home” model.
- Maintains the current Medicare Medical Home Demonstration.

**Medication Management**

- Creates a program to support medication management services by local health providers. These services will help reduce dangerous medication interactions and medical errors and help patients and families better manage chronic illness.
Independence At Home

- Creates a new Independence at Home Medical Practice Pilot Program, beginning January 1, 2012 to provide Medicare beneficiaries who have multiple chronic conditions with coordinated, primary care services in their homes or residences from a team of qualified health professionals. The team of health professionals will share in any savings achieved from reducing preventable hospitalizations and readmissions, improving health outcomes, and improving the efficiency of care.

Shared Decision Making

- Creates a program to develop, test, and disseminate educational tools to help patients, caregivers, and authorized representatives improve their understanding of the risks and benefits of treatment options, and make informed decisions about their care.

Care Transitions

- Designates transitional care as a high priority for quality measure development, accountability, and quality improvement. Care transitions currently represent the most dangerous points in the continuum of care for vulnerable patients.
- Provides funding to hospitals and community-based entities to provide transitional care services to high-risk Medicare beneficiaries.

PAYMENT TO IMPROVE QUALITY AND COORDINATION OF CARE

The new law takes critically important steps to realign our payment system to promote higher quality, better coordinated care.

Increased Payment for Primary Care

- Increases Medicaid payment rates for primary care physicians to the same level as Medicare payment rates in 2013 and 2014.
- Beginning in 2011, provides 10% Medicare bonus payments (for 5 years) to primary care practitioners as well as general surgeons practicing in health professional shortage areas.

RBRVS Reforms

- The new law gives the Secretary discretion to make appropriate changes to the relative value units (RVUs) that determine how much physicians are reimbursed for certain services. These changes will help create incentives for health care professionals to provide services that are critically important to vulnerable older adults and people with chronic conditions.

Readmissions

- Avoidable hospital readmissions are a symptom of the lack of care coordination in our health care system and poor transition management. The new law reduces payments to hospitals for “excess” readmissions in three conditions selected by the Secretary, beginning October 2012, and requires rates to be publicly reported on Hospital Compare.
Health Care Acquired Conditions

- High rates of health care acquired infections disproportionately affect the most vulnerable patients with the highest interaction with the health care system. Requiring public reporting and restricting or eliminating payment will help to dramatically reduce the rate of health care acquired conditions. The new law requires Medicare to track the rates of health care acquired conditions, publicly report these rates, and ultimately adjust payments to providers with high rates of health care acquired conditions.

Value-Based Purchasing

- Value-based purchasing links payment to provider performance and quality of care, providing much-needed incentives for quality improvement. The new law establishes a value-based purchasing program for hospitals, starting in FY2013, and puts long term care hospitals, inpatient rehabilitation facilities, and hospice providers on a path toward value-based purchasing by requiring quality measure reporting programs starting in 2014. The law also directs the Secretary to develop a plan for moving skilled nursing facilities and home health agencies into a value-based purchasing payment system.

Physician Quality Reporting Program

- The new law extends and improves the Physician Quality Reporting Program, which pays clinicians for reporting on the quality of care they provide. It paves the way for payment based on quality of care and is an essential step for holding physicians more accountable for the quality of care they provide to Medicare beneficiaries.

Resource-Based Feedback Program

- The new law requires the Secretary to establish a feedback program on physician resource use, beginning in 2012. This program could result in physicians changing practice patterns in a way that improves the quality of care provided, reduces overutilization, and decreases costs.

MEASUREMENT AND QUALITY IMPROVEMENT

The new law’s quality measurement provisions will help build an effective foundation for improving quality of care provided, especially for the most vulnerable patients. Having the right quality measures, focused on areas of greatest importance to patients, will help us reorient the system to be more focused on patient outcomes, care coordination, patient-centeredness, and reducing disparities. Having the right quality measures and collecting that data effectively will be essential to ensuring that the new payment and delivery strategies described above are meeting the needs of patients.

The new law requires:

- A national strategy for quality improvement – requires the Secretary to develop a national strategy for improving health care quality, with a focus on improving patient health outcomes and functional status, coordination of care, equity of care and reduction of health disparities, and patient experience.
• **Development and endorsement of quality measures** – requires the development and endorsement of quality measures in the above priority areas. These measures are the building blocks for our work to make the health care system function better for vulnerable older adults and people with multiple chronic conditions.

• **Multi-stakeholder consultation** – requires the Secretary to convene multi-stakeholder groups to provide input on the selection of quality measures and national priorities for quality improvement for use in public reporting and public health care programs.

• **Collection and stratification of quality data** – Requires the Secretary to collect, aggregate and publicly report data on quality and resource use, and to report data stratified by race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

• **Dissemination of quality improvement interventions** – Requires AHRQ to undertake various activities to test, scale, and disseminate interventions to improve quality and efficiency in health care, including translating best practices for quality improvement into actual practice.

**WORKFORCE**

The health reform law makes strengthening and expanding the health care workforce a priority, with programs aimed at increasing the supply of qualified primary care providers, and better training health care workforce to meet the complex health needs of older patients.

• Provides grants to geriatric education centers to support training in geriatrics, chronic care management, and long-term care.
• Requires federally funded geriatric education centers to offer free or low cost training to family caregivers who support frail older adults and individuals with disabilities.
• Creates grants to provide training opportunities for direct care workers employed in long-term care settings.
• Expands eligibility for Geriatric Academic Career Awards to faculty in the fields of nursing, social work, psychology and pharmacy, dentistry, and allied health professions.
• Establishes federal traineeships for individuals preparing for advanced degrees in geriatric nursing, long term care, and geropsychiatric nursing.
• Provides grants to foster greater interest among health professionals to enter the field of geriatrics, long term care, and chronic care management.
• Establishes a National Health Care Workforce Commission to set the nation on a path to recruiting, training, and retaining a health care workforce that meets the nation’s current and future needs.
• Establishes a Center for Health Care Workforce Analysis to describe and analyze the workforce, and ensure that the nation’s workforce needs are addressed.

**PREVENTION**

The new health reform law makes preventive care more affordable and accessible.

• Waives Medicare cost-sharing for most preventive services, requiring Medicare to cover 100% of the cost.
• Provides coverage, with no cost-sharing, for an annual wellness visit and development of a personalized prevention assessment and plan.
**DUAL ELIGIBLES**

Beneficiaries that are dually eligible for both Medicare and Medicaid are among the most vulnerable, and have a high need for medical services – but these two programs have largely failed to coordinate benefits and services provided to these patients.

- The health reform law establishes a new office within CMS to improve coordination between Medicare and Medicaid for dually eligible beneficiaries. This new office could help to dramatically improve the way these two important programs work together to meet patients’ needs.

**HOME- AND COMMUNITY-BASED SERVICES**

For many vulnerable older adults and people with chronic conditions, being able to access needed services at home or in their community is tied to a higher quality of life, more independence, and better health outcomes.

- The new law increases federal Medicaid payments for the states that provide home- and community-based services to individuals otherwise eligible for nursing home care.