

NEW MODELS OF CARE (SECTION-BY-SECTION ANALYSIS)

(Information compiled from the Democratic Policy Committee (DPC) Report on The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. Available online at <http://dpc.senate.gov/healthreformbill/healthbill96.pdf>.)

Improved coordination for dual eligible beneficiaries

Sec. 2601. 5-year period for demonstration projects. Clarifies that Medicaid waivers for coordinating care for dual eligible beneficiaries could be authorized for as long as five years.

Sec. 2602. Providing Federal coverage and payment coordination for dual eligible beneficiaries.

Requires the Secretary to establish a Federal Coordinated Health Care Office (CHCO) within CMS by March 1, 2010. The purpose of the CHCO would be to bring together officials of the Medicare and Medicaid programs to (1) more effectively integrate benefits under those programs, and (2) improve the coordination between the Federal and State governments for individuals eligible for benefits under both Medicare and Medicaid (dual eligibles) to ensure that dual eligibles have full access to the items and services to which they are entitled.

Health homes for people with chronic illness

Sec. 2703. State option to provide health homes for enrollees with chronic conditions. Provide States the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination.

Payment bundling

Sec. 2704. Demonstration project to evaluate integrated care around a hospitalization.

Establishes a demonstration project, in up to eight States, to study the use of bundled payments for hospital and physicians services under Medicaid.

Sec. 3023. National pilot program on payment bundling. Directs the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. Requires the Secretary to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending. **Section 10308** provides the Secretary of HHS authority to expand the payment bundling pilot if it is found to improve quality and reduce costs. Also, directs the Secretary to test bundled payment arrangements involving continuing care hospitals within the bundling pilot program.

Global Payment system demonstration project

Sec. 2705. Medicaid global payment system demonstration project. Establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five States that would allow participating States to adjust their current payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure.

Accountable care organizations

Sec. 2706. Pediatric Accountable Care Organization demonstration project. Establishes a demonstration project that allows qualified pediatric providers to be recognized and receive payments as (ACO) under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. Pediatric ACOs that met these guidelines and provided services at a lower cost would share in those savings.

Sec. 3022. Medicare shared savings program. Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program. **Section 10307** provides additional flexibility to the Secretary of HHS to implement innovative payment models for participating Accountable Care Organizations, including models currently used in the private sector.

Emergency psychiatric demonstration project

Sec. 2707. Medicaid emergency psychiatric demonstration project. Requires the Secretary of HHS to establish a three-year Medicaid demonstration project in up to eight States. Participating States would be required to reimburse certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.

Center for Medicare and Medicaid Innovation

Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS. Establishes within the Centers for Medicare and Medicaid Services (CMS) a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare. Successful models can be expanded nationally. **Section 10306** adds payment reform models to the list of projects for the Center to consider, including rural telehealth expansions and the development of a rapid learning network. Ensures that quality measures used by the Center are consistent with the quality framework within the underlying bill, and requires the Secretary to focus on models that both improve quality and reduce costs.

Independence at Home program

Sec. 3024. Independence at home demonstration program. Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes.

Community-based transitions programs

Sec. 3026. Community-based care transitions program. Provides funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission. The program shall be conducted for a 5-year period, beginning January 1, 2011. Appropriates \$500 million for FY 2011-2015.

Hospice

Sec. 3140. Medicare hospice concurrent care demonstration program. Directs the Secretary to establish a three-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time. The demonstration would be conducted in up to 15 hospice programs in both rural and urban areas and would evaluate the impacts of the demonstration on patient care, quality of life and spending in the Medicare program.

Community-based interprofessional health teams

Sec. 3502. Grants or contracts to establish community health teams to support the patient-centered medical home. Creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive,

community based, coordinated care. **Section 10321** clarifies that nurse practitioners and other primary care providers can participate in community care teams.

Medication management

Sec. 3503. Grants to implement medication management services in treatment of chronic disease. Creates a program to support medication management services by local health providers. Medication management services will help manage chronic disease, reduce medical errors, and improve patient adherence to therapies while reducing acute care costs and reducing hospital readmissions.

Sec. 10328. Improvement in Part D medication therapy management (MTM) programs.

Requires Part D prescription drug plans to include a comprehensive review of medications (either in person or through telehealth technology) and a written summary of the review as part of their medication therapy management programs. Plans must also enroll beneficiaries who qualify on a quarterly basis and allow for opt out.

Shared decision making

Sec. 3506. Program to facilitate shared decisionmaking. Establishes a program at HHS for the development, testing, and disseminating of educational tools to help patients, caregivers, and authorized representatives understand their treatment options.

Healthy lifestyle initiatives

Sec. 4108. Incentives for prevention of chronic diseases in Medicaid. The Secretary would award grants to States to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions.

Co-location of primary and specialty care in community-based mental health settings

Sec. 5604. Co-locating primary and specialty care in community-based mental health settings. Authorizes \$50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.

Nursing homes

Sec. 6114. National demonstration projects on culture change and use of information technology in nursing homes. Requires the Secretary to conduct two facility-based demonstration projects that would develop best practice models in two areas. The first would be designed to identify best practices in facilities that are involved in the “culture change” movement, including the development of resources where facilities may be able to access information in order to implement culture change. The second demonstration would focus on development of best practices in information technology that facilities are using to improve resident care.

Medical malpractice

Sec. 6801. Sense of the Senate regarding medical malpractice. Expresses the sense of the Senate that health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, states should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives.

Sec. 10607. State demonstration programs to evaluate alternatives to current medical tort litigation. Authorizes grants to States to test alternatives to civil tort litigation. These models would

be required to emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes. Patients would be able to opt-out of these alternatives at any time. The Secretary of HHS would be required to conduct an evaluation to determine the effectiveness of the alternatives.

Environmental health hazards

Sec. 10323. Medicare coverage for individuals exposed to environment health hazards.

Provides Medicare coverage and medical screening services to individuals exposed to environmental health hazards as a result of a public health determination under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

FYI only

Sec. 3123. Extension of the Rural Community Hospital Demonstration Program. Extends the program for five years, as amended by **Section 10313**, expands eligible sites to additional States and additional rural hospitals, and makes adjustments to payment levels provided within the demonstration program.

From the CMS website at

<https://www.cms.gov/DemoProjectsEvalRpts/downloads/RCHApplication.pdf>:

The Centers for Medicare & Medicaid Services (CMS) is conducting a five-year “Rural Community Hospital Demonstration Program” as mandated under section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. While section 410A allows up to 15 hospitals in sparsely populated states to participate, nine hospitals are currently participating in the program. CMS is conducting a new solicitation that will allow up to 6 new hospitals to participate in the demonstration for the remainder of the time period allowed by the law. This demonstration is scheduled to end in 2010.

Sec. 3126. Improvements to the demonstration project on community health integration models in certain rural counties. The Medicare Improvements for Patients and Providers Act (MIPPA, P.L. 110-275) authorized a demonstration project that will allow eligible rural entities to test new models for the delivery of health care services in rural areas. This provision will expand the demonstration to allow additional counties to participate and will also allow physicians to participate in the demonstration project.