California HealthCare Foundation

# Implementing National Health Reform in California:
## Payment and Delivery System Changes

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*Prepared for*
California HealthCare Foundation

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**Manatt Health Solutions** is the interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, a law and consulting firm. Manatt Health Solutions provides expertise in health care coverage and access, health information technology, health care financing and reimbursement, and health care restructuring, as well as strategic and business advice, policy analysis and research, project implementation, alliance building/advocacy, and government relations services. For more information, visit www.manatt.com.


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## About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better heath care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

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# I. Introduction and Background

Federal health reform will change the way millions of Californians purchase health insurance and receive health care services. More than 3 million uninsured Californians will be able to obtain coverage under the Patient Protection and Affordable Care Act (ACA) — 2 million of whom will be newly eligible for Medi-Cal.[1,2] Beyond these large numbers of newly insured, the ACA will have an even wider impact with its provisions altering how providers and hospitals are reimbursed for and deliver care. The ACA includes changes to mandatory reimbursement rules that will reduce fees paid to institutions under Medicare fee-for-service (FFS), and establishes demonstration projects and grant programs intended to test and rapidly deploy new care delivery models.

In many respects, the reimbursement changes and care delivery reforms complement each other: The care delivery projects may help providers and hospitals accommodate the lower reimbursement rates by helping them find ways to reduce costs while improving quality.

Taken as a whole, the payment and care delivery reforms discussed in this report have broad implications for the health care delivery system, and they stand to impact all health care consumers in the United States.

## A. Reimbursement and Care Delivery Reforms

Central to ACA's payment reform efforts are reimbursement changes that will reduce FFS payments to hospitals for preventable hospital readmissions and hospital-associated infections, and budget-neutral or cost-saving provisions such as the Hospital Value-Based Purchasing program intended to pay incentives to hospitals that meet specific performance measures. These changes are projected to save Medicare $11.4 billion over 10 years (2010 to 2019).[3] In addition, ACA establishes a number of reimbursement pilot programs to test alternate payment models.

Besides reimbursement reforms, ACA features a series of pilots and demonstration projects focused on coordinating and improving care delivery for Medicare FFS and Medicaid beneficiaries. These efforts include several projects such as the Medicare Shared Savings Program establishing accountable care organizations (ACOs), as well as patient navigator and community-based care transition programs. Some observers believe these demonstrations represent a comprehensive realignment of the health care delivery infrastructure; others are skeptical that they will prove sustainable or replicable on a national scale. What is clear is that in order to reach their full potential, these programs will require support from state policymakers and program administrators, and very close collaboration among a wide range of providers, payers, state and local health agencies, and consumers.

Woven throughout ACA's payment and care delivery provisions is the principle of transparency. The ACA outlines a number of requirements to support open and transparent program oversight and fraud and abuse monitoring. These programs typically include a substantial set of reporting obligations and mandates for a broad range of participating stakeholders. The data generated by these reporting requirements, if made broadly available to support detailed program and policy analyses, could greatly enhance decisionmaking by state and federal policymakers and program administrators and staff; as well as by providers, consumers and purchasers.

## B. Potential Outcomes

It remains to be seen whether payment and care delivery reforms can produce enough savings — and to what extent those savings will accrue to the public programs that administer them — to offset ACA's expansion of coverage under the Medicaid program. In California where the market is far ahead of the national curve in adoption of managed care, the low-hanging fruit in terms of savings opportunities may not exist. The burden of implementation of many of ACA's Medicaid provisions and the state's 1115 waiver programs will fall squarely on the shoulders of California's Medicaid managed care plans. The pressure they will face to increase capacity, enroll new members, expand their networks to accommodate them, reduce costs, and improve outcomes will be enormous and may not be achievable without policy, programmatic, and fiscal support.

Further, planned ACA reductions in reimbursement to hospitals may cause significant financial hardship for a number of institutions, including safety-net hospitals, and will likely also result in further cost-shifting onto the commercial market, applying upward pressure on commercial premiums. Given the state's ongoing fiscal crisis and concerns over the national debt, additional reductions in spending for entitlement programs, including Medicaid, are likely. Policymakers will need to consider how to address these critical contingencies as more individuals receive insurance coverage under ACA and test the capacity of the health care delivery system. In some states such as Oregon and Florida, policymakers used legislation to enable the creation of state-based ACOs for Medicaid and other populations. It will be important to consider the extent to which these arrangements could be established in California, how they align with the current Medi-Cal migration from FFS into managed care, and what additional benefits could result from Medi-Cal ACOs.

This report is the third in a series commissioned by the California HealthCare Foundation (CHCF) describing the implications of ACA and their expected impact on California's health care delivery system, public coverage programs, and private insurance markets. The initial policy analysis, published in June 2010, focused on health insurance coverage provisions; the second report, published in March 2011, addressed access to care.[4] This policy report focuses on reimbursement changes, ACA pilot programs, grants, and other provisions designed to demonstrate alternative health care delivery and payment models. It also reviews related transparency provisions that are intended to make information and data more forthcoming for individuals, health care purchasers, and policymakers. The report has been informed by the perspectives of 11 federal and state officials, stakeholders, and thought leaders; the list of interviewees is included in Appendix A.

# II. Shifts in Managed Care and Payment Arrangements: The California Context

Despite the overall decline in managed care enrollment over the past seven years, more than 15 million of California's 38 million residents currently receive care through delegated or capitated arrangements with provider organizations in the commercial market, or through Medi-Cal, Healthy Families, and Medicare Advantage plans.[5,6] A steady decline in the commercial managed care market has been partially offset by a rise in managed care enrollment among individuals covered by Medi-Cal and Healthy Families. The Medi-Cal managed care market will continue to expand under the new federal 1115 waiver (discussed in more detail below).

The changes in the managed care market and cost-shifting have contributed to more consolidation in both the hospital and provider group markets.[7,8] Of the 394 general acute care hospitals in California, 36% (about 140) belong to one of seven hospital systems while 8% (just over 30) are public.[9]

In the 1990s, many hospitals entered into global risk arrangements with Knox-Keene licensed physician organizations. However, challenges associated with managing global risk forced many hospitals to shift toward shared risk arrangements with providers and carriers. Subsequent financial losses incurred by both providers and hospitals caused many of these institutions to withdraw from commercial shared risk arrangements altogether in favor of more traditional per diem or diagnosis related group (DRG) payments. Today, hospitals rely heavily on these reimbursements from private payers to cover expenses associated with more costly Medicare and Medi-Cal patient populations. In 2007, private payers contributed almost half of total patient revenues while accounting for only one-third of discharges.[11]

**Table 1. Largest Hospital Systems in California**

| | HOSPITALS | | LICENSED BEDS | |
|---|---|---|---|---|
| | Number | Percent of Total | Number | Percent of Total |
| Catholic Healthcare West | 30 | 8% | 7,088 | 9% |
| Kaiser | 31 | 8% | 7,039 | 9% |
| Sutter Health | 27 | 7% | 5,182 | 6% |
| Tenet Healthcare | 20 | 5% | 3,824 | 5% |
| Adventist Health System | 15 | 4% | 2,753 | 3% |
| St. Joseph Health System | 11 | 3% | 1,853 | 2% |
| University of California | 8 | 2% | 3,215 | 4% |
| All Others | 252 | 64% | 49,662 | 62% |
| Total | 394 | | 80,616 | |

Source: California HealthCare Foundation. *California Health Care Almanac, California Hospital Facts and Figures,* April 2010.[10]

Most public hospitals have a lower commercial payer mix compared with other acute care hospitals, reducing cost-shifting options. These hospitals remain critical providers of care for Medi-C million al and uninsured patients, providing more than half of all hospital care for the state's 6.6 million uninsured. Medi-Cal accounts for nearly two-thirds of their patient revenues.[12]

California's community clinics are also vital providers for Medi-Cal and Healthy Families beneficiaries and for the uninsured. These clinics deliver primary care and other services for more than 4 million FFS and managed care patients in California.[13] Medi-Cal remains the predominant payer, accounting for over half of patient revenues.

## A. Aligning ACA Reforms with Existing California Initiatives

While California's managed care experience may help position providers and hospitals to take advantage of the numerous pilot programs contained within ACA, many providers and carriers believe that ACA's delivery reforms represent a step backward for California.[14] Full and partial capitation, shared risk pools, and pay-for-performance quality incentive programs have been part of the California reimbursement landscape for well over a decade. Many providers and hospitals are questioning why they should assume additional risk as proposed under federal ACO demonstration programs if, in their view, the reward does not significantly outweigh their investment costs or downside risk.

In contrast, institutions in California have been willing to enter into modified capitated arrangements. Early commercial ACO-like demonstrations supported by CalPERS have produced promising reductions in costs.[15] However, such arrangements are more reminiscent of a capitated managed care arrangement than a proposed federal ACO model. Further, it is unclear if the incurred cost savings are sustainable over the long run or if the savings have significantly exceeded the costs required to establish the programs.[16]

Ultimately, health reform offers California policymakers, program staff, providers, and hospitals an opportunity to develop and test new care delivery and reimbursement models. All stakeholders will need to consider how these models can align with and reinforce existing initiatives. Medi-Cal in particular will need to assess whether hospital and provider networks that serve large numbers of Medi-Cal beneficiaries have the capacity and resources to test innovative care delivery and reimbursement models at the same time they are being asked to accommodate growing enrollment under health reform. Emerging models such as the Accountable Care Network in Los Angeles show promising signs of innovative care delivery models specifically targeting Medi-Cal and other safety-net populations.[17]

## B. Bridge to Reform 1115 Waiver

Another important element in California's health reform landscape is the state's $10 billion Bridge to Reform 1115 waiver. The waiver was approved by the federal government on November 2, 2010, and establishes a series of programs to prepare California's health care delivery system and safety-net providers for federal health reform. Payment and delivery system changes authorized by the waiver include:

- Expansion of county-based coverage for up to 500,000 low-income adults who will become newly eligible in 2014 under federal health reform.[18] Participating counties must ensure that beneficiaries are enrolled in a medical home and meet other program requirements.
- Mandatory enrollment of 380,000 Medi-Cal-only seniors and persons with disabilities (SPDs) into fully capitated managed care.
- Creation of the Delivery System Reform Incentive Pool (DSRIP) program, which could provide up to $3.3 billion to public hospitals that: make improvements to their health information technology (IT) infrastructure; enhance care delivery for patients with chronic conditions; make measurable improvements in health care quality; and develop innovative care delivery models.
- Implementation of pilot programs to test alternative health care delivery models for children with special health care needs who are eligible for the California Children's Services (CCS) program.

Under the waiver, the state will receive up to $8 billion in federal Medicaid funds over the next five years. DSRIP represents a significant investment in a relatively small pool of hospitals, and Medi-Cal managed care enrollment is already swelling to accommodate the newly eligible low-income and SPD populations. Many Medi-Cal managed care plans may be challenged to meet the unique requirements of new populations, develop the infrastructure required to support them, and contract with provider organizations to ensure an adequate and effective health care delivery network.

# III. ACA Reimbursement and Payment Reforms

Fee-for-service reimbursement remains the dominant payment model for health care services in the U.S. and is still employed by Medi-Cal as the primary reimbursement mechanism for half of its enrollees. Traditional FFS models have been criticized for providing few incentives for providers to coordinate care and control costs; for encouraging over-utilization; and for rewarding providers for making mistakes that result in additional services. In an FFS payment model, volume is rewarded over value; providers may be penalized financially for improving the quality of the care they deliver.

The ACA includes both mandatory reimbursement changes and pilots to test better ways of paying for health care that reward higher-value care. Several mandatory quality-based payment reforms are directed at acute care hospitals, while demonstrations and pilots target reimbursement changes for ambulatory providers and institutions. Payment models to be tested include bundled payments, value-based purchasing for providers, and all-payer models, among others.

## A. Government-Mandated Reimbursement Reforms

The ACA-mandated payment reforms described below stand to significantly impact Medicare and Medicaid providers, particularly acute care hospitals. Mandatory reimbursement adjustments will apply considerable downward pressure on Medicare and Medi-Cal rates. At the same time that many hospitals will see their reimbursements cut, the total number of Medi-Cal patients will increase. The combination of these factors will have implications systemwide as hospitals face increasing pressure to cost-shift onto commercially insured individuals and groups. Institutions with smaller commercial payer bases, including the majority of safety-net hospitals, will be hard-pressed to make up volume with their commercial populations.

Policymakers and Medi-Cal managed care plan administrators will therefore need to carefully consider how to support and test new value-based purchasing, shared savings, and other payment and delivery models. It will also be important to monitor the impact of these reforms on safety-net hospitals to ensure that they remain viable.

### Hospital Readmissions Payment Reductions (§3025)

Beginning in federal fiscal year 2013, hospitals with readmission rates that exceed their risk-adjusted expected rate will see their Medicare inpatient payments reduced. The reduction will be approximately equal to the dollar value of the payments made for the excessive number of readmissions. In federal fiscal years 2013 and 2014, the readmission payment penalty policy will be based on readmissions related to three conditions (it will expand to seven in 2015), and grants the federal government authority to expand the number of conditions in future years, including all-cause readmissions. Some hospitals can expect to face considerable reductions in Medicare reimbursement: The Centers for Medicare and Medicaid Services (CMS) has estimated that this program will generate $8.2 billion in savings through 2019. To avoid reimbursement penalties, hospitals will need to assertively manage processes and metrics to reduce potentially avoidable readmissions.

Public hospitals in California must pay particular attention to this policy change, as readmissions tend to be higher in the sicker populations served by these institutions. Data provided by the Office of Statewide Health Planning and Development (OSHPD) and reported through the California Hospital Assessment and Reporting Taskforce (CHART) indicate that potentially avoidable readmissions to public hospitals participating in DSRIP, and almost all non-University

of California public hospitals, were markedly higher than state averages.[19] Medicare beneficiaries typically represent between 10% to 15% of these hospitals' total discharges; payment reductions to this major source of revenue would significantly impact their bottom line.

