FEDERAL AND MINNESOTA DELIVERY AND PAYMENT REFORM OPTIONS

…beyond our Health Care Home program

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PROGRAM →	FEDERAL- Center for Medicare and Medicaid Innovation within CMS [sec. 3021]	FEDERAL- Medicare Shared Savings Program [sec. 3022]	FEDERAL - Pediatric ACO Demonstration Project [sec 2706]	STATE – Health Care Delivery Systems Demonstration Project [256B.0755]
GENERAL	Test payment and service delivery models… [including] primary care; direct contracting with providers and suppliers; geriatric assessments and comprehensive care plans; movement to salary based payment; community based health teams; patient decision support; fully integrated dual; all-payer payment reform	"shall establish a shared savings program (in this section referred to as the 'program') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery."	"to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act (as added by section 3022)." FOLLOWS MEDICARE SHARED SAVINGS PROGRAM	The commissioner of Human Services shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed upon total cost of care or risk-gain sharing payment arrangement.
APPLYING	To be determined (TBD)	"(A) ACO professionals in	"authorize a participating	SAME AS MEDICARE SHARED

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ENTITY		group practice arrangements. ''(B) Networks of individual practices of ACO professionals. ''(C) Partnerships or joint venture arrangements between hospitals and ACO professionals. ''(D) Hospitals employing ACO professionals. ''(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate. The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.	State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments" (as described under subsection	SAVINGS criteria plus A managed care plan or county-based purchasing plan may participate in this demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).
ENTITY	TBD	Formal legal structure for		"provide required covered services

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QUALIFICATIONS/ CERTIFICATION		shared savings Primary care …that are sufficient for the number of Medicare fee for service beneficiaries 5000 beneficiary minimum Promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care Use technologies Patient centeredness criteria		and care coordination; establish a process to monitor enrollment and ensure the quality of care provided; in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs; provide a system for advocacy and consumer protection; and adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers." "The commissioner may require a health care delivery system to enter into additional third-party contractual relationships for the assessment of risk and purchase of *87.7*stop loss insurance or another form of insurance risk management related to the delivery of care described in paragraph ."
IDENTIFICATION OF PATIENTS	Open to all public program patient populations "model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures"	Assignment of FFS beneficiaries based on utilization of primary care	All Medicaid and CHIP program participants	DHS recipients in MA and Minnesota Care Entity serves the county. The commissioner may assign an applicant.
RISK	unspecified	"benchmark shall		For commissioner to determine

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STRATIFICATION		be adjusted for beneficiary characteristics" MONITORING AVOIDANCE OF AT-RISK PATIENTS.—If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.		
PAYMENT MODEL	Part of model	Continue parts A and B FFS payment plus "shared savings" Benchmark, method and amount of shared savings TBD		Establish uniform statewide methods of forecasting utilization and cost of care Establish a total cost of care benchmark or a risk/gain sharing payment model to be paid for services provided to the recipients enrolled in a health care delivery system.
OUTCOMES	Budget neutrality not initially required	Triple aim Secretary to establish standards Incorporate PQRI (physician quality reporting incentive)		"identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings"
FUNDING	$5 million design etc.	Assumed cost neutrality	General	Not funded to design, implement or

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	FY10 $10 billion total for FY 2011-19 $10 billion for each subsequent 10 year period $25 million to evaluate	"estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO.… updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee for-service program, as estimated.."	There are authorized to be appropriated such sums as are necessary to carry out this section.	evaluate
DURATION OF PROJECT	May be expanded if meets quality and cost reduction targets	3 or more years	1/1/12-12/31/16 3 or more years	Effective date 7/1/11 No duration or end date