

Health Care Reform: Delivery of Services

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Physicians must be prepared for the implications of the Patient Protection and Affordable Care Act (the “Act”), including, but not limited to, changes to delivery of care.

In simple terms, the Act promotes a shift from the traditional fee-for-service model to payment models that promote and reward savings to Federally funded health care programs.

Bundled Payment Model

One such model set forth in the section 3023 of the Act, the “bundled payment” model, directs the Secretary of Health and Human Services (the “Secretary”) to establish a five year national voluntary pilot program that encourages hospitals, physicians, and post-acute care providers to integrate care during an “episode of care”. An “episode of care” is defined to include: three days prior to an admission to the hospital, the length of stay in the hospital, and 30 days following the discharge from the hospital. Under the bundled payment model, payment will be linked to the episode of care so as to align financial incentives of the physician and the hospital, and perhaps all providers serving the patient during the episode of care. Services to be included under the bundled service model include: a) acute care inpatient services; b) physician services delivered in and out of the hospital; c) post-acute care services, including, home health services, skilled nursing services, inpatient rehabilitation services and inpatient hospital services furnished by a long-term care hospital; and d) other services the Secretary determines appropriate.

If the bundled payment model achieves its goals of reducing costs and improving care, then the Secretary must, prior to January 1, 2016, submit a plan to Congress to expand the pilot program.

The bundled payment model, as well as other mandates set forth in the Act, will likely push physicians toward clinical integration models. Examples of such integration models set forth in the Act include accountable care organizations (“ACO”) and health homes, and medical homes.

Accountable Care Organizations

Section 3022 of the Act provides that no later than January 1, 2012, the Secretary will establish a shared savings program that promotes accountability for a patient population and coordinates items and services under Medicare parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

ACOs that meet quality performance standards established by the Secretary will be eligible to receive payments for shared savings. ACOs are organizations that link various providers that together take responsibility for improving the health status and efficiency of care for a specific patient population. ACOs, which are not a new concept, contemplate payment mechanisms that tie incentive provider payments to quality, outcomes and resource utilization, rather than productivity alone. The following groups of providers which have established a mechanism for shared

governance are eligible to participate as ACOs: 1) physicians and practitioners in group practice arrangements; 2) networks of individual practices of physicians and practitioners; 3) partnerships or joint ventures between hospitals and physicians and practitioners; 5) hospitals employing physicians and practitioners; and 6) such other groups of providers and suppliers as the Secretary determines appropriate.

Under the program, the Secretary will determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided by an ACO professional. Payments will continue to be made to providers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings if it meets quality performance standards and it meets savings requirements.

The Act further provides for the establishment of the Pediatric Accountable Care Organization Demonstration Project. It provides that the Secretary will establish a shared savings program that promotes accountability for a patient population and coordinates items and services under Medicare parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. ACOs that meet quality performance standards established by the Secretary will be eligible to receive payments for shared savings.

Health Homes

Section 2703 of the Act gives States the option of enrolling Medicaid recipients with two or more chronic conditions, or one chronic condition with the likelihood of developing another chronic condition into a “health home”. The term “health home” is defined as a designated provider or a health team selected by an eligible beneficiary. A designated provider can be a physician, a clinical practice or clinical group practice, a rural clinic, a community health center, a community mental health center, a home health agency, or any other entity or provider as determined by the State and approved by the Secretary. Health home providers shall be treated as medical assistance providers, except that during the first 8 fiscal year quarters, the Federal medical assistance percentage applicable to such payments will be equal to 90%.

Medical Homes

Section 3502 of the Act directs the Secretary to create a program to provide grants to, or enter into contracts with, States that meet certain criteria to establish community based interdisciplinary, interprofessional (“Health Teams”) to support primary care practices. The Health Teams will contract with primary care physicians to provide primary care support, and can include specialists, nurses, pharmacists, nutritionists, social workers, and mental health providers. The Health Team must support patient centered care and demonstrate a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology to facilitate coordination.

While the Act leaves us with many unanswered questions, one thing is abundantly clear, the delivery of care is changing. Clinical integration is, in some form, the future of our health care delivery system. It is unlikely that physicians or other providers will be practicing in silos.