California's Bridge to Reform 1115 waiver provides a framework and an opportunity for Medi-Cal to encourage hospitals to improve care coordination and discharge planning in an effort to reduce readmissions, which could help minimize the reimbursement penalties of this payment policy. Medi-Cal can use the waiver's DSRIP program as a lever to steer participating hospitals toward implementing advanced care delivery and care coordination programs, and to focus efforts on high-cost and dual-eligible patients with chronic conditions. The waiver also grants Medi-Cal the authority to test ACOs, enhanced primary care programs, and other models for the CCS program to reduce readmissions. The results of various pilots, which will be carried out through a request for proposal process, could serve as a basis for more widespread adoption of alternative payment and delivery structures for other segments of publicly insured individuals in California.[20]

## Payment Adjustments for Hospital-Acquired Conditions (HACs) (§3008 and §2702)

Medicaid will introduce payment adjustments for underperforming hospitals related to hospital-acquired conditions (HACs): potentially preventable conditions resulting from treatment in a hospital.[23] The ACA extends rules around non-payment for HACs under Medicare (which have been in effect since October 1, 2008) to Medicaid. Under the new ACA provisions, Medicaid will not reimburse hospitals for 10 types of hospital-acquired conditions and other injuries and illnesses deemed preventable. The ACA allows states to add additional conditions and injuries to state HAC programs and expand the penalties beyond hospitals, conditional on CMS approval.

**Table 2. Hospital Readmissions Reduction Program (§3025)**

| | |
|---|---|
| **What it says** | To account for "excess readmissions," effective October 1, 2012, Medicare Diagnosis Related Group (DRG) payment rates will be reduced based on a hospital's ratio of actual to expected readmissions. The reduction applies to the base DRG payment only.<br>For fiscal year (FY) 2013 the readmissions policy will apply to the three measures currently being reported on Hospital Compare: heart attack (AMI), heart failure, and pneumonia.[21] In FY 2015, the policy will expand to include COPD, CABG, PTCA, and other vascular conditions. |
| **Who it affects** | Medicare subsection (d) hospitals (acute care hospitals).[22] |
| **Effective date(s)** | Begins FY 2013 (October 1, 2012). The maximum payment reduction is 1% in FY 2013, 2% in FY 2014, and capped at 3% for FY 2015 and beyond. |
| **What needs to be done** | The federal government issued final regulations August 18, 2011.<br>Hospitals will be required to submit the appropriate information for CMS to calculate hospital-specific all-payer readmission rates, which will be publicly reported on Hospital Compare. |
| **Who's responsible** | CMS, Medicare subsection (d) hospitals (acute care hospitals). |
| **The bottom line** | Hospitals will need to aggressively manage processes and metrics to avoid reimbursement penalties. Commercial payers tend to follow Medicare in payment structures and will likely be looking to evolve their pay-for-performance programs and reimbursement structures to align with this policy. Medi-Cal should use its authority under the Bridge to Reform 1115 waiver to test new reimbursement and care delivery programs that focus on reducing preventable readmissions. |

Several commercial payers in California have followed Medicare's lead and instituted their own payment policies for "never events": particularly shocking medical errors (such as wrong-site surgery) that should never occur.[24] However, California is not one of the 17 states that has implemented a statewide no-pay program for HACs.

While ACA mandates a July 1, 2011 start, CMS issued a final rule on June 1, 2011 stating it will delay compliance action until July 1, 2012 to allow states time to comply. In other words, Medi-Cal has until September 30, 2012 to submit a plan to implement the rule.

Beginning in 2015, ACA also adds a 1% Medicare DRG payment reduction for acute care hospitals with HAC rates in the top quartile nationally.[25]

## Hospital Value-Based Purchasing Program (§3001)

Beginning in federal fiscal year 2013, Medicare will launch a Hospital Value-Based Purchasing program. Under this program, incentives will be paid to hospitals that perform successfully against quality and patient satisfaction metrics, and that have health IT infrastructure in place to capture, assemble, and analyze patient-specific data and report measures to CMS. While participation is voluntary, all acute care hospitals will experience a reduction in their DRG base payment rate to fund the incentive pool; the payment reductions will occur irrespective of whether a hospital receives an incentive payment.

Under the final rule on the Value-Based Purchasing program published by CMS in May 2011, 12 performance measures (a subset of those measures already reported on CMS's Hospital Compare website) will be tied to $850 million in Medicare hospital payments.[26] In FY 2014, outcome and efficiency measures will be added. Beginning in 2015, physicians participating in Medicare will also be subject to a new budget-neutral value-based reimbursement system.

The redistributive nature of the program means that some hospitals will receive greater reimbursement than what they are currently paid under Medicare's hospital Inpatient Prospective Payment System (IPPS), while others will not recoup the reductions in IPPS payments made to create the value-based payment incentive pool.[27]

Similar measures are in place under Medi-Cal's DSRIP program, which outlines specific enhancements to health IT infrastructure for public hospitals to adopt in support of higher quality care. As such, Medi-Cal should align DSRIP requirements related to health IT adoption and use, as well as related reporting requirements and performance measures, with the requirements of the federal Value-Based Purchasing program. This would create an additional incentive for DSRIP hospitals to institute processes to improve performance and quality for the publicly insured patient population.

**Table 3. Medicare Hospital Value-Based Purchasing Program (§3001)**

| | |
|---|---|
| **What it says** | A Value-Based Purchasing program will pay hospitals based on their performance for certain quality measures. The incentive payments will be based on both attainment and improvement. |
| **Who it affects** | Medicare subsection (d) hospitals (acute care hospitals). |
| **Effective date(s)** | FY 2013 (Based on discharges occurring on or after Oct. 1, 2012). The schedule for the reductions is as follows: 1% in FY 2013, 1.25% in FY 2014, 1.5% in FY 2015, 1.75% FY 2016, and 2% in FY 2017 and beyond. |
| **What needs to be done** | The federal government issued regulations implementing the voluntary program in 2011.<br>Participating hospitals must adjust their IT infrastructure, to collect and analyze patient-specific data and report measures to CMS. |
| **Who's responsible** | CMS, Medicare subsection (d) hospital (acute care hospitals). |
| **The bottom line** | This budget-neutral program is a reimbursement redistribution from lower-performing to higher-performing hospitals. Those unable to meet quality measure targets will see their Medicare reimbursements decrease. |

### Other Value-Based Purchasing Pilots

**Value-Based Purchasing for Physicians and Physician Practice Groups (§3007).** Directs the Health and Human Services (HHS) Secretary to develop and implement a budget-neutral payment system to adjust the Medicare physician fee schedule based on the quality and cost of the care they deliver. By January 1, 2012, specific measures of quality and cost, specific dates for implementation of the payment modifier, and the initial performance period must be established.[28] Beginning no later than January 1, 2017, the modifier will be applied to all physicians and groups of physicians participating in Medicare.

**Value-Based Purchasing for Skilled Nursing Facilities (§3006a), Home Health Agencies (§3006b), and Ambulatory Surgical Centers (§10301).** Directs the HHS Secretary to develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. The ACA required a plan for ambulatory surgical centers be submitted to Congress no later than January 1, 2011, while plans for skilled nursing facilities and home health agencies were due no later than October 1, 2011.[29]

## Medicaid Reimbursement for Primary Care (§1202 of the Health Care and Education Reconciliation Act)

This provision of ACA establishes a temporary floor for Medicaid payments to primary care physicians. The floor is set at Medicare levels for two years, in 2013 and 2014, with the difference between current Medicaid rates and Medicare rates being fully federally funded.

Medi-Cal currently faces a shortage of primary care and specialty physicians; roughly half of all practicing California physicians have closed their practices to new Medi-Cal patients.[30] With 2 million new Medi-Cal enrollees expected as a result of ACA, access problems will be considerably exacerbated if provider supply issues are not addressed. Policymakers and program leaders need to carefully consider how to attract and retain providers into Medi-Cal over the long term to accommodate the influx of new Medi-Cal beneficiaries. Increasing reimbursement rates, creating and expanding medical school loan repayment programs, and expanding medical training opportunities (such as the new medical school campuses in Riverside and Merced) are examples of some options.

Low reimbursement is a root cause of Medi-Cal's low provider participation. California physicians are much less likely to have Medi-Cal patients (68%) than patients with private insurance (92%) or Medicare coverage (78%), with widely varying participation rates among specialties.[31] Further, Medi-Cal patients are concentrated in a small share of practices and clinics, with 25% of physicians providing care to 80% of Medi-Cal patients.[32]

The Medicaid payment rate increases for primary care providers must also be reflected in capitation rates paid to Medicaid managed care plans and passed on to providers. This is particularly important for physicians in California, where Medi-Cal pays less than half of what Medicare pays for primary care services, and where overall Medi-Cal physician fees rank 47th among all states.[33]

While payment and access provisions under ACA will provide some support to help meet the state's expanded capacity requirements, they are not enough to resolve longstanding provider participation issues.[34] It is unlikely that primary care physicians will substantially alter their participation in Medi-Cal without some guarantee that fee increases will become permanent. While managed care organizations tend to offer better reimbursement, they will be similarly pressured to reduce rates and cannot be relied upon to resist this pressure without additional federal and state assistance.

**Table 4. Medicaid Reimbursement for Primary Care (§1202 of the Health Care and Education Reconciliation Act)**

| | |
|---|---|
| **What it says** | The program establishes a temporary reimbursement rate floor for Medicaid payments to primary care physicians. The floor is set at Medicare levels for two years, 2013 and 2014. Differences between current reimbursement rates and Medicare rates are fully federally funded. |
| **Who it affects** | Primary care physicians with a designation of family medicine, general internal medicine, or pediatric medicine. |
| **Effective date(s)** | January 1, 2013 through December 31, 2014. |
| **What needs to be done** | Payment arrangements between the Medi-Cal FFS program and primary care providers need to be modified to accommodate the temporary rate change. Medi-Cal managed care plans will similarly be required to ensure their capitated and FFS rates are equivalent to or better than proscribed Medicare rates. |
| **Who's responsible** | CMS, DHCS, and Medi-Cal managed care plans. |
| **The bottom line** | While ACA increases reimbursement for primary care services for two years, it expires at the end of 2014 and may not be sufficient to increase the supply of primary care physicians to care for the 2 million additional Medi-Cal beneficiaries expected under ACA. Providers will likely want to see permanent reimbursement parity with Medicare to entice more providers to open their practices to new Medi-Cal patients. |

## B. Reimbursement Pilot Programs

As the nation's largest health insurance program covering 46 million Americans (including 4.7 million Californians) and accountable for over 20% of the nation's health care spending, Medicare has tremendous market leverage.[35, 36] In an effort to reduce Medicare cost increases and shift toward a payment system that rewards care coordination, value, and outcomes, ACA establishes a number of pilot programs to test alternate payment models.

### Medicare and Medicaid Payment Bundling Demonstrations (§3023 and §2704)

ACA's five-year Medicare bundling pilot program (§3023) directs the Health and Human Services (HHS) 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 starting no later than January 1, 2013. Under a system of bundled payments (also known as "episode of care" payments), an insurer pays a single price for the services needed in a patient's entire episode of care, beginning three days prior to a hospital admission and ending 30 days after discharge with "applicable conditions."[37] Medicare services included in the bundled payment can include: acute care inpatient services, physician services delivered inside and outside of the hospital setting, long term care, and others as defined by the HHS Secretary. The single payment inclusive of multiple services cannot exceed what it would cost to provide the same services outside of the pilot.

The Medi-Cal FFS program and managed care plans should take note and carefully consider how bundled payment programs can help control hospital and provider costs. Inpatient costs alone in the FFS program represent approximately one-fifth of total Medi-Cal expenditures, and managed care plans will likely see increases in the proportion of inpatient expenditures as they enroll more SPDs through the Bridge to Reform 1115 waiver. Results of existing federal and Integrated Healthcare Association (IHA) bundled payment pilots should help inform potential policy and program actions for Medi-Cal and their managed care plans (see sidebar, Experiments with Bundled Payment Options). Nationally, other bundled payment programs, including Geisinger Health System's ProvenCare model, have demonstrated promising results. ProvenCare's coronary artery bypass surgery program demonstrated that ProvenCare patients had shorter lengths of stay, incurred 5% lower hospital charges, were more likely to be discharged to the home, and had lower readmission rates compared with those receiving conventional care.[38]

### Experiments with Bundled Payment Options

Providers and payers in California have recently tested bundled payment options. In August 2010, Cedars-Sinai Medical Center, UCLA Health System, and Hoag Memorial Hospital Presbyterian joined a bundled episode-of-care pilot in Los Angeles and Orange counties for hip and knee replacements. The pilot was supported by the Integrated Healthcare Association (IHA) in Oakland and focused on commercial PPO patients. The lump-sum payments were negotiated individually by each participating hospital and four California health insurers: Aetna, Blue Shield of California, Cigna, and Health Net.

In February 2011, IHA was awarded a three-year, $2.9 million grant by the Agency for Healthcare Research and Quality (AHRQ) to build upon the Los Angeles and Orange county pilot and expand the project statewide. The program will eventually involve 20 teams of physicians, hospitals, surgery centers, and other providers, including:

- Physician organizations: Brown & Toland Physicians, HealthCare Partners, Monarch HealthCare, and St. Joseph Heritage Healthcare.
- Hospitals: Cedars-Sinai, Hoag Memorial Hospital Presbyterian, Huntington Hospital, Mission Hospital, Saddleback Memorial Medical Center, St. Joseph Hospital, St. Jude Medical Center, Tenet California, and UCLA Medical Center.
- Ambulatory surgery centers: Monterey Peninsula Surgery Centers.
- Health plans: Aetna, Blue Shield of California, Cigna, and HealthNet.

