Major Affordable Care Act Delivery and Payment Reforms
Summary Table

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A number of Affordable Care Act (ACA) provisions and programs are focused on the "triple aim"[1] of improving the quality of health care, reducing health care costs and improving population health. These efforts include the testing and expansion of new models of delivering and paying for care such as Accountable Care Organizations (ACOs) and Patient Centered Medical Homes. While these efforts are primarily focused on transforming the clinical health care system, they also offer opportunities and have implications for the public health system.

Background on delivery and payment reform efforts

Much of our current health care payment system is based on **fee-for-service (FFS) reimbursement,** which generally means that payers reimburse providers for each service rendered to consumers. Most Medicare and Medicaid providers are reimbursed on some kind of fee-for-service basis, and many private insurers also pay providers on a fee-for-service basis. But such agreements don't limit the quantity of services a provider may render and bill for, and a commonly cited issue with FFS payments is that they incentivize overtreatment and overbilling.

On the other end of the payment methodology spectrum are **global payments**, also called capitated payments. Under these payment arrangements, payers offer providers a fixed amount per member, often either per month or per year **(PMPM or PMPY)**, regardless of service utilization. Managed care organizations use a variety of tools to contain costs and encourage quality and efficiency, and capitated payments are common among them. Capitation is intended to encourage preventive care and population health management, since providers have an incentive to keep their patients healthy and thus keep their costs of care lower than the fixed payments they receive. According to Frakt and Mayes in their September 2012 *Health Affairs* article, capitation is also intended to incentivize "the right care, at the right time, in the right place, with the right use of resources."[2] However, Frakt and Mayes note that capitation has limitations as well, including financial risk for providers whose costs to meet their patients' needs exceed the fixed payments they receive. Whereas FFS payments may incentivize overtreatment, global payments could incentivize stinting on care. The payment and delivery reforms in the Affordable Care Act are largely aimed at testing new payment methodologies, or new applications or combinations of current payment methods, in order to adjust incentives and risks among payers and providers and move toward the triple aim.

APHA is leading an effort to develop recommendations to support health department leaders and other senior public health officials as they respond and adapt to the transforming health system. As the project proceeds, this document is being released as a background resource to support public health leaders in their own research efforts. Find it on APHA's website at http://www.apha.org/advocacy/Health+Reform/.

Major Affordable Care Act Delivery and Payment Reforms (listed by category)

Jump to: Accountable Care Organizations (ACOs) • Patient Centered Medical Homes (PCMHs) • Health Care Innovation Awards • State Innovation Models (SIMs) • Pay-for-Performance (P4P) Programs • Bundled Payments for Care Improvement Initiative • Partnership for Patients

Categories or general models of delivery and payment reform efforts are listed in light blue rows. Subcategories or specific examples are listed in white rows. Not all categories have subcategories. Also note: this chart focuses on delivery and payment reforms that are likely to be most relevant for the public health system. It is not a comprehensive list of all such reforms.

Reform model	Summary	Authority/ administration	Participants/ scope	Funding/ duration
Accountable Care Organizations (ACOs)[3, 4]	Networks of providers that coordinate care for patient populations. ACOs receive bonuses for meeting quality and cost targets (and in some cases, incur penalties for not meeting targets).	See subprograms.	See subprograms.	See subprograms.
o Medicare Shared Savings Program (MSSP)[5, 6, 7] o One-sided risk o Two-sided risk o Advanced Payment[8]	Different options for new and intermediate ACOs (one- and two-sided risk models) as well as rural and other practices that are interested in starting an ACO but need help in initiating the process (Advanced Payment model).	ACA § 3022. Administered by CMMI.	**Payer:** Medicare fee-for-service (FFS). **Providers:** Physicians, hospitals, others. 220 ACOs. **Population:** 2.4 million Medicare patients, including 650,000 in the Advanced Payment model.	$175 million. First ACOs announced in 2012, more in 2013. Funded at least through 2014.
o Pioneer ACO Model[9, 10, 11, 12]	Greater rewards and risks for more advanced ACOs; ACOs must also contract with private insurers and Medicaid.	ACA § 3021. Administered by CMMI.	**Payer:** Medicare FFS. **Providers:** Physicians, hospitals, others. 32 ACOs originally, 23 continuing. **Population:** 669,000 Medicare patients.	$77 million. Three to five years: Jan 2012–2015, optional to 2017.

