Reforming the Health Care Delivery System

Medicare currently reimburses health care providers on the basis of the volume of care they provide rather than the value of care. For each test, scan or procedure conducted, Medicare provides a separate payment, rewarding those who do more, regardless of whether the test or treatment contributes to helping a patient recover. The *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act* include a number of proposals to move away from the "a la carte" Medicare fee-for-service system toward paying for quality and value.

Linking Payment to Quality

- ✓ Establishes value-based purchasing to provide incentive payments to hospitals that meet certain quality performance standards starting in FY2013.
- ✓ Starts other providers on a path toward value-based purchasing with new quality reporting programs for inpatient rehabilitation facilities, long-term care hospitals, hospice providers and PPS-exempt cancer hospitals in FY2014.
- ✓ Requires the Secretary of Health and Human Services (HHS) to submit a plan to Congress for moving home health providers and skilled nursing facilities to value-based purchasing systems by FY2012.
- ✓ Provides physicians with timely feedback on their performance compared to peers and establishes new physician payment incentives based on the quality and efficiency of care provided to Medicare beneficiaries.
- ✓ Reduces payments to hospitals with high rates of preventable hospital acquired infections.
- ✓ Creates an independent, non-profit Patient-Centered Outcomes Research Institute, funded by public and private payers, to identify what works best to improve health quality and outcomes of care.

Strengthening the Quality Infrastructure

- ✓ Requires the Secretary of HHS to establish a national strategy to improve health care quality, create a Federal interagency working group to provide advice on the national quality improvement strategy and priorities, and ensure collaboration with multi-stakeholder groups.
- ✓ The Secretary will identify gaps in quality measures and fund measure development.

Encouraging Development of New Patient Care Models

- ✓ Establishes a national program for "Accountable Care Organizations."
    - o ACOs are teams of providers that work together to coordinate care across health care settings to improve quality for a patient and reduce costs. Participating ACOs are required to meet performance and patient outcome standards and may share in the savings that result from keeping costs below what Medicare would have otherwise paid. ACOs change the model for taking care of patients by integrating care, improving quality, and reducing costs.
- ✓ Establishes a new Innovation Center to develop and test new patient-centered payment models designed to encourage evidence-based, coordinated care in Medicare, Medicaid, and CHIP, with the authority to expand successful models.
- ✓ Creates a national, voluntary pilot program to encourage hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for Medicare through bundled payment

models. Rather than paying separately for each hospital stay and necessary care after discharge, bundled payments align provider incentives by paying a lump sum for an entire episode of care. This will ensure more attention to discharge planning and follow-up care that reduces complications and unnecessary hospital readmissions.

- ✓ Requires the Secretary of HHS to implement a program to reduce potentially preventable hospital readmissions. Beginning in FY2012, hospitals will receive reduced payments for potentially preventable readmissions for the three conditions that are currently endorsed by the National Quality Forum and will have authority to expand the policy to include other conditions in future years.
- ✓ Creates a payment incentive program for hospitals and community-based organizations that provide transitional care services to Medicare beneficiaries at high-risk of rehospitalization.

Independent Payment Advisory Board

- ✓ Establishes the Independent Payment Advisory Board to make recommendations to Congress to strengthen the Medicare program.
- ✓ Protects benefits and beneficiary cost-sharing from any recommended cuts.
- ✓ Requires automatic implementation of the Board’s recommendations unless Congress enacts alternative proposals with an equivalent impact.

Modernizing and Improving Medicaid through Delivery System Reforms

- ✓ Creates a new state option where Medicaid beneficiaries with chronic conditions will designate a provider as their medical home to deliver or coordinate their care.
- ✓ Expands existing quality measures and establishes priorities for the development and use of quality measures through a Medicaid Quality Measurement Program.
- ✓ Prohibits federal matching payments to states for Medicaid services related to health care-acquired conditions.
- ✓ Establishes a demonstration project for bundled payments for acute care and post acute care under the Medicaid program.
- ✓ Allows large safety-net providers to alter their provider payment system from a fee-for-service structure to a capitated, global payment structure through a Medicaid Global Payment demonstration project.
- ✓ Allows pediatric medical specialty practices to qualify as “accountable care organizations” under state Medicaid programs.