The demonstration will expand the effort over three years to include 10 acute conditions and procedures, and to cover HMO, Medicare Advantage, and Medi-Cal managed care populations.[40]

Medi-Cal can get a jump-start by participating in another demonstration project — authorized under ACA though funding has not yet been appropriated — to evaluate integrated care around hospitalizations (§2704).[39] Should federal funding be made available for the Medicaid pilot, five-year demonstration projects in up to eight states would be selected through a competitive process starting January 1, 2012. Participating Medicaid programs would make bundled payments for the provision of integrated care during an episode of care, including a hospital stay and concurrent physician services provided during hospitalization. A participating Medicaid program may target its initiative to particular categories of beneficiaries such as dual-eligibles, SPDs or other patients with complex needs, or particular geographic regions within the state. If Medi-Cal participates, it must determine which services to include in its bundled payment and decide whether to test this approach in its fee-for-service program, which accounts for a shrinking share of inpatient hospital spending; or to partner with Medi-Cal managed care plans to test this approach in its managed care population.

**Table 5. National Pilot Program on Medicare Payment Bundling (§3023)**

| | |
|---|---|
| **What it says** | This Medicare pilot program for integrated care will use bundled payments for the services needed in a patient's entire episode of care involving a hospitalization to improve coordination, quality, and efficiency of health care services. |
| **Who can participate** | *Providers:* Hospitals, physician groups, skilled nursing facilities, home health agencies.<br>*Applicable beneficiaries:* Individuals entitled to or enrolled for Medicare Part A and Part B benefits (excludes beneficiaries enrolled in Part C or a PACE program). |
| **Effective date(s)** | January 1, 2013 to December 31, 2018. |
| **What needs to be done** | The federal government will establish an application process outlining program requirements. At a minimum, selected entities will be required to collect and report data on quality measures.<br>California hospitals and integrated delivery networks will need to monitor opportunities to participate, submit competitive applications, and engage with CMS to support pilot programs. |
| **Who's responsible** | CMS; eligible providers. |
| **The bottom line** | New Medicare payment mechanisms provide significant opportunities for California providers and hospital systems. California institutions with experience in local bundled payment initiatives or who aim to form tighter hospital-physician organizations could participate and benefit from federal funding to better coordinate care. Medi-Cal should consider participating in a separate project featuring Medicaid bundled payment for integrated care around hospitalization (should funding be appropriated for it), to evaluate its effectiveness in improving quality and reducing costs. |

### Other Value-Based and Episode-of-Care Medicare Payment Pilots

**Independence at Home Demonstration Program (§3024).** Provides incentives for physicians, physician assistants, and nurses to: develop home-based primary care teams for Medicare beneficiaries; provide 24-7 availability of home visits; and use electronic health information systems, remote monitoring, and mobile diagnostic technology. Participating practices may share savings in excess of 5%.

**Pay-for-Performance Pilot Testing for Certain Providers (§10326).** Directs the HHS Secretary to conduct separate pilot programs for inpatient rehabilitation facilities, inpatient psychiatric hospitals, long term care hospitals, PPS-exempt cancer hospitals, and hospice providers to test the implementation of a value-based purchasing program.

**Medicare Hospice Concurrent Care Demonstration Program (§3140).** Will allow up to 15 hospice programs to test the impact of providing Medicare patients with both hospice care and all other Medicare benefits on patient care, quality of life, and cost-effectiveness.

# IV. ACA Delivery Reform Demonstrations and Pilot Programs

The Centers for Medicare and Medicaid Services has realigned and created new offices to more readily advance Medicare and Medicaid delivery reforms under ACA. The ACA establishes a Medicare-Medicaid Coordination Office within CMS to improve the integration of care for beneficiaries eligible for both Medicare and Medicaid (dual-eligibles or "duals"), and creates a new Center for Medicare and Medicaid Innovation (CMMI, also called the "Innovation Center") within CMS. The purpose of the Innovation Center is to test innovative payment and service delivery models that reduce program expenditures while preserving or enhancing quality in the Medicare and Medicaid programs. The ACA appropriates $10 billion for the Innovation Center to test new models initiated from 2011 to 2019 through the Medicare, Medicaid, and CHIP programs without having to seek specific legislative authority.

## A. Innovation Center Programs

The Innovation Center will test many, but not all of the delivery reform programs specifically outlined in ACA, as well as develop and pilot its own models. Section 3021 of ACA establishes the Innovation Center and describes care delivery and payment approaches the Center may consider. It also grants the Innovation Center broad authority to develop and test new care delivery models for populations experiencing deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Innovation Center has centered its agenda around a three-part aim: to improve patient experience, improve patient outcomes, and reduce costs.

A table of Innovation Center-led initiatives is included in Appendix B. To date, its efforts have been organized primarily around two programmatic themes: Patient Care Models and Seamless Coordinated Care Models. As of August 31, 2011, two initiatives have been introduced under the Patient Care Model umbrella: The Partnership for Patients and Bundled Payments for Care Improvement Initiative.

### The Partnership for Patients

The Partnership for Patients aims to support physicians, nurses, and other clinicians working in and out of hospitals to make patient care safer, and to support effective transitions of patients from hospitals to other settings. The two goals of the partnership are to decrease preventable hospital-acquired conditions by 40% by 2013, and to decrease overall hospital readmissions by 20% by 2013. CMS estimates achieving these goals could save up to $35 billion across the health care system — including up to $10 billion in Medicare savings — over the next three years.[41] The Innovation Center has committed $500 million in technical assistance to hospitals to meet the goals of the partnership (see Appendix B).

As of August 2011, over 220 California hospitals have signed the Partnership for Patients pledge along with 214 other stakeholders including associations, consumer groups, and employers.[42] In California, 82% of hospitals reported having participated in one or more such collaborative initiatives in the past (see sidebar, Provider-Payer Safety Collaborative Initiatives). Meaningful impact of these initiatives on safety or costs, however, has been difficult to measure. In 2008, California enacted "Nile's Law," requiring hospitals to submit data on hospital-associated infections (HAIs) beginning January 2009.[43] In its January 2011 inaugural report, the California Department of Public Health (CDPH) reported that it was missing data from up to 20% of hospitals.[44] Aligning the reporting requirements of CDPH and Partnership for Patients would reduce hospital reporting burdens and may improve participation in both initiatives.

### Provider-Payer Safety Collaborative Initiatives

**The California Healthcare-Associated Infection Prevention Initiative (CHAIPI):** Blue Shield of California Foundation (BSCF) funded a $4.5 million project to evaluate the impact of automated surveillance technology on reduction in healthcare-associated infections (HAIs). The pilot launched in 2005 with 11 hospitals and expanded to include 50 nonprofit hospitals across the state by 2008. Participating hospitals focused on two foundational infection prevention practices: (1) appropriate hand hygiene, and (2) appropriate contact precautions. Each hospital also selected a hospital-specific emphasis on one or two specific HAIs and measured progress against hospital-specific goals. The initial 11-hospital pilot (July 2005 to June 2007) resulted in 605 patients protected from HAI, 4,641 hospital days avoided, and $3 million in hospital savings. BSCF estimates its initial $1 million investment in the CHAIPI pilot lowered costs of care by more than $9 million total in all-payer savings. Initial results from 10 of the hospitals participating in the second phase of the initiative show that 905 patients were likely prevented from acquiring an infection, hospitals alone saved over $4.1 million, and there was a 29% reduction in MRSA, a bacterial infection that is highly resistant to antibiotics.

**Patient Safety First — A California Partnership for Health:** In January 2010, Anthem Blue Cross, California's three regional hospital associations, and the National Health Foundation launched a three-year, $6 million effort to improve the quality and consistency of care Californians receive. The collaborative's three initial areas of focus include: (1) perinatal care: reduction of elective deliveries prior to 39 weeks; (2) sepsis: reduction of incidence and morbidity by 25% statewide over three years; and (3) hospital-acquired infections in the ICU setting: reduction of incidence of (with a target of 0 in three years) ventilator-associated pneumonia (VAP), central line blood stream infections (CLBSI), and catheter-associated urinary tract infections (CAUTI).

## Bundled Payments for Care Improvement Initiative

In August 2011, the Innovation Center invited providers to apply, test, and develop four different bundled payment models. (This Innovation Center initiative is distinct from the National Pilot Program on Medicare Payment Bundling mandated by ACA, described above.) Three models involve a retrospective bundled payment arrangement, and one model would pay providers prospectively.[45] Participating providers will have flexibility in selecting conditions to bundle, developing the health care delivery structure, and determining how payments will be allocated among participating providers. Final applications from interested providers were due by October 21, 2011 for Model 1 and will be due by March 15, 2012 for Models 2-4.

In addition to the initiatives just described, a number of initiatives focused on improving care coordination have been introduced under the Seamless Coordinated Care Model umbrella. These are discussed below.

## State Demonstrations to Integrate Care for Dual-Eligible Individuals

The overall goal of this demonstration is to identify and validate delivery system and payment integration models that can be rapidly tested and, upon successful demonstration, replicated in other states. Dual-eligibles account for 16% to 18% of enrollees in Medicare and Medicaid, but roughly 25% and 45% of spending in these programs respectively.[46] In April 2011, CMS awarded up to $1 million in funding each to 15 states, including California, to support the design of innovative service delivery and payment models for dual-eligible individuals.[47] States were awarded funding to build upon existing programs to create new patient-centered programs that align acute, behavioral health, and long term supports and services, and improve the patient experience and quality of care for dual-eligible beneficiaries.

There are 1.1 million duals residing in California, representing one out of eight duals nationally.[48] Nearly 70% of Medicaid spending nationally for duals is for long term care services, which are mostly not covered under Medicare or by private insurance.[49] This places a greater burden on state Medicaid programs and highlights the need for care coordination. Only 175,000, or 20%, of California's duals are enrolled in a Medicare managed care plan, a Medi-Cal managed care plan, or in a fully integrated Program for All-Inclusive Care for the Elderly (PACE) plan, which targets seniors who qualify for a nursing home-level of care.[50] In 2007, the state spent $3.2 billion on long term care services and supports for duals, representing 75% of total Medi-Cal long term care spending.[51] Under Senate Bill 208 (2010), Medi-Cal is required to develop a program to provide more streamlined and coordinated care for duals.

Medi-Cal plans will enroll up to 150,000 duals in four pilots over the next two years with a goal of making integrated care for duals available statewide by 2015, based on the successes and lessons learned in the pilots.[52] The pilots will provide coverage for California dual-eligible beneficiaries through an integrated delivery system that includes all medical services, long term services and supports (LTSS), and coordination with or coverage for behavioral health services.

With the ongoing state budget fiscal crisis and the increased attention on reducing entitlement spending in Washington, Medi-Cal needs to sharpen its focus on reducing expenditures for its dual-eligible population. Moving duals into managed care programs in which provider networks have the potential to better coordinate care is a necessary first step.

**Table 6. State Demonstrations to Integrate Care for Dual-Eligible Individuals**

| | |
|---|---|
| **What it says** | This program aims to identify and validate delivery system and payment integration models that can be rapidly tested and, upon successful demonstration, replicated in other states. |
| **Who can participate** | 15 states won awards, including California. |
| **Effective date(s)** | April 2011 to May 2012 for planning contracts. |
| **What needs to be done** | The primary outcome of the initial design period will be a demonstration proposal that describes how the state would structure, implement, and evaluate a model aimed at improving the quality, coordination, and cost-effectiveness of care for dual-eligible individuals. |
| **Who's responsible** | California Department of Health Care Services in coordination with CMS. Medi-Cal managed care and PACE plans will likely be tasked with carrying out pilots. |
| **The bottom line** | Duals account for 18% of enrollees but 45% of spending for Medicaid, and 75% of all long term care spending in the Medi-Cal program. The demonstration allows Medi-Cal to test care delivery models tailored to support-ing the high-intensity medical needs of dual-eligible beneficiaries. The July 9, 2011, State Medicaid Director Letter describes opportunities to enter into new contracting arrangements to support such pilots and should be considered by Medi-Cal to support one of the state's highest-cost populations. |

## Medicaid Health Home State Plan Option (§2703)

Beginning on January 1, 2011, states will have the option to amend their Medicaid plans to create "health homes" for Medicaid beneficiaries, including duals, with chronic conditions. The health home model of service is designed to be a longitudinal "home" that expands on the traditional medical home models that many states have developed in their Medicaid programs. It seeks to build additional linkages and enhance coordination and integration of medical and behavioral health care and LTSS to better meet the needs of people with multiple chronic illnesses.[53]

States that implement this option will receive enhanced financial resources from the federal government to support health homes in their Medicaid programs.

The health home option has the potential to provide additional financial resources to Medi-Cal providers to coordinate care for beneficiaries with chronic conditions. To help states with the initial costs, CMS will pay 90% of health home reimbursements for the first two years. CMS will also provide up to $500,000 per state, available at a state's regular Medicaid matching rate, to support planning activities around developing a state plan amendment for the health home option.

To date, Medi-Cal has not invested in establishing a statewide medical home program, though there are some medical home-component requirements for providers under the Bridge to Reform and previous 1115 waivers. Assistance to participate in the state option planning process requires an upfront investment which is currently being supported by The California Endowment. However, long term reimbursement after the initial eight quarters of enhanced federal match will require additional state funding. Policymakers will therefore need to consider how they will allocate resources to support a program in the long term, should it be successful.

Existing Medicaid medical home programs in other states have been shown to reduce overall costs primarily by reducing emergency room visits and unnecessary hospital admissions. A nationally recognized medical home program in North Carolina saved the state between $186 million and $194 million in fiscal year 2009 alone.[54] Illinois reported a savings of more than $220 million in the first two years of its Medicaid medical home program.[55]

Given these results, Medi-Cal should strongly consider testing and evaluating health home programs in its efforts to both improve outcomes and reduce costs.