Reform model	Summary	Authority/ administration	Participants/ scope	Funding/ duration
Patient Centered Medical Homes (PCMHs)[13, 14]	Primary care practices (PCPs) that receive monthly fees to provide "whole person" enhanced care for patients (primarily those with chronic illnesses).	See subprograms.	See subprograms.	See subprograms.
o Multi-payer Advanced Primary Care Practice Demonstration (MAPCP)[15, 16, 17]	Connects Medicare with existing state efforts to coordinate Medicaid and private insurers in supporting PCMH care for chronically ill patients. States are linking PCMHs to health promotion and disease prevention initiatives.	Social Security Amendments of 1967, § 402 (as amended). CMMI linking with state-led efforts.	**Payers:** Medicare FFS, Medicaid, private insurers. **Providers:** 1,200 PCPs expected in 8 states. **Population**: More than 900,000 chronically ill Medicare patients.	$283 million. Three years: phased in starting July 2011, through 2014.
o Federally Qualified Health Center Advanced Primary Care Practice Demonstration (FQHC APCP)[18, 19]	Medicare payments to support FQHCs in adopting medical home practices for most patients and in becoming accredited by the National Committee for Quality Assurance (NCQA) as medical homes.	ACA § 3021. Administered by CMMI with the Health Resources and Services Administration (HRSA).	**Payer:** Medicare FFS. **Providers:** 479 FQHCs in 44 states. **Population**: 200,000 Medicare patients.	$42–$50 million. Three years: November 1, 2011–October 31, 2014.
o Medicaid Health Home State Plan Option[20, 21, 22, 23]	New option for state Medicaid programs to support medical home care for chronically ill patients. Includes enhanced FMAP (federal payments to states). States must coordinate with the Substance Abuse and mental Health Services Administration (SAMHSA).	ACA § 2703. Administered by the Centers for Medicare & Medicaid Services (CMS).	**Payer:** Medicaid. **Providers:** PCPs in 12 states currently (20+ more expected). **Population**: Chronically ill Medicaid patients.	Ongoing since Jan. 2011. Only 2 years of enhanced federal payments to each state.
o Comprehensive Primary Care Initiative (CPCi)[24, 25]	Similar to MAPCP except that CMMI, rather than the states, coordinates multi-payer efforts.	ACA § 3021. Administered by CMMI.	**Payers:** Medicare FFS, Medicaid, private insurers. **Providers:** 7 localities, 497 PCPs in total. **Population:** 315,000 Medicare and 16,000 Medicaid patients.	$322 million. Four years: 2012–2016.

Reform model	Summary	Authority/ administration	Participants/ scope	Funding/ duration
Health Care Innovation Awards[26]	Funding for organizations that are implementing compelling new ideas to deliver better health, improved care and lower costs. The aim is to identify and test new payment and service delivery models and to rapidly train and deploy a new workforce. Round two funding announcement opened in June 2013.	ACA § 3021. Administered by CMS.	**Participants:** 107 providers, payers, local governments, public-private partnerships and multi-payer collaboratives in the 50 states. **Population**: Medicare, Medicaid and CHIP patients; focus on high-risk populations.	Up to $1 billion for round one, up to $1 billion for round two. Awards range from about $1 million to $30 million. Three years.
State Innovation Models (SIM) Initiative[27]	Supports the development and testing of state-based models for multi-payer payments and health care delivery system transformation in order to improve health system performance.	See subprograms.	See subprograms.	Up to $300 million. See subprograms for duration.
o Model Design Awards[28]	Funding to produce a State Health Care Innovation Plan in six months, which will then be used to apply for a second round of Model Testing awards.	ACA § 3021. Administered by CMMI.	**Participating States:** 16. **Population**: Focus on Medicare, Medicaid and Children's Health Insurance Program (CHIP) patients.	About $32 million in total. Six months.
o Model Pre-Testing Awards[29]	Funding to continue working on a comprehensive State Health Care Innovation Plan, which must be completed and submitted to CMS in six months.	ACA § 3021. Administered by CMMI.	**Participating States:** Three. **Population**: Focus on Medicare, Medicaid and CHIP patients.	About $4 million in total. Six months.
o Model Testing Awards[30]	Support for states that are ready to implement their State Health Care Innovation Plan; a proposed strategy to use all available state levers to transform the health care delivery system.	ACA § 3021. Administered by CMMI.	**Participating States:** Six. **Population**: Focus on Medicare, Medicaid and CHIP patients.	Over $250 million in total. 42 months.

