average Medicare spending for chronically ill persons with functional limitations is twice that for people without such functional limitations and more than four times that of patients with two or fewer chronic health problems. At the same time, health care spending under traditional fee-for-service Medicare and Medicare Advantage plans has continued to increase and is deemed fiscally unsound for the future.

In response to these factors, the Affordable Care Act established the Center for Medicare & Medicaid Innovation (CMMI), which is to “test payment and service delivery models ... and the quality of care received by individuals,” with an overall goal of delivering value-based care.

Other organizations, including the American Medical Association, the American College of Physicians, and the American Academy of Family Physicians, have also proposed models to improve services while curtailed expenses— with variable involvement of long-term care and physicians.

Accountable Care Organizations
An ACO is a group of providers and suppliers of services that work together to coordinate patient care within the original Medicare structure. There are now three types of ACOs: Medicare Shared Savings Program (the original, fee-for-service, risk-sharing model), Advance Payment Model (which provides additional starts-up resources to build needed infrastructure), and the Pioneer ACO Model (which allows for an eventual per-beneficiary, per-month payment/alternative payment method).

In all models, LTC has no direct ability to participate as an ACO provider but can have substantial influence on the system’s shared savings or losses. ACOs have no means of changing the LTC resource utilization group (RUG) reimbursement structure or resource-based relative-value scale (RBRVS) for physician reimbursement but will obviously want some form of control over such expenditures.

Possible means could be direct ownership of a nursing facility, employment of the physician providing services, improved case management, and utilizing LTC outcome or readmission measures in selecting LTC facilities utilized. LTC information technology and reporting capabilities will also be significant factors in selection of LTC facilities. The ability of the medical director and attending physicians to ensure quality care could be a key factor in maintaining a relationship with an ACO.

Bundled Payments
Medicare’s current payment system can be fragmented and volume driven. Under the Bundled Care Initiative, all services related to an episode of illness would be reimbursed in a single payment with the goal of efficient yet quality care.

Four models are being investigated. The first is a retrospective payment system set by applying a discount to historically-based prices, with a possible gain-sharing arrangement. This model is further subdivided into three options: 1) inpatient stay in the general acute care stay, 2) inpatient stay plus postdischarge services, and 3) postdischarge services only. A fourth model is being investigated, consisting of only inpatient stay under a prospective-payment bundle, with physicians and other practitioners submitting “no-pay” claims to Medicare and being paid by the hospital.

The second and third models would pay the LTC physician from the bundled payment using a discounted target price based on historical fee-for-service prices. LTC physicians could have substantial impact on savings via length of stay and readmissions. Gain-sharing would need to be negotiated between the model organization and the LTC physician.

Comprehensive Primary Care
Under this limited CMMI demonstration project, Medicare will work with commercial and state health plans to offer bonus payments to primary care doctors who better coordinate patient care. Physicians will be expected to manage care for patients with high health needs, ensure access to care, deliver preventive services, engage patients and caregivers, and coordinate care across the medical neighborhood.

CMS will pay participating practices a risk-adjusted, monthly care-management fee and eventually share in any cost savings. While the model is not LTC-based, primary care doctors who can provide the best, cost-effective skilled nursing facility services, and transitions of care will benefit.

Qualified Health Center
This is a CMMI demonstration project officially began in November 2011 and was designed to evaluate the effectiveness of the patient-centered medical home (PCMH). Four different quality assurance-based accrediting organizations for PCMH status have evolved. Each set its own standards for becoming a PCMH, with similar but slightly different qualifying attributes.

The core to all is a personal practitioner in a practitioner-directed, team-based medical practice; whole-person orientation; coordinated and/or integrated care; quality and safety; enhanced access; and payment characteristics. There are three levels of PCMH, depending on the degree to which standards are met, and only the top level is eligible for the CMMI demonstration project.

While LTC is not eligible to be a medical home, the use of relatively high-cost skilled nursing facility (SNF) services can substantially affect the fiscal success of the project. The medical director and nursing home physician can have a significant impact on the cost effectiveness of SNF utilization and PCMH success.

Innovation Advisors Program
This program is to assist seasoned individuals to develop key skill sets as they refine, apply, and sustain the managerial and technical skills needed to drive delivery system reform.

These skills can include health economics and finance, population health, systems analysis, and operations research. These people will in turn help CMMI, including testing new models of care delivery, working with local groups in furthering delivery system reform, and utilizing their knowledge and skills in their home organization or area to improve health, care, and costs.

The first selected individuals started training in January 2012. While the impact of this project on the LTC physician is unknown, many geriatricians and LTC physicians were among them. A second wave of applicants will soon be considered, with a total of 200 people to ultimately be selected.

Chronic Care Coordination
A joint workgroup of the AMA/Specialty Society RVS Update Committee (RUC) and the current Procedural Terminology (CPT) Editorial Panel, the Chronic Care Coordination Workgroup (CWW) is providing strategic direction to CPT and RUC to address the adequacy of coding and valuation of care coordination services and management of chronic diseases.

A request to CMS to immediately implement payment for anticoagulant management, telephone calls, team conferences, and patient education was submitted on Oct. 3, 2011, and reiterated on March 12, 2012. CWW also noted there should be a focus on creating new CPT codes to describe activities related to care transition and care coordination. If the CPT Editorial Panel approves new codes, the services could be surveyed and considered at the October 2012 RUC meeting, with submission to CMS by mid-October.

The details of these proposed codes are unavailable at this time, but they could have an obvious impact on LTC physicians in handling transitions of care and ensuring adequacy of services to lower both avoidable hospitalizations and subsequent SNF stays.

Enhanced Coordination
CMS in March 2012 requested applications for participation in the initiative called “New Opportunity for Better Care for Nursing Facility Residents Through Enhanced Coordination Efforts.” CMS will partner with eligible, independent, non-nursing facility organizations to use evidence-based interventions to reduce avoidable hospitalizations. Among eligible organizations are physician practices and care-management organizations.

Such providers must hire staff who maintain a physical presence at the nursing facility to implement preventative services, work in cooperation with existing providers, provide support for improved communication and coordination among existing providers, facilitate residents’ transitions to and from inpatient hospitals and nursing facilities, and coordinate and improve management and monitoring of prescription drugs, including psychotropic drugs.

Interventions will be judged for their efficacy in improving health outcomes and providing residents with better care. CMS will give preference to locations where there are high Medicare costs and high hospital-readmission rates and where dually eligible beneficiaries account for a high percentage of nursing facility residents. The project is expected to last 4 years.

Of all the proposed projects discussed, this certainly has the most direct applicability and potential to affect the LTC physician. Demonstration sites must have the commitment of the medical director and attending physicians, working in conjunction with other sites of service, including the hospital and emergency department, to be successful. AMDA has been active in establishing transitions-of-care principles that should become an integral part of a successful project.

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