**Table 7. Medicaid Health Home State Plan Option (§2703)**

| | |
|---|---|
| **What it says** | This program provides states the option to offer health home services to eligible individuals with chronic conditions who select a designated health home provider. States participating in this option must also require that Medicaid participating hospitals refer emergency room patients with chronic conditions to designated providers. |
| **Who can participate** | State Medicaid programs.<br>Eligible beneficiaries must have at least two chronic conditions; one chronic condition and at risk for another; or one serious and persistent mental health condition. |
| **Effective date(s)** | January 1, 2011 to December 31, 2016. |
| **What needs to be done** | DHCS needs to submit a state plan amendment to implement this provision. Amendments must propose a method for monitoring preventable hospital readmissions and a plan for use of health information technology in providing services under this provision. |
| **Who's responsible** | DHCS must establish administrative oversight; participating providers and plans must establish medical homes. |
| **The bottom line** | Health home services are reimbursed at a 90/10 federal match for the first eight quarters of the state's health home program; this program presents an important funding opportunity to establish new health homes or strengthen existing programs. Policymakers should consider whether a current health home, disease management, or targeted case management program would be eligible to transfer under this provision. Policymakers must also consider funding sources to support the program after the enhanced federal match ends.<br>Hospitals participating in the DSRIP program and clinics with medical home experience may be well-suited partners for Medi-Cal. |

## Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration

This CMS demonstration in partnership with the Health Resources Services Administration (HRSA) will test the effectiveness of doctors and other health professionals working in teams to improve care for up to 195,000 Medicare patients. CMS will provide an estimated $42 million each to as many as 500 FQHCs over three years to coordinate care for Medicare patients. To qualify, FQHCs will be expected to achieve National Committee for Quality Assurance (NCQA) Level 3 patient-centered medical home (PCMH) recognition to help patients manage chronic conditions; and demonstrate how the PCMH model can improve quality of care, promote better health, and lower costs. (The application submission deadline for eligible FQHCs was August 26, 2011.) Up to $1 billion is expected to be invested nationally over the course of the program.

California clinics and primary care practice providers have been relatively slow to achieve NCQA-PCMH certification. As of March 2011, over 1,800 provider groups nationally have been NCQA-certified, but only 155 of those are in California.[56] Achieving Level 3 NCQA recognition requires significant investment in workflow redesign and infrastructure development; certification requires a fully functional electronic health record (EHR) system, adoption and use of evidence-based guidelines, population health management and care coordination, culturally competent care, and patient self-management support. Clinics in California are catching up and have been rapidly adopting EHRs; in 2011, 47% of clinics reported having an EHR in place, compared with just 3% in 2005.[57] California clinics are also increasingly participating in health home demonstrations.[58]

The Advanced Primary Care Practice Demonstration's focus on Medicare patients might be a challenge for many California clinics. The vast majority of clinics have a patient mix of Medi-Cal, indigent, or uninsured; on average fewer than 5% of a California clinic's patient mix is Medicare.[59] The Medicare and Medi-Cal populations are significantly different, and have different health care needs. Seniors tend to have more chronic conditions: 40% have multiple chronic conditions, compared with 24% of non-seniors. Seniors also suffer far more frequently from a specific set of diseases such as hypertension and heart disease than do non-seniors, requiring different treatment pathways and more frequent visits and follow-up care.[60] To be competitive in securing APCP funding and succeed in developing PCMHs that support this population, California FQHCs must pay special attention to the specific and unique needs of California's Medicare and dual-eligible members.

**Table 8. Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration**

| | |
|---|---|
| **What it says** | This demonstration tests whether payment of a monthly care coordination fee ($6.00 per month for each eligible Medicare beneficiary) assists participating FQHCs in providing and expanding the delivery of continuous, comprehensive, and coordinated primary health care. |
| **Who can participate** | FQHCs that have provided primary care medical services to at least 200 eligible Medicare beneficiaries in the most recent 12-month period, including those with both Medicare and Medicaid (dual eligible) coverage. |
| **Effective date(s)** | October 1, 2011 to September 30, 2014. |
| **What needs to be done** | Participating FQHCs are expected to achieve NCQA Level 3 patient-centered medical home recognition, help patients manage chronic conditions, and actively coordinate care for patients. |
| **Who's responsible** | CMS, HRSA, and eligible FQHCs. |
| **The bottom line** | The APCP's focus on Medicare patients might be a challenge for many California clinics, most of whom are not PCMH-recognized and whose patient mix is predominantly Medi-Cal, indigent, or uninsured. Health home initiatives funded by the California Endowment could help increase clinic participation by supporting PCMH training and Level 3 NCQA recognition. |

### Community-Based Care Transitions Program (CCTP) (§3026)

The CCTP Program provides funding to test models for improving care transitions for high-risk fee-for-service Medicare beneficiaries, including duals. CCTP aims to improve transitions of beneficiaries from the inpatient hospital setting to other care settings to improve quality of care, reduce readmissions for high-risk beneficiaries, and document measureable savings to the Medicare program. Medicare subsection (d) hospitals with 30-day readmission rates in the top quartile in their state for heart attack, heart failure, and/or pneumonia are eligible to submit an application in partnership with community-based organizations (CBOs) that provide care transition services.[61] CBOs may submit an application with any subsection (d) hospital, regardless of the hospital's readmission rate. Up to $500 million in program funding over five years is expected.

California has 47 designated subsection (d) hospitals with high readmission rates.[62] In 2013, Medicare will stop paying for many readmissions within 30 days of discharge. The CCTP program provides an opportunity for these hospitals to reduce avoidable readmissions — and avoid financial penalties — by developing better infrastructure and processes for care transitions from the hospital to those responsible for the next phase in a patient's recovery. The CCTP program also provides an opportunity for hospitals to partner with local health departments; with Administration of Aging (AoA) and Aging and Disability Resource Connection (ADRC) program participants; and with other community-based organizations to support the long term care, home care, skilled nursing facility, hospice, and other care transition needs of Medi-Cal seniors and persons with disabilities in new managed care programs.[63]

Participation by eligible hospitals in the Medicare CCTP program would also complement care transition improvement efforts under the Bridge to Reform 1115 waiver. Under the waiver, California will work with CMS to establish a mechanism within its Money Follows the Person (MFP) demonstration — "California Community Transitions" — to increase opportunities for eligible individuals to access home- and community-based services (HCBS) upon discharge from hospitals and nursing facilities as an alternative to institutional services. Medi-Cal should work closely with CMS to ensure its MFP demonstration aligns with CCTP, and should support and help guide CCTP applications to ensure that the program provides funding for organizations in California and captures lessons for those institutions and the Medi-Cal program.

In addition to the voluntary Medicare- and Medicaid-related demonstration projects supported by the Innovation Center, other grant programs and delivery system reform pilots are being tested. These initiatives involve multiple providers across the continuum of care and require coordination around both care delivery and payment distribution. Some demonstrations may overlap with current initiatives underway through public and commercial payers in California. As a result, many of these programs will require careful consideration by state policymakers.

An overview of key demonstration programs is included in Appendix C.

**Table 9. Community-Based Care Transitions Program (§3026)**

| | |
|---|---|
| **What it says** | This program tests models for improving care transitions for Medicare FFS beneficiaries at highest risk for preventable re-hospitalization. Program goals are to: reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measurable savings to the Medicare program. |
| **Who can participate** | Eligible hospitals partnering with a community-based organization or community-based organizations that provide such care transition services. Eligible hospitals are inpatient prospective payment system (IPPS) hospitals identified by the HHS Secretary as having high readmission rates. Priority is given to applicants that partner with Administration on Aging grantees with care transition experience, and entities that provide services to medically underserved populations, small communities, and rural areas. |
| **Effective date(s)** | January 1, 2011 to December 31, 2015, open solicitation demonstrations. |
| **What needs to be done** | Applications to participate must include a detailed proposal with at least one evidence-based care transition intervention. |
| **Who's responsible** | Eligible applicants. |
| **The bottom line** | Medi-Cal and California providers have made important investments in improving transitions in care, but more work needs to be done. This pilot could provide a unique opportunity for California hospitals on the high readmission list to foster stronger partnerships with community-based organizations, both to extend care support for high-risk beneficiaries and avoid new penalties under Medicare. CCTP can also be leveraged by Medi-Cal to support its efforts to bolster care management for duals under the Bridge to Reform waiver. |

## B. Accountable Care Organizations

ACA authorizes the federal government to test new health care payment and delivery models through accountable care organizations (ACOs). ACOs will be accountable for the cost and quality of care for FFS Medicare beneficiaries by offering more effective and efficient care, and will share resulting savings or losses with the federal government. New federal rules have been proposed to support the federal ACO initiative. Together with a companion framework for granting waivers under federal Stark and anti-kickback laws, and gain-sharing provisions of the Civil Monetary Penalties Law, these rules present a new framework for care delivery and reimbursement in the Medicare program.

### Medicare Shared Savings Program (MSSP) (§3022)

The MSSP ACO program, combined with the Pioneer ACO demonstration (an Innovation Center program; see sidebar, Pioneer Accountable Care Organization (Pioneer ACO) Model), are expected to support as many as 180 ACOs facilitating care for up to five million Medicare FFS beneficiaries, and could save Medicare $1.5 billion nationwide over three years.[64, 65] ACOs created as a result of MSSP may negotiate new payment and care delivery arrangements with other payers, including those in the commercial sector and within other publicly funded programs.

**Table 10. Medicare Shared Savings Program (MSSP) (§3022) and Pioneer ACO**

| | |
|---|---|
| **What it says** | Providers may participate in three- to five-year shared savings programs with Medicare by managing and coordinating care for at least 5,000 FFS Medicare beneficiaries (15,000 for most Pioneer ACOs), and demonstrating improvements in quality and decreases in expected expenditures. Failure to meet requirements could result in penalties and removal from the demonstration program. |
| **Who can participate** | *Providers:* An MSSP ACO may include physicians in group practices; networks of individual providers; partnerships or joint venture arrangements between hospitals and providers; or hospitals employing providers. FQHCs may form Pioneer ACOs but can only participate and not independently form an MSSP ACO.<br>*Beneficiaries:* Assignment to an MSSP ACO is retroactive based on factors including where beneficiaries receive a plurality of primary care. Pioneer ACO assignment may be driven by certain specialty care encounters and assignment may be retrospective or prospective. |
| **Effective date(s)** | *MSSP ACO:* No later than January 1, 2012.<br>*Pioneer ACO:* Applications were due August 19, 2011; program initiation expected in Q4 2011. |
| **Funding** | Budget neutral; total expected combined savings estimated at up to $1.5 billion over three years. |
| **What needs to be done** | *MSSP ACO:* CMS must issue final regulations implementing the program. Interested qualified institutions must submit applications conforming to program requirements.<br>*Pioneer ACO:* Interested entities must submit applications. Selected ACOs will be required to submit data on quality measures and work with other payers to align payment strategies, among other program requirements. |
| **Who's responsible** | Centers for Medicare and Medicaid Services (CMS); participating entities. |
| **The bottom line** | These are optional demonstration programs, up to 180 of which may be funded nationally. Capitated provider organizations in California have extensive experience managing risk and may be well-suited to participate. However, extensive requirements and risk, and a perception of limited benefit may limit provider participation, especially in the MSSP ACO program. Lack of alignment between federal ACO programs, Medi-Cal, and commercial demonstrations will further limit ACOs, appeal. |

### Pioneer Accountable Care Organization (Pioneer ACO) Model

The Innovation Center's Pioneer ACO Model is designed to allow organizations with advanced care coordination and experience with capitated payment to rapidly test an ACO model. Pioneer ACO participants must have 15,000 Medicare beneficiaries assigned to them. Participating entities are eligible for both shared savings and shared losses in all three years of the program. Eligibility for shared savings will be based on performance on a set of 65 quality measures, mirroring those in MSSP. Participants are required to enter into pre-paid population-based reimbursement arrangements. By the third year, these ACOs are expected to generate a majority of their total revenues from outcomes-based payment arrangements.

The Innovation Center is currently considering an Advance Payment Initiative for those ACOs entering the Medicare Shared Savings Program to test whether and how pre-paying a portion of future shared saving could increase participation in the Medicare Shared Savings Program. The Innovation Center is also offering four learning sessions in 2011 for providers who are interested in forming an ACO. The sessions will focus on core competencies for ACO development, such as improving care delivery to increase quality and reduce costs; using health information technology and data resources effectively; and building capacity to assume and manage financial risk.

## Pediatric Accountable Care Organization Demonstration Project (§2706)

ACA authorizes a pediatric-specific ACO program for Medicaid. The ACO requirements articulated in ACA include clinical and administrative systems needed to support evidence-based medicine; coordinated care including the use of telehealth and other enabling technologies; the ability to report quality and cost measures; and the ability to meet patient-centeredness criteria, such as the use of patient and caregiver assessments or the use of individualized care plans. Once a process is defined and funding appropriated, states may apply to participate in the demonstration which is scheduled to run from January 1, 2012 to

December 31, 2016. Funding for this program has been authorized but not yet appropriated; see Appendix C for details.

Under the Bridge to Reform 1115 waiver, Medi-Cal is authorized to create ACOs to support high-need children with complex conditions. As the program develops, the Department of Health Care Services will need to decide whether it will adopt federal ACO rules (if it has a choice), undertake a state-based rule-making process to define a Medi-Cal ACO, or provide a framework for its contracted managed care plans to develop their own ACO program for this population.

In developing a Medi-Cal ACO program, DHCS should carefully assess how they can fully leverage and extend existing managed care networks. Creating a program that adds significant administrative, actuarial, and operational activities that do not align with either the federal ACO program or emerging commercial ACO models in California would reduce the program's overall effectiveness and cost savings and likely limit participation. In addition, program requirements that necessitate significant changes to existing network arrangements may prove challenging for many Medi-Cal and commercial providers to meet and could add to program costs. As an early warning sign, many organizations have voiced concerns that the proposed ACO requirements are too burdensome and do not create a risk/reward profile that is worth undertaking.