Reform model	Summary	Authority/ administration	Participants/ scope	Funding/ duration
Pay-for-Performance (P4P) Programs[31]	Various efforts to incentivize quality and efficiency in patient care and move the health care system away from volume-based payments. P4P does not refer to a specific program but, rather, is a categorization of certain types of programs.	See subprograms.	See subprograms.	See subprograms.
o Hospital Value-based Purchasing (VBP)[32, 33]	Medicare FFS payments to hospitals will depend in part on their performance on a range of quality and patient-experience measures. The ACA also requires CMS to implement this program for Medicare payments to skilled nursing facilities (via SNF fees) and physicians (via the physician fee schedule, or PFS) in the future.	ACA § 3001 (for FFS payments to hospitals). Administered by CMS. (SNF: § 3006. PFS: § 3007.)	**Payer:** Medicare FFS. **Providers:** Nearly all Medicare hospitals and, eventually, SNFs and physicians. **Population:** Medicare patients of affected providers.	Ongoing since Oct. 2012. New hospital measures to be introduced over time, along with new providers.
o Hospital Readmissions Reduction Program[34]	Medicare payments to hospitals will be reduced for "excessive readmissions," determined through a comparison of hospitals' performances with national averages.	ACA § 3025. Administered by CMS.	**Payer:** Medicare FFS. **Providers:** Nearly all Medicare hospitals. **Population:** Medicare patients of affected providers.	Ongoing since Oct. 2012. New measures to be introduced over time.
Bundled Payments for Care Improvement Initiative[35, 36]	Medicare is testing four new payment approaches; all involve providing one bundled payment to multiple providers to encourage greater coordination and efficiency of care.	ACA § 3023. Administered by CMS.	**Payer:** Medicare FFS. **Providers:** Hospitals, physicians and community providers. **Population:** Medicare patients of affected providers.	$118 million. Three years: 2013–2015.

Reform model	Summary	Authority/ administration	Participants/ scope	Funding/ duration
Partnership for Patients[37]	Initiative aimed at reducing hospital acquired infections (HAIs) by 40 percent and unnecessary readmissions by 20 percent by the end of 2013.	See subprograms.	See subprograms.	See subprograms.
o Community-based Care Transitions Program (CCTP)[38]	Per-discharge payments to community-based organizations that partner with hospitals and other providers to offer a continuum of care transition services as a means of reducing unnecessary readmissions.	ACA § 3026. Administered by CMMI.	**Payer:** Medicare FFS. **Providers:** Eligible community-based organizations that apply (currently 102 organizations). **Population:** "High-risk" Medicare patients.	Up to $500 million. Five years: 2011–2015. Two year agreements that can be extended.
o Hospital Engagement Networks[39]	Funding for state, regional, and national hospital networks. Additional funding for expert organizations to identify and disseminate HAI-reduction best practices and resources and to track hospitals' progress toward meeting quality measures.	ACA § 3021. Administered by CMMI.	**Payer:** CMMI. **Providers:** 26 networks supporting more than 3,700 hospitals in the 50 states. **Population:** n/a.	$230 million to date, up to $500 million in total. Ongoing since April 2011.

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