States including New York, Oregon, and others have enacted laws to create ACO demonstrations, certification programs, or requirements to transition Medicaid and other beneficiaries into alternative shared-savings programs. Given the issues described above and the preliminary reluctance expressed by many providers toward the federal ACO program, as well as decades of experience in risk-based contracting arrangements, policymakers in California should consider how they can align policies to encourage broader participation in shared-savings programs for commercial and government-sponsored insurance programs that are best suited to California's unique delivery system.

**Table 11. Pediatric Accountable Care Organization Demonstration Project (§2706)**

| | |
|---|---|
| **What it says** | States may apply for the five-year shared-savings demonstration program and support the enrollment of children in ACOs. Program requirements have not yet been released but are expected to require participants to use clinical and administrative systems needed to support evidence-based medicine and coordinated care; use health IT and telehealth; report quality and cost measures; and meet patient-centered care criteria. |
| **Who can participate** | States and provider organizations treating publicly insured children (regulations and/or program guidance forthcoming as to which beneficiaries and programs will be included). |
| **Effective date(s)** | January 1, 2012 to December 31, 2016. |
| **Funding** | The program is authorized under ACA; however, funding has not yet been appropriated. Federal budget pressures may prevent the program from receiving fiscal support. |
| **What needs to be done** | Federal funding must first be appropriated to support the demonstrations, and program requirements and/or regulations must be issued. Eligible entities (states) would be required to apply through what likely would be a competitive application process. |
| **Who's responsible** | Centers for Medicare and Medicaid Services (CMS); California Department of Health Care Services. Medi-Cal managed care plans and provider organizations would likely be tasked with executing the program. |
| **The bottom line** | If this project is funded, DHCS would need to work closely with hospital and provider organizations and Medi-Cal managed care plans to establish the shared-savings program for children, enroll them in pilots, and track and report quality, cost, utilization, and other measures. The program could serve as a basis for a more widespread rollout of shared savings models for high-need, high-cost children with complex conditions, including children enrolled in CCS. |

## C. Patient-Centered Medical Homes

While previous provisions describe state-plan options to create health homes for beneficiaries with chronic conditions, additional patient-centered medical home (PCMH) programs have been authorized that include a broader pool of program participants. These PCMH demonstrations are designed to promote integrated service delivery, team-based care, and flexible models of care management. Under ACA, PCMH pilots will focus on incentives and reimbursement arrangements that emphasize primary care case management, disease management, care coordination, and the use of physician extenders and other home- and community-based care providers.

### Community Health Team Support for Patient-Centered Medical Homes (§3502, §10321)

ACA authorizes a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, inter-professional "health teams." Although not currently funded (see Appendix C for details), if implemented, the demonstration would require health teams to provide medical home services to eligible individuals with chronic conditions, coordinate their care, improve access to services, share information across settings, and promote effective prevention, treatment, and patient management strategies. States, state-designated entities (SDEs), and Indian tribes or tribal organizations may apply, and must provide capitated payments to primary care providers (including obstetrics and gynecology practices) within the hospital service areas served by the eligible entities. Awardees must also submit a plan for achieving long term financial sustainability within three years.

While the demonstration is not specific to Medicare or Medicaid, the participants must provide services to individuals with specified chronic conditions. States and SDEs could therefore target hospital service areas with large pockets of Medicaid and dual-eligible beneficiaries with chronic conditions, and identify prospective primary care and community-based organizations with whom they could enter into contracts. Given the high-cost, high-need nature of these populations, a federally funded demonstration targeting these groups could provide an excellent opportunity for Medi-Cal to test the efficacy of such a program, demonstrate value and sustainability, and consider more widespread rollout as an alternative delivery and reimbursement model to care for high-cost, high-need individuals and populations.

**Table 12. Community Health Team Support for Patient-Centered Medical Homes (§3502, §10321)**

| | |
|---|---|
| **What it says** | This program provides grants for (or contracts with) eligible entities to establish community-based interdisciplinary, inter-professional teams ("health teams") to support primary care practices providing care to beneficiaries with chronic conditions, including 24-hour care management and support during transitions in care settings. |
| **Who can participate** | States or state-designated entities (SDEs); participating practices must be primary care providers. |
| **Effective date(s)** | To be determined. |
| **What needs to be done** | CMS has yet to issue program guidance or an application; the state or its SDE will need to submit an application to participate once the program is launched.<br>A primary care provider who contracts with a care team must: (1) provide a care plan to the care team for each patient participant; (2) provide access to participant health records; and (3) meet regularly with the care team to ensure integration of care. |
| **Who's responsible** | CMS; California DHCS. |
| **The bottom line** | Medi-Cal could serve as the lead agency and apply with Medi-Cal managed care organizations and focus initiatives in high-need areas. Many of these plans already have capitated contracts in place with primary care and other provider organizations, and they could use this demonstration to test alternative contracting mechanisms within their existing or expanded networks. |

### Medicaid Long Term Care

ACA includes several provisions targeted to making long term care accessible and affordable, and to shift care from institutional to community settings. New options and incentives will be available for Medicaid home- and community-based services (HCBS), providing authority and funding for a series of demonstration projects and pilot programs that develop, integrate, and pay for home- and community-based long term care services.

Medicaid is the primary payer for 64% of the almost 1.4 million nursing home residents nationwide.[66] In California, over 100,000 residents are in nursing homes and, as the senior population is expected to triple in the next 40 years, nursing home capacity will need to expand considerably. Currently, Medi-Cal is the primary payer for 67% of California nursing home residents and spends $13.7 billion annually on long term care, accounting for nearly one-third of all Medi-Cal expenditures.[67]

The growing cost pressures of long term institutional care are daunting. One study suggests that the Medicaid expenditures needed to support one adult in a nursing home are almost enough to support three adults with physical disabilities through HCBS.[68] Fostering opportunities to provide HCBS-supported care options continues to be attractive both in terms of potentially reducing Medi-Cal costs around institutional stays, and for patient satisfaction and quality of life. However, these HCBS options present their own challenges: they require considerable up-front investment, are resource-intensive, and can instigate the "woodwork effect" where families currently taking care of family members may move dependents into new HCBS programs, further driving up costs. Thus, while participation in ACA long term care programs could allow Medi-Cal to increase patient care options by leveling the playing field between institutional and home-based services, the programs need to be considered carefully. A list of long term care demonstrations and state plan options is provided in Appendix C.

# V. Transparency Provisions

ACA CONTAINS BOTH GENERAL TRANSPARENCY provisions and requirements specific to individual programs and demonstrations. This discussion focuses on ACA's transparency and reporting requirements linked to specific payment and delivery system provisions. These requirements are quite detailed and include: reporting of financial performance and program expenditures; quality of care, process, and outcome measures; patient experience and patient safety provisions; and other components. Much of the reported data will be posted on publicly available websites such as CMS's Hospital Compare, where the data can be used to identify higher- or lower-performing institutions on a range of measures, such as hospital-associated infection rates and readmission rates.[69] Reported data may also be used to determine reimbursement, as is the case in the proposed MSSP ACO program.

While many ACA initiatives contain transparency provisions to track changes in cost and quality, a framework for collectively using these data to support meaningful policy and purchaser decisionmaking has not been defined and could significantly advance beneficiary, purchaser, and public policy changes. Federal and state websites posting these data are helpful, but unless the data are actionable and incorporated into purchaser and policy decisionmaking, the full utility of publicly reported measures will not be realized.

## A. Transparency Components of ACA Payment and Care Delivery Programs

The transparency requirements associated with each individual ACA program tend to be focused on reporting quality, utilization, and financial information. Examples include:

- The Independence at Home Demonstration Program requires participating entities to report quality measures to the HHS Secretary. These measures will be incorporated into program evaluations and reports to Congress that provide an analysis of the program's impact on care coordination, expenditures, access to services, and service quality.
- The Hospital Value-Based Purchasing program requires hospitals to report results of each performance measure, and must also report outcomes, clinical processes of care, patient experience, hospital-acquired conditions, and patient safety measures.
- The Medicare Shared Savings Program and Pioneer ACO demonstrations have extensive reporting requirements described in initial federal guidance, including 65 quality measures. ACOs would also provide organizational information regarding provider participation, governing body representatives, leadership, financial information, and distribution of shared savings among participants. Total payments to ACOs would also be based on publicly reported quality and outcome measures.
- Other programs with transparency components include: Pay-for-Performance and Payment Bundling Pilots; Patient-Centered Medical Home and Community Transformation demonstrations; Medicare Payment Adjustment for Hospital-Associated Infections (and for potentially preventable hospital readmissions); among others.

## B. Developing a Cohesive Transparency and Information Framework

The substantial reporting requirements contained within ACA will be layered on top of existing state and federal reporting requirements, some of which will likely need to be brought into alignment to reduce administrative burdens to hospital and provider organizations and encourage their participation. Aligning state and federal reporting requirements would also allow these institutions to devote more resources to resolving quality and patient safety issues identified through public reporting.

Some of the existing reporting requirements upon which ACA's requirements will be layered include:

- Voluntary reporting efforts for hospitals under CHART, a publicly available hospital quality "report card." Currently, more than 240 hospitals representing 86% of California's daily census participate in the program.[70]
- OSHPD-required data from health facilities who must report: quarterly summary financial and statistical data under Section 12874 of the Health and Safety Code; hospital charges; and fair pricing and charity care policies, among others.[71, 72]
- New CDPH reporting programs as a component of licensing and certification, including requirements for publicly reporting surgical site infections (SSIs) under Health and Safety Code 1288.55.[73]

State policymakers and program staff should consider how to effectively integrate the significant quantity of data that will be generated under these programs into the existing state reporting framework. For example, OSHPD and CDPH should assess their current reporting requirements, perform gap analyses comparing their requirements with existing and emerging ACA (and other federal) programs, and develop a roadmap to align reporting processes with the federal government. If this is not done, reporting compliance, accuracy, and completeness will suffer as institutions stretch resources to meet state and federal mandates, and fewer entities may decide to participate in optional care redesign and alternative reimbursement programs that add to their reporting burden.

Information generated by programs such as the Medicaid Health Home State Plan Option, or the state's 1115 waiver programs should also be considered. Making these data available to conduct analyses and research would support better assessment of programs and participants, inform policy decisions, and promote successful implementations that may be worth replicating broadly. Using them to drive decisions regarding participation in qualified health plans, value-based purchasing, insurance design, and incentive programs would likely drive significant improvements in outcomes and processes associated with publicly reported measures.

Individually, ACA requirements can provide useful information to help guide program development and document meaningful changes (or failures) associated with each program. Collectively, these provisions could be used to package data into useful and actionable information, guiding employer and individual purchasing decisions through California's health benefit exchange, and contributing to value-based insurance designs.

# VI. Observations and Conclusions

ACA's patchwork quilt of delivery reform pilots and the "building block" approach outlined by the federal government provides important levers and experiments to test and learn from. However, California cannot rely on ACA alone to resolve longstanding cost and quality problems in the health care delivery system. The state will need to create and align policies and programs designed to increase efficiencies and stabilize costs through a mix of alternative reimbursement models and care delivery reform approaches.

Other conclusions include the following:

- Mandatory ACA reimbursement changes will have a significant impact on hospital systems, squeezing margins and accelerating both cost-shifting onto the commercial market and vertical and horizontal consolidation. Safety-net hospitals in particular will be less able to shift costs to commercial payers due to their payer mix. Consequently, they may find their financial position jeopardized and be faced with reducing or eliminating services at a time when demand for them is expected to increase under federal health reform. Policymakers will have to carefully consider policy options, both with respect to premium pressures in the commercial market, and financial problems that many safety-net hospitals will face.
- ACA's demonstration programs and pilots to improve care delivery are patchwork in nature and fall short of a comprehensive, permanent package of health care delivery reform efforts. While this is largely attributable to the limitations of the legislation, the likely result will be a set of demonstrations that point toward needed outcomes, without a policy mechanism for moving the entire industry toward the needed end goal of generating better health care with less money.
- Much of the burden to reduce costs and improve care in the Medicaid program will be borne by managed care plans, which will be increasing their enrollments under both ACA and the Bridge to Reform 1115 waiver. Growing pressure on California lawmakers to make additional cuts in state spending, and on federal policymakers to reduce the federal deficit may result in further cuts to entitlement programs such as Medicaid. These ACA initiatives will therefore require significant policy, financial, and programmatic support if they are to enable the kinds of reforms envisioned by the state and federal government.
- California's decades-long experiment with managed care also raises the question as to what makes ACA and its myriad demonstrations different this time around. With the less-than-enthusiastic reception by providers and hospitals to the federal ACO program, state policymakers should consider how they can foster greater accountability for coordinating care and containing costs across settings, and supporting broader adoption of shared-savings arrangements in the private health insurance market and in Medi-Cal. California policymakers can learn both from other states that will be requiring Medicaid enrollment into their state-based accountable care organizations, and from commercial ACO-like demonstrations currently underway, and should consider how California-ACO models might be broadly rolled out in public coverage programs.

- Finally, while many ACA initiatives contain transparency provisions to track changes in cost and quality, a framework for collectively using these data to support meaningful policy and purchaser decisionmaking has not been defined. To truly drive value-based purchasing and insurance design, pressure in the FFS Medicare program in the form of payment reductions needs to coincide with pressure on commercial purchasing. A cohesive transparency framework that transforms data into actionable information for better decisionmaking would support purchasing decisions such as those made in health benefit exchanges, driving value-based purchasing and insurance design through the exchange.

To maximize the likelihood and impact of lasting reform, state policymakers and program leaders should take full advantage of the demonstrations under ACA, the Bridge to Reform 1115 waiver, and commercial efforts; study their impact; and consider how successful initiatives can be instituted in state-supported coverage programs. To do so will require careful attention to the needs, limitations, and resources of Medi-Cal managed care organizations, safety-net hospitals, clinics, and others who provide the majority of care for California's safety-net populations. Ultimately, the burden — and opportunity — of health reform under ACA may fall to providers and hospitals to navigate the landscape and support real and lasting changes to how Californians pay for and receive health care.

## Appendix A: List of Interviews

### FEDERAL GOVERNMENT

Melanie Bella, Director, Federal Coordinator Care Office (Duals Office), Centers for Medicare and Medicaid Services

Richard Gilfillan, head of CMS Innovation Center, and a former head of the Geisinger Health Plan in Pennsylvania

Jim Hester, Senior Advisor to CMS Innovation Center

### STATE GOVERNMENT

Toby Douglas, Medi-Cal Director, California Department of Health Care Services

David Maxwell-Jolly, Undersecretary, California Health and Human Services Agency

### CALIFORNIA STAKEHOLDERS AND THOUGHT LEADERS

Duane Dauner, President and CEO, California Hospital Association

Jay Gellert, CEO, Health Net

Howard Kahn, CEO, L.A. Care Health Plan

Ralph Silber, CEO, Community Health Center Network

Wright Lassiter, CEO, Alameda County Medical Center

Arnold Millstein, Director, Clinical Excellence Research Center

## Appendix B: Center for Medicare and Medicaid Innovation Initiatives

The following table lists Innovation Center initiatives implemented as of June 2011.

| INITIATIVE | DESCRIPTION |
|---|---|
| The Partnership for Patients | The Partnership for Patients is a public-private partnership that aims to support physicians, nurses, and other clinicians working in and out of hospitals to make patient care safer and to support effective transitions of patients from hospitals to other settings.<br><br>The two goals of the new partnership are to decrease preventable hospital-acquired conditions by 40% by 2013 (as compared to 2010 numbers) and to decrease overall hospital readmissions by 20% by 2013. CMS estimates achieving these goals could save up to $35 billion across the health care system, including up to $10 billion in Medicare savings, over the next three years. |
| Hospital Engagement Contractors | The Partnership for Patients will contract with large health care systems, associations, state organizations, or other interested parties to support hospitals in the hard work of redesigning care processes to reduce harm. "Hospital Engagement Contractors" will be asked to conduct the following:<br>• Design intensive programs to teach and support hospitals in making care safer.<br>• Conduct trainings for hospitals and care providers.<br>• Provide technical assistance for hospitals and care providers.<br>• Establish and implement a system to track and monitor hospital progress in meeting quality improvement goals. |
| State Demonstrations to Integrate Care for Dual-Eligible Individuals (contracts awarded) | The overall goal of the State Demonstrations to Integrate Care for Dual-Eligible Individuals is to identify and validate delivery system and payment integration models that can be rapidly tested and, upon successful demonstration, replicated in other states. In April 2011, CMS awarded contracts to up $1 million each to 15 states to develop a demonstration proposal around how the state will structure, implement, and evaluate a model aimed at improving the quality, coordination, and cost-effectiveness of care for dual-eligible individuals. |
| Federally Qualified Health Center (FQHC) Advanced Primary Care Demonstration Projects | Applications from eligible FQHCs for the FQHC Advanced Primary Care Demonstration project were due September 9, 2011. This demonstration project, operated by CMS in partnership with the Health Resources Services Administration (HRSA), will test the effectiveness of doctors and other health professionals working in teams to improve care for up to 195,000 Medicare patients. The FQHC Advanced Primary Care Practice demonstration will show how the patient-centered medical home model can improve quality of care, promote better health, and lower costs. |
| Multi-Payer Advanced Primary Care Practice Demonstration (pre-ACA; contracts awarded) | Eight states were selected to participate in a demonstration project to evaluate the effectiveness of doctors and other health professionals across the care system working in a more integrated fashion and receiving a common payment method from Medicare, Medicaid, and private health plans.[74] |
| Medicaid Health Home State Plan Option | This new state plan option allows patients enrolled in Medicaid with at least two chronic conditions to designate a provider as a "health home" to help coordinate treatments for the patient. States that implement this option will receive enhanced financial resources from the federal government to support "health homes" in their Medicaid programs. The Innovation Center will be assisting with learning, technical assistance, and evaluation activities. |
| Pioneer Accountable Care Organizations Model | The Pioneer ACO Model is designed to allow organizations with advanced care coordination and capitated payment experience to rapidly test an ACO model. Pioneer ACO participants must have 15,000 Medicare beneficiaries assigned to them. Participating entities are eligible for both shared savings and shared losses in all three years of the program. Eligibility for shared savings will be based on performance on a set of 65 quality measures (quality reporting requirements mirror those in the Medicare Shared Savings Program (MSSP)). Participants are required to enter into pre-paid population-based reimbursement arrangements. By the third year, these ACOs are expected to generate a majority of their total revenue from outcomes-based payment arrangements. At this time, Medicare FFS payments will be reduced to 50% with per-beneficiary per-month payments covering the rest of estimated payments. CMS may use findings from the Pioneer ACO Model to inform the MSSP. |

| INITIATIVE | DESCRIPTION |
|---|---|
| Bundled Payments for Care Improvement Initiative | The Bundled Payment for Care Improvement initiative will test episode-based payment for acute care and associated post-acute care, using both retrospective and prospective bundled payment methods. Participating providers will have a degree of flexibility in selecting conditions to bundle, developing the health care delivery structure, and determining how payments will be allocated among participating providers. Applicants propose a target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models would be paid for their services under the traditional FFS system; after the conclusion of the episode, the total payments would be compared with the target price. Participating providers may then be able to share in those savings. |
| ACO Advance Payment Initiative (proposed) | The Innovation Center is currently considering an Advance Payment Initiative for those ACOs entering the Medicare Shared Savings Program to test whether and how pre-paying a portion of future shared saving could increase participation in the Medicare Shared Savings Program. |

## **Appendix C:** Funding Opportunities to Promote Payment and Delivery System Innovation

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
|---|---|---|---|---|---|
| **a. Medicare Care Delivery and Payment Reforms** | | | | | |
| Section 3001<br>Hospital Value-Based Purchasing Program (Medicare) | Establishes a program under which value-based incentive payments are made in a fiscal year to acute care hospitals that meet a set of performance standards across a fiscal year.<br>Performance measures will cover at least the following five specific conditions or procedures: acute myocardial infarction (AMI); heart failure; pneumonia; surgeries, as measured by the Surgical Care Improvement Project; and hospital-associated infections. | The program aims to be budget neutral or to promote cost savings.<br>Incentives are paid from a reduction in DRG payment for all hospitals. | October 1, 2012. | CMS promulgated final regulations on April 29, 2011. | California public hospitals with the exception of most UC facilities are less likely to have adopted EHRs than other hospitals—they likely will be challenged to meet requirements which will result in DRG reductions from Medicare. |
| Section 3007<br>Value-based payment modifier under the physician fee schedule | Mandates development and implementation of a budget-neutral payment system to adjust the Medicare physician fee schedule based on the quality and cost of the care they deliver. | Budget neutral. | Phased in over two years beginning in 2015. | CMS issued final regulations on November 29, 2010. | |
| Section 3008<br>Medicare Payment Adjustment for Hospital-Acquired Conditions (Medicare) | Mandates a Medicare payment adjustment for hospital-acquired conditions. Hospitals in the top 25th percentile of rates of hospital-acquired and other high-cost and common conditions will face Medicare penalties. | The program aims to be budget neutral or promote cost savings. The CMS Office of the Actuary estimates $3.2 billion in Medicare savings from through 2019. | October 1, 2014. | | |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **a. Medicare Care Delivery and Payment Reforms (cont.)** | | | | | |
| **Section 3022**<br>Medicare Shared Savings Program ("Accountable Care Organizations") | Allows providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the costs savings they achieve in the Medicare program.[75] This new category of Medicare contactors will be able to contract with CMS to share in the Medicare savings which result from using new patient care models that coordinate care, particularly for beneficiaries with chronic conditions, or those using an episode-based approach to managing health care services, including the important transitions from hospitals to nursing home or home-based care with community support. | The program aims to be budget neutral or to promote cost savings.<br>Providers are paid standard Medicare fee-for-service rates but have the opportunity to share in savings and/or losses. | No later than January 1, 2012. | A Notice of Proposed Rulemaking was issued April 7, 2011. The comment period closed June 6, 2011. | The DMHC Financial Solvency Standards Board is currently considering how it may regulate ACOs in their various forms.<br>Medi-Cal pediatric ACO could be formed to support high-need pediatric population.<br>Medi-Cal managed care organizations could help drive adoption, but need to consider alignment with current market offerings and proposed federal ACO requirements. |
| **Section 3025 (as modified by Section 10309)**<br>Medicare Payment Adjustment for Acute Care Hospitals (Medicare) | Mandates a Medicare payment adjustment for hospitals paid under the inpatient prospective payment system (IPPS) for potentially preventable readmissions for conditions with risk-adjusted readmission measures that are currently endorsed by the National Quality Forum. | This provision is intended to produce savings.<br>The CMS Office of the Actuary estimates $8.2 billion in Medicare savings from 2013 to 2019. | October 1, 2012. | CMS issued final regulations on August 18, 2011. | The majority of California public hospitals and almost all non-UC public hospitals have worse than average readmission rates. While Medicare typically represents 10% to 15% of business, financial penalties could be substantial enough to warrant action to support better discharge planning and care coordination responses. |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **a. Medicare Care Delivery and Payment Reforms (cont.)** | | | | | |
| Section 5501 (as modified by Section 10501)<br><br>10% Medicare Bonus Payment for Primary Care (Medicare)<br><br>10% Medicare Bonus for Some Surgical Procedures (Medicare) | 10% Medicare bonus payment for primary care services (office and other outpatient visits) furnished by primary care physicians, nurse practitioners, clinical nurse specialists, and physician assistants, provided at least 60% of their Medicare-allowed charges in a prior period were for primary care services.[76]<br><br>10% Medicare bonus for major surgical procedures for general surgeons providing care in health professional shortage areas.[77] | Paid for through Medicare.<br><br>The CMS Office of the Actuary estimates that this provision will cost $1.3 billion from 2010 to 2019. | January 1, 2011 through December 31, 2015. | CMS issued final regulations on November 29, 2010. | Approximately 1.6 million of California's 4.6 million Medicare beneficiaries are enrolled in Medicare Advantage plans; bonus calculations do not include charges for services provided under Medicare Advantage. |
| **b. Medicare Pilots and Demonstrations** | | | | | |
| Section 3021: Innovation Center<br><br>Pioneer ACO | The Pioneer ACO Model is designed to allow organizations with advanced care coordination and capitated payment experience to rapidly test an ACO model. Participants will receive standard Medicare FFS rates for the first two years and are eligible for both shared savings and losses in all three years of the program. In the third year, Medicare FFS payments will be reduced to 50% with per-beneficiary per-month payments covering the rest of estimated payments. | Funded through the Innovation Center.<br><br>The program is intended to be budget neutral or generate savings. CMS estimates the program may save up to $430 million over three years. | The deadline for final applications was August 19, 2011.<br><br>CMS intends to implement the program in Q3/Q4 of 2011. | CMS issued a Request for Applications on May 17, 2011. | Prevalence of capitation and emerging commercial ACO pilots in the state should support demonstrations in California and allow providers and hospitals to meet payer participation requirements. |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **b. Medicare Pilots and Demonstrations (cont.)** | | | | | |
| Section 3021: Innovation Center<br><br>Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration | This demonstration will test whether payment of a monthly care coordination fee assists participating FQHCs in providing and expanding the delivery of continuous, comprehensive, and coordinated primary health care. | Funded through the Innovation Center.<br><br>CMS estimates it will pay $42 million to up to 500 FQHCs over three years. | Applications were accepted through September 9, 2011. | CMS issued a Request for Applications on June 6, 2011. | The APCP's focus on Medicare patients might be a challenge for many California clinics, whose patient mix is predominantly Medi-Cal, indigent, or uninsured. Recently funded health home initiatives under the California Endowment should support increased participation. |
| Section 3021: Innovation Center<br><br>Bundled Payments for Care Improvement Initiative | The Bundled Payment for Care Improvement initiative will test episode-based payment for acute care and associated post-acute care, using both retrospective and prospective bundled payment methods. | This provision is intended to generate cost savings. | CMS anticipates that the program will launch in early 2012. Participants will have a three-year performance period with the possibility of extending for an additional two years. | CMS issued an application and guidance on August 23, 2011. | |
| Section 3023<br><br>National Pilot Program on Payment Bundling (Medicare) | Establishes a voluntary pilot program to test and evaluate Medicare Part A and Part B payment bundling methodologies for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization. The program aims to improve the coordination, quality, and efficiency of health care services. The HHS Secretary will establish eight applicable medical conditions for the program plus required quality measures. | This provision is intended to be budget neutral. | No later than January 1, 2013. | | California providers are participating in a number of non-Federal bundled payment pilots, the results of which should help inform potential policy and program implications for the Medi-Cal program. |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **b. Medicare Pilots and Demonstrations (cont.)** | | | | | |
| Section 3024<br><br>Independence at Home Demonstration Program (Medicare) | Establishes a Medicare demonstration program to test a payment incentive and service delivery model that utilizes physician- (primarily primary care physicians) and nurse practitioner-directed home-based primary care teams designed to reduce expenditures and improve health outcomes for applicable beneficiaries (beneficiaries who have two or more chronic illnesses, a nonelective hospital admission within the past 12 months, previous acute or subacute rehabilitation services, and two or more functional dependencies). | Transfer from the Medicare Part A and B Trust Funds.<br><br>$5 million per year for FYs 2010 through 2015.<br><br>Participating entities may share in savings in excess of 5%. | No later than January 1, 2012, for a period of up to three years. | | Medicare Advantage and PACE plans are excluded, which will limit participation by some California providers. |
| Section 3026<br><br>Community-Based Care Transition Program | This demonstration program provides funding to test models for improving care transitions for high-risk Medicare fee-for-service beneficiaries. The goals of the program are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measureable savings to the Medicare program. | Transfer from the Medicare Part A and B Trust Funds.<br><br>$500 million for FYs 2011 to 2015. | Program launched April 12, 2011. | CMS issued a Solicitation for Applications on April 12, 2011. | Local governmental area agencies on aging may be eligible to apply as CBOs. |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **b. Medicare Pilots and Demonstrations (cont.)** | | | | | |
| Section 3140<br>Medicare Hospice Concurrent Care Demonstration Program | This demonstration program authorizes the HHS Secretary to allow Medicare beneficiaries in up to 15 sites to receive hospice services as well as other Medicare services at the same time for up to three years. | The program is intended to be budget neutral. | Not specified. | | |
| Section 3510<br>Patient Navigator Program (Medicare) | Reauthorizes demonstration programs to provide patient navigator services within communities to assist patients overcome barriers to health services with an emphasis on Medicare beneficiaries with chronic conditions. | $3.5 million appropriated for FY 2010, and such sums as may be necessary for each of FYs 2011 through 2015. | FY 2010. Total grant period must not exceed four years. | The grant application was released May 11, 2010. Applications were due June 18, 2010. | Northeast Valley Health Corporation in San Fernando, California received one of six patient navigator grants in 2008. |
| Section 10326<br>Pilot Testing Pay-for Performance Program for Certain Providers (Medicare) | Directs the HHS Secretary to conduct separate pilot programs for inpatient rehabilitation facilities, inpatient psychiatric hospitals, long term care hospitals, PPS-exempt cancer hospitals, and hospice providers to test the implementation of a value-based purchasing program. | This provision is intended to be budget neutral. | No later than January 1, 2016. | | |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **c. Medicaid Care Delivery and Payment Reforms** | | | | | |
| Section 2702<br><br>Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions | States cannot receive federal match to reimburse Medicaid providers for hospital-acquired conditions specified in the regulation. States may expand the list of applicable provider-preventable conditions for which Medicaid payment will be prohibited. | CMS estimates that the impact of the rule will be a net $2 million in savings for FY 2011 ($1 million for the federal share and $1 million for the state share), with an aggregate federal cost savings of $46 million for FYs 2011 through 2019. | July 1, 2011; however, CMS will not enforce compliance until July 1, 2012. | CMS issued final regulations on June 6, 2011. | The state will need to submit a state plan amendment to implement these provisions.<br><br>The state/OSHPD may need to build a provider reporting system capable of meeting program requirements. |
| Section 2703<br><br>Medicaid State Plan Option to Provide Health Homes for Chronically Ill Patients | This program provides states the option to offer health home services to eligible individuals with chronic conditions who select a designated health home provider. The chronic conditions include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight. Medicaid beneficiaries participating in the health home must have at least two chronic conditions, one chronic condition and be at risk for another, or one serious and persistent mental health condition. | Health home services are reimbursed at 90/10 Federal match for the first eight quarters of the state's health home program.<br><br>The CMS Office of the Actuary estimates that federal costs will be approximately $1.1 billion from 2010 to 2019. | Available beginning January 1, 2011. | CMS issued a State Medicaid Director Letter on November 16, 2010. | California needs to submit a state plan amendment to implement this provision. California should consider whether an existing health home, disease management, or targeted case management program would be eligible to transfer under this provision, thus drawing a higher FMAP rate for the first eight quarters. |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **c. Medicaid Care Delivery and Payment Reforms (cont.)** | | | | | |
| Section 1202 (of the Health Care and Education Reconciliation Act)<br><br>Medicaid Reimbursement for Primary Care | Requires states to pay physicians for primary care services (evaluation and management services (E/M) and immunization administration) furnished in 2013 and 2014 at a rate that is no less than 100% of the Medicare payment rate. (If greater, the Medicare payment rate in effect in 2009 is to be used.)<br><br>Medicaid managed care plans must make payments to physicians consistent with these minimum payment rates, regardless of the manner in which payments are made by the plans, including capitation payments.<br><br>Limited to physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine. | Funding appropriated.<br><br>For services furnished in calendar years (CYs) 2013 and 2014,100% federal funding for the difference between the payment rates required under this provision and the level of payment in effect on July 1, 2009.<br><br>Regular federal matching applies for any payment amounts above the minimum requirement. | January 1, 2013 through December 31, 2014. | | California will need to determine whether it can leverage the federally funded increased reimbursement to expand its provider network.<br><br>Since the enhanced FMAP will expire at the end of CY 2014, California will need to determine whether it will continue to reimburse Medicaid primary care providers for these procedures and services at the enhanced rate and assume the state's share of these additional costs in CY 2015 and beyond. |
| **d. Medicaid Pilots and Demonstrations** | | | | | |
| Section 3021: Innovation Center<br><br>Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees | CMS is interested in testing two payment models for states interested in integrating primary, acute, behavioral health, and long term services and supports for their dual-eligible population:capitation and managed fee-for-service (FFS). | States can share in savings. | Letter of intent was due October 1, 2011.<br><br>Expected Implementation date: Late 2012. | CMS released a State Medicaid Director letter on July 8, 2011. | California must determine whether it is interested in testing either or both financial models. To apply, California must first submit a Letter of Intent and subsequently work with CMS to determine whether it meets established criteria. |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **d. Medicaid Pilots and Demonstrations (cont.)** | | | | | |
| Sectin 3021: Innovation Center<br><br>Improving Readmission Rates for Dual Eligible Nursing Home Residents | CMS is interested in working with independent organizations to partner with interested nursing facilities. The organizations would work with nursing homes to test interventions such as using nurse practitioners in nursing facilities, supporting transitions between hospitals and nursing facilities, and implementing best practices to prevent falls, pressure ulcers, urinary tract infections, or other events that lead to poor health outcomes and expensive hospitalizations. | Unknown. | Fall 2011. | | Process for participation is still under development. |
| **e. Grants and Contracts** | | | | | |
| Section 3021: Innovation Center<br><br>State Demonstrations to Integrate Care for Dual-Eligible Individuals | The overall goal of this initiative is to identify and validate delivery system and payment integration models that can be rapidly tested and, upon successful demonstration, replicated in other states. The primary outcome of the initial design period will be a demonstration proposal that describes how the state would structure, implement, and evaluate a model aimed at improving the quality, coordination, and cost-effectiveness of care for dual-eligible individuals. | $15 million.<br><br>$1 million contracts awarded to 15 states each: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. | 12 months from the date of the signed contract between CMS and the state (April or May 2011, depending on the state). | CMS issued the solicitation in December 2010. Awardees were announced in April 2011. | California received a $1 million grant to design a demonstration proposal. |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **e. Grants and Contracts (cont.)** | | | | | |
| Section 3021: Innovation Center<br><br>Hospital Engagement Contractors | The Innovation Center seeks entities to provide technical assistance to hospitals to improve the quality of care. Eligible applicants include large systems, associations, state organizations, and other interested parties. The selected entities, known as hospital engagement contractors (HECs), will design and conduct various types of training events (e.g., webinars, meetings, conferences) for hospitals. The trainings will focus on developing and evaluating quality improvement projects. The HECs are encouraged to target the 10 areas of focus of the Partnership for Patients but can also target additional conditions. | $500 million through the Partnership for Patients. | June 22, 2011. | CMS issued a Solicitation for Proposals on June 22, 2011. | California should assess whether any state institutions should seek technical assistance. |
| Section 4201 (as modified by Section 10403)<br><br>Community Transformation Grants (CTGs) | Establishes a competitive grant program for states and other eligible entities, including national networks of community-based organizations (CBOs), to promote individual and community health and prevent the incidence of chronic disease. Programs can focus on weight issues and obesity, tobacco use, mental illness, or other activities that are consistent with the goals of promoting healthy communities. | Discretionary program.<br><br>$900 million is available through the Prevention and Public Health Fund (appropriated). | FYs 2010 to 2014. | The Centers for Disease Control issued a Request for Applications in May 2011. Applications were due July 15, 2011. | States, as well as state-designated entities, local governments, nonprofit organizations, and others are eligible to apply. The list of California entities that filed Letters of Intent to apply can be found on the CDC website. |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **e. Grants and Contracts (cont.)** | | | | | |
| National Dissemination and Support for Community Transformation Grants (CTGs) | Grant funding for national networks of CBOs. These national networks will support the efforts of the CTG program by funding national networks of community-based organizations to disseminate and provide for the replication of successful program models and activities.<br><br>National networks of CBOs with activities in at least 85% of U.S. states and territories are eligible to apply. Minority-serving organizations that have local affiliates and chapters in at least four states and have the ability to reach at least 30% of their selected racial and ethnic population are also eligible to apply for funding. | Discretionary program.<br><br>$4.2 million annually for five years.<br><br>Funded through the Prevention and Public Health Fund. | FYs 2011 to 2016. | The Centers for Disease Control issued a Request for Applications in June 2011. Applications were due July 22, 2011. | In some cases, there are opportunities for sub-recipient funding to local communities. |
| Section 5604<br><br>Co-Locating Primary and Specialty Care | Authorizes grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings. | $50 million was authorized for FY 2010. Sums deemed necessary are authorized for FYs 2011 to 2014. | FYs 2010 to 2014. | Grants were awarded on September 24, 2010. | The following entities in California received grants: Alameda County Behavioral Health Care Services, Asian Community Mental Health Board, County of San Mateo, Glenn County Health Services Agency, and Tarzana Treatment Centers Inc. |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **f. Programs Authorized but Not Appropriated** | | | | | |
| Section 2704<br>Integrated Care Around a Hospitalization (Medicaid) | This demonstration program will test whether a bundled payment for integrated care around a hospitalization, including physician services, improves quality and reduces expenditures. | No funds have been appropriated. | No later than January 1, 2012. | | |
| Section 2705<br>Medicaid Global Payment System Demonstration Project | This demonstration project will allow up to five participating states to adjust their current payment structure for safety-net hospitals from a fee-for-service model to a global capitated payment structure. | Funds as necessary to operate the program were authorized but not appropriated. | FY 2010 to FY 2012. | | |
| Section 2706<br>Pediatric Accountable Care Organization Demonstration Project | This demonstration project will allow qualified pediatric providers to be recognized and receive payments as accountable care organizations (ACOs) under Medicaid. The pediatric ACO would be required to meet certain performance guidelines. | Funds as necessary to operate the program were authorized but not appropriated.<br>Participating entities will be eligible for shared savings. | January 1, 2012 to December 31, 2016. | | While CMS has yet to launch this program, California is considering using 1115 waiver authority to create pediatric ACOs to support high-need children with complex conditions. DHCS has initiated a Request for Proposal process to assess potential pediatric ACO participants for the California Children's Services program. |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **f. Programs Authorized but Not Appropriated (cont.)** | | | | | |
| Section 3502 (as modified by Section 10321)<br><br>Community Health Teams to Support the Patient-Centered Medical Home | CMS would provide grants or contracts to eligible entities to establish community-based interdisciplinary, inter-professional teams (''health teams'') to support primary care practices providing care to beneficiaries with chronic conditions. Participating providers will be reimbursed through capitated payments. Eligible entities include a state, a state-designated entity, or an Indian tribe or tribal organization. | Discretionary program; no funds have been appropriated. | Undetermined. | | In order to participate in the program, the state must submit an application to the HHS Secretary, and meet federal requirements. Alternatively, the state may designate a state-designated entity to act on its behalf. |
| Section 3503<br><br>Grants to Implement Medication Management Services in Treatment of Chronic Disease | This section establishes a grant program for eligible entities to implement medication management services provided by licensed pharmacists, as a collaborative, multidisciplinary, inter-professional approach for the treatment of chronic diseases for targeted individuals. The goal is to improve the quality of care and reduce overall costs in the treatment of such diseases. Participation requires an annual comprehensive medication review by a licensed pharmacist or other qualified provider and follow-up interventions. | Funds have not been appropriated. | No later than May 1, 2010. | | |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **g. Long Term Care Provisions (Options for State Medicaid Programs)** | | | | | |
| Section 2401<br>Medicaid Community First Choice Option | State plan amendment option to provide coverage of home- and community-based attendant services and supports, such as assistance to accomplish activities of daily living, to those who meet the state's nursing facility clinical eligibility standards. | 6% FMAP increase. The CMS Office of the Actuary estimates federal expenditures of $23.5 billion from 2010 to 2019. | October 1, 2011. | CMS issued proposed regulations on February 25, 2011. | California would need to submit a state plan amendment to offer these services. |
| Section 2402<br>Home- and Community-Based Services State Plan Options | Simplify provision of home- and community-based services through a state plan option rather than pursuing more onerous Federal waiver authority. Provides a full range of Medicaid services to individuals whose income does not exceed 300% of the Supplemental Security Income (SSI) standard. | Regular match rate.<br>The CMS Office of the Actuary estimates federal expenditures of $1.6 billion from 2010 to 2019. | April 1, 2010. | CMS issued a State Medicaid Director Letter August 6, 2010 (SMDL # 10-015). | California currently offers HCBS services through a waiver. California could take advantage of the state plan option under 1915(i) to provide HCBS services to individuals eligible for waiver coverage up to 300% FPL. California would need to revise the state plan via an amendment. |
| Section 2403<br>Medicaid Money Follows the Person (MFP) Rebalancing Demonstration | Demonstration established through the Deficit Reduction Act of 2005 (P.L. 109-171) to reduce reliance on institutional care and develop community-based systems of care. The ACA modifies eligibility rules to require that individuals reside in an inpatient facility for not less than 90 days. | $450 million in new money was appropriated for each year from FY 2011 to 2016. The CMS Office of the Actuary estimates federal expenditures of $2.25 billion from 2010 to 2019.<br>In February 2011, 13 states were awarded more than $45 million in MFP grants to start the program, with a total of $621 million committed through 2016. | April 22, 2010. | CMS issued a State Medicaid Directors Letter June 22, 2010.<br>An Invitation to Apply was released July 26, 2010. | California is one of 43 states currently participating in the MFP Rebalancing Demonstration. |

| SECTION/TITLE | OVERVIEW | FEDERAL FUNDING | EFFECTIVE DATE | REGULATIONS PROMULGATED | CALIFORNIA ALERT |
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| **g. Long Term Care Provisions (Options for State Medicaid Programs) (cont.)** | | | | | |
| Section 10202(a)<br>Balancing Incentive Payments Program | Expands and diversifies Medicaid coverage for home- and community-based long term services and makes structural changes to improve coordination and access to such services. Creates new financial incentives for states to shift Medicaid beneficiaries out of facilities and into HCBS. | 2% to 5% FMAP increase.<br>Allocates up to $3 billion for Medicaid home- and community-based services, which align with CMS actuarial estimates of $3 billion in federal expenditures from 2010 to 2019. | October 1, 2011 through September 30, 2015. | | California will need to assess whether it is eligible for the program (spends less than 50% of its long term care spending on HCBS services). With its history of participation and investments in HCBS initiatives, California will likely not meet the required threshold. |

Sources:
Patient Protection and Affordable Care Act (P.L. 111-148) and Modifications by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).
The Scan Foundation, Policy Brief No. 2, March 2010.
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Note: Blue-shaded programs have not yet been appropriated funding.

## Endnotes


1. Peter Long and Jonathan Gruber, "Projecting The Impact Of The Affordable Care Act On California," *Health Affairs*, January 2011.

2. California HealthCare Foundation, "What Will Federal Health Reform Mean to Californians?" March 2010 (www.chcf.org).

3. Centers for Medicare and Medicaid Services, *Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended,* April 22, 2010 (www.cms.gov).

4. Melinda Dutton and Alice Lam, *Implementing National Health Reform in California: Opportunities for Improved Access to Care,* March 2011; and William Bernstein, Patricia Boozang, Paul Campbell, Melinda Dutton, and Alice Lam, *Implementing National Health Reform in California: Changes to Public and Private Insurance,* June 2010 (www.chcf.org). Both reports prepared for California HealthCare Foundation by Manatt Health Solutions.

5. Cattaneo & Stroud, *2010 Update, HMO & Medical Group Activity in California, 2004-2010*, August 2011 (www.cattaneostroud.com).

6. California HealthCare Foundation, *California Health Care Almanac: California Health Plans and Insurers*, October 2010 (www.chcf.org).

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10. Ibid. Totals may not add to 100% due to rounding.

11. Ibid.

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12. The Kaiser Family Foundation website, State Health Facts (www.statehealthfacts.org).

13. California Office of Statewide Health Planning and Development (OSHPD), 2007.

14. Observations from interviews conducted as part of this report.

15. CalPERS, "Integrated Health Care Pilot Exceeds Expectations," news release, April 12, 2011 (www.calpers.ca.gov).

16. William Bernstein, Jonah Frohlich, Francis LaPallo, Arun Patel, and Martin Thompson, *Accountable Care Organizations in California: Programmatic and Legal Considerations*, California HealthCare Foundation report prepared by Manatt Health Solutions, July 2011 (www.chcf.org).

17. Cope Health Solutions, *Regional Safety Net Accountable Care Network*, April 2011 (www.copehealthsolutions.org).

18. California Department of Health Care Services, *California Bridge to Reform: A Section 1115 Waiver Fact Sheet*, November 2010 (www.dhcs.ca.gov).

19. California HealthCare Foundation website, CalHospitalCompare.org (www.calhospitalcompare.org).

20. State of California, Department of Health Care Services, Notice to Prospective Proposers, in Request for Proposals Number 11-88024, "California Children's Services Demonstration Projects," April 19, 2011 (www.dhcs.ca.gov).

21. The measures included in the policy must represent high-volume and high-cost conditions, and be endorsed by the National Quality Forum (NQF). The measures must have appropriate exclusions for readmissions that are unrelated to the prior discharge, such as planned admissions or transfers to another hospital.

22. A Medicare subsection (d) hospital is defined by Section 1886 of the Social Security Act as (in part): "a hospital located in one of the fifty States or the District of Columbia other than — (i) a psychiatric hospital (as defined in Section 1861(f)), (ii) a rehabilitation hospital (as defined by the Secretary), (iii) a hospital whose inpatients are predominantly individuals under 18 years of age, (iv)(I) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days." (www.ssa.gov)

23. The ACA defines a hospital-acquired condition as: "a condition identified for purposes of subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary." (ACA §3008(a)(3).)

24. The term "never event" was first introduced in 2001 by Ken Kizer, MD, former CEO of the National Quality Forum (NQF), in reference to particularly shocking medical errors (such as wrong-site surgery) that should never occur. The NQF initially defined 27 such events in 2002 and revised and expanded the list in 2006. See (www.psnet.ahrq.gov/resource.aspx?resourceID=5363).

25. The conditions include those already selected for the current Medicare HAC payment policy and any additional conditions the Secretary deems appropriate. (ACA §3008.)

26. Centers for Medicare and Medicaid Services website, Hospital Compare (www.hospitalcompare.hhs.gov).

27. IPPS is a system of Medicare reimbursement for Part A benefits which bases most hospital payments on the patient's diagnosis at the time of hospital admission. Payment amounts for particular services are determined according to the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).

28. From January 1, 2015 through December 31, 2016, the modifier applies only to physicians as defined in Section 1861(r). Beginning on January 1, 2017, the HHS Secretary may include all eligible professionals as defined for the physician quality reporting program.

29. U.S. Department of Health and Human Services, *Report to Congress: Medicare Ambulatory Surgical Center Value-Based Purchasing Implementation Plan*, 2011 (www.cms.gov).

30. Andrew B. Bindman, Philip W. Chu, and Kevin Grumbach, *Physician Participation in Medi-Cal 2008*, California HealthCare Foundation, July 2010 (www.chcf.org).

31. Ibid.

32. Ibid.

33. Stephen Zuckerman, Aimee Williams, and Karen Stockley, *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare*, California HealthCare Foundation report prepared by The Urban Institute, April 2009 (www.chcf.org).

34. Melinda Dutton and Alice Lam, *Implementing National Health Reform in California: Opportunities for Improved Access to Care*, California HealthCare Foundation prepared by Manatt Health Solutions, March 2011 (www.chcf.org).

35. State Health Facts (www.statehealthfacts.org).

36. Simons, Brandi, "Can 'bundled' payments help slash health costs?," *USA Today*, Oct. 26, 2009.

37. "Applicable conditions" will include up to 10 different conditions selected by the HHS Secretary, based on a variety of statutory factors. Medicare Part C and PACE are excluded.

38. Alfred Casale, Ronald Paulus, Mark Selna, Michael Doll, Albert Bothe, Jr., Karen McKinley, Scott Berry, Duane Davis, Richard Gilfillan, Bruce Hamory, and Glenn Steele, Jr., "'ProvenCare℠': A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care," *Ann Surg* 2007 246 (4): 613-21.

39. The program is authorized under ACA, though funding has yet to be appropriated for it. Other program details are listed in Appendix C.

40. Integrated Healthcare Association, "IHA Bundled Episode Payment and Gainsharing Demonstration: Project Description," March 14, 2011 (www.iha.org), accessed June 15, 2011.

41. U.S. Department of Health and Human Services, "Partnership for patients to improve care and lower costs for Americans," news release, April 12, 2011 (www.hhs.gov).

42. Centers for Medicare and Medicaid Services, *Partnership for Patients Health Care Pledge*, accessed August 23, 2011 (http://partnershippledge.healthcare.gov).

43. Helen Halpin, Arnold Milstein, Stephen Shortell, Megan Vanneman, and Jon Rosenberg, "Mandatory Public Reporting Of Hospital-Acquired Infection Rates: A Report From California," *Health Affairs*, April 2011. Nile's Law requires hospitals to report: (1) rates of bloodstream infections associated with health care that were caused by methicillin-resistant *Staphylococcus aureus* and *Clostridium difficile* (with the total number of inpatient days); (2) rates of vancomycin-resistant enterococcal bloodstream infections (with total number of inpatient days); (3) rates of bloodstream infections associated with central-line catheters (with the number of days of inpatient central-line catheter use); and (4) rates of infections associated with health care at surgical sites or in the organs or space (other than the incision) that is opened or manipulated during surgery.

44. Deborah Schoch, "California Health Department releases Infection data, but with caveats," CHCF Center for Health Reporting, January 2, 2011 (www.centerforhealthreporting.org).

45. In a *retrospective* bundled payment arrangement, CMS and providers would set a target payment amount for a defined episode of care. Applicants would propose the target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models would be paid for their services under the original Medicare fee-for-service (FFS) system, but at a negotiated discount. At the end of the episode, the total payments would be compared with the target price. Participating providers may then be able to share in those savings. In *prospective* arrangements, CMS would make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians, and other practitioners. Physicians and other practitioners would submit "no-pay" claims to Medicare and would be paid by the hospital out of the bundled payment.

46. Centers for Medicare and Medicaid Services, *State Demonstrations to Integrate Care for Dual Eligible Individuals*, Informational Bulletin, December 10, 2010 (www.cms.gov).

47. In April 2011, 15 states were awarded grants of up to $1 million each: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. The demonstrations are broken into two phases: a design phase and an implementation phase. The design phase will last for a period of 18 months. States will have 12 months to develop an implementation proposal, and the Innovation Center and Office of Duals will use the last six months to review proposals and negotiate with states. Demonstration implementation contracts will be awarded at that point. (It is important to note that if a state receives a design phase contract, it is not necessarily guaranteed an implementation contract.) Implementation of the demonstrations will likely begin in the fall or winter of 2012.

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49. Ibid.

50. California Department of Health Care Services, Response to Requests for Proposal: State Demonstrations to Integrate Care for Dual Eligibles, January 28, 2011 (www.dhcs.ca.gov).

51. Ibid.

52. Ibid.

53. Centers for Medicare and Medicaid Services, *State Medicaid Director Letter #10-024: Health Homes for Enrollees with Chronic Conditions,* November 16, 2010 (www.cms.gov).

54. Cost savings were reported in an actuarial analysis of Community Care of North Carolina (CCNC), conducted by Mercer. Results were reported at CCNC's website at (www.communitycarenc.org), accessed June 20, 2011.

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56. NCQA Database (http://recognition.ncqa.org) accessed March 2011.

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58. The Community Clinics Initiative with financial support from the California Endowment launched the Health Home Innovation Fund to provide flexible funding supporting local partnerships among private and public safety-net providers and local health plans and develop health homes. (www.communityclinics.org).

59. California Office of Statewide Health Planning and Development (OSHPD), 2007.

60. Gerard Anderson and Katherine Wilson, *Chronic Disease in California, Facts and Figures,* California HealthCare Foundation, 2006 (www.chcf.org).

61. The ACA defines CBOs as organizations that provide care transition services across the continuum of care through arrangements with hospitals, and whose governing bodies sufficiently represent multiple health care stakeholders, including consumers. (ACA §3026.)

62. Centers for Medicare and Medicaid Services, High Readmission Hospitals, 2011 (www.cms.gov/DemoProjectsEvalRpts/downloads/CCTP_FourthQuartileHospsbyState.pdf).

63. In 2010, the Aging and Disability Resource Center (ADRC) program awarded a grant to the California Health and Human Services Agency to expand current care transition models to underrepresented communities over a two-year period (September 30, 2010 to September 30, 2012). The grant supports four California ADRC programs that are currently implementing Care Transitions Intervention (CTI): Riverside ADRC with Riverside County Regional Medical Center, Orange ADRC with area hospitals serving OneCare members, San Francisco ADRC with St. Mary's Medical Center, and San Diego ADRC with Sharp Memorial Hospital.

64. U.S. Department of Health and Human Services, *Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program, Federal Register*, 76 (67) (April 7, 2011): 19,528.

65. Center for Medicare and Medicaid Innovation, *Pioneer Accountable Care Organization (ACO) Model Request for Application*, May 17, 2011 (http://innovations.cms.gov).

66. State Health Facts (www.statehealthfacts.org).

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68. Enid Kassner, Susan Reinhard, Wendy Fox-Grage, Ari Houser, and Jean Accius, *A Balancing Act: State Long-Term Care Reform,* AARP Public Policy Institute, July 2008 (www.aarp.org).

69. Hospital Compare (www.hospitalcompare.hhs.gov).

70. California HealthCare Foundation, *California Hospital Assessment and Reporting Taskforce (CHART)*, May 2009 (www.chcf.org).

71. California Codes: Health and Safety Code, Section 128675-128810.

72. California Code of Regulations, Title 22, Social Security, Division 7, Health Planning and Facility Construction, Chapter 9, Hospital Charges and Fair Pricing Policies Reporting.

73. California Department of Public Health, *AFL Revision Notice. All Facilities Letter (AFL) No. 11-32: Requirements for Reporting Surgical Site Infections,* April 27, 2011.

74. Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota will participate in this demonstration that will ultimately include up to approximately 1,200 medical homes serving up to one million Medicare beneficiaries.

75. The following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program: ACO professionals in group practice arrangements; networks of individual practices of ACO professionals; partnerships or joint venture arrangements between hospitals and ACO professionals; hospitals employing ACO professionals; such other groups of providers of services and suppliers as the HHS Secretary determines appropriate.

76. Primary care services are defined as those provided in a primary care physician office, or other outpatient visits, nursing facility visits, domiciliary and rest home visits, and home visits. Primary care physicians are defined as physicians working in family medicine, internal medicine, geriatric medicine, or pediatric medicine.

77. Major surgical procedures are defined as those with a 10- or 90-day global period.