Implementing New Health Care Delivery System Models

AHA View

The AHA supports accelerating the development and use of alternative payment and delivery models to reward better, more efficient, coordinated and seamless care for patients. Hospitals should be encouraged to adopt these models through an appropriate balance of risk and rewards, rather than through use of penalties – an approach that uses more "carrots" than "sticks." In addition, there must be incentives in place to motivate patients to engage actively in their own care. Payers must ensure predictability and stability in payments while hospitals build the infrastructure necessary to redesign care. At the same time, they must share more accurate and timely data with providers. Finally, the federal government should refrain from changing the rules governing these programs mid-stream, remove regulatory barriers and provide increased flexibility to allow hospitals to manage care successfully in these new models.

Background

Many hospitals, health systems and payers are adopting delivery system reforms with the goal of better aligning provider incentives to achieve the Triple Aim of improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. These reforms include forming accountable care organizations (ACOs), bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations. Private payers and large employers are working with hospitals and health systems to pursue these models, as is the federal government. Specifically, in early 2015, Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell announced a goal of 30 percent of fee-for-service (FFS) Medicare payments being tied to alternative payment models, such as ACOs, by the end of 2016 and to increase that amount to 50 percent of FFS payments by 2018.

Key Priorities

The AHA is working with its members to help test and adopt new payment systems and models of care. These include:

- Establishing ACOs, where appropriate;

- Testing bundled payments;

- Participating in Center for Medicare & Medicaid Innovation (CMMI) demonstration projects;

- Engaging in Medicaid delivery system reform; and

- Enhancing population health.

Establishing ACOs

ACOs are groups of physicians, hospitals and other health care providers who come together to better coordinate care to improve quality and reduce cost. Medicare ACOs were a key delivery system reform initiative included in the

Affordable Care Act (ACA), though some hospitals have been participating in similar arrangements with private payers for several years. The Centers for Medicare & Medicaid Services (CMS), in collaboration with CMMI, operates two major Medicare ACO programs: the Medicare Shared Savings Program (MSSP) and the Pioneer ACO program. In addition, CMMI has developed two programs, the Advanced Payment ACO and the ACO Investment Model, to help small and rural providers with the up-front costs of participating in the MSSP. According to CMS, as of Jan. 1, 2015, there are more than 420 Medicare ACOs in operation, serving more than 7.8 million program beneficiaries.

While hospitals and health systems are committed to the concept of accountable care, the AHA continues to have significant concerns about the design of the Pioneer and MSSP ACO models. The programs place too much risk and burden on providers with too little opportunity for reward in the form of shared savings. In December 2014, CMS proposed revisions to the MSSP intended to encourage continued and enhanced participation in the program and reduce administrative burden for participating ACOs. Though some of CMS's proposals could make the program more attractive to new applicants and existing ACOs, the AHA has urged CMS to move the program away from using penalties rather than rewards to encourage ACOs to accept greater risk.

In March 2015, CMMI announced a new model, the Next Generation ACO, for ACOs that are ready to accept advanced risk. Whereas the existing ACO models are essentially based on a FFS structure, this new model will include an option in later years for ACOs to receive a population-based or capitated payment. In addition, the Next Generation model will include incentives to encourage beneficiaries to seek care within their ACO network. This model also will remove regulatory barriers to allow ACOs to better manage and coordinate care. The AHA will continue to press CMS to eliminate those barriers for participants in all ACO models.

Additionally, the AHA continues to work with the HHS Office of Inspector General, the Department of Justice, the Federal Trade Commission and the Internal Revenue Service on the legal issues around establishment of ACOs and to better facilitate clinical integration. To learn more about efforts around clinical integration, see the AHA's March 2014 *TrendWatch*, "The Value of Provider Integration."

Testing Bundled Payments
Bundled payments reimburse providers a set fee for an episode of care and have the potential to promote higher quality and better coordinated care at a lower cost. Bundling is being tested in both private and public insurance markets. The largest effort is the CMS-CMMI Bundled Payments for Care Improvement (BPCI) initiative. CMS has identified 48 conditions for testing under the initiative, and the associated diagnosis-related groups (DRGs) encompassed by these conditions account for about 70 percent of Medicare admissions.

BPCI participants are testing four bundled payment models:

- Model 1 includes only inpatient hospitalization services for targeted Medicare-severity DRGs (MS-DRGs). Medicare pays participants traditional FFS payment rates, less a negotiated discount. Physicians are paid separately. In the hopes that hospitals and physicians will better coordinate care, participants may share in gains from care redesign.

- Model 2 includes the inpatient hospitalization, physician and related post-discharge services for 30, 60 or 90 days post-discharge. Medicare pays participants their "expected" Medicare payments, less a negotiated discount. Participants keep any savings achieved on bundled services.

- Model 3 includes only post-discharge services. Payments are made as in Model 2.

- Model 4 includes inpatient hospitalization, physician and related readmission services. Medicare pays participants a prospectively determined amount.

There has been significant interest in the program, with 870 entities representing more than 6,400 providers, including hospitals, physician group practices and post-acute care providers, participating in the exploratory phase of the BCPI. However, only 105 entities, representing 243 providers, have signed on to move into the risk-bearing phase. The remaining providers have until Oct. 1, 2015 to take on risk or leave the program.

The AHA has conducted extensive data analysis to help hospitals better understand the intricacies of a bundled payment system. (Refer to the AHA policy issue brief, "Moving Towards Bundled Payment," for more information.) Chief among the issues addressed include considerations for:

- Identifying which episodes are well-suited to payment bundling based on their prevalence and cost, the level of variation in program payment and the availability of evidence-based care guidelines;

- Developing the case for risk-adjustment for factors that cause substantial variation in episode payments, such as beneficiary demographic and clinical characteristics, and facility characteristics; and

- Patient placement at discharge affecting episode costs.

The AHA supports bundled payment, including a post-acute bundle, but much work is still needed to ensure that bundling is workable for patients and providers, including monitoring the BCPI initiative and evaluating the results.

Participating in CMMI Demonstration Projects
CMMI was created by the ACA to serve as a vehicle for transforming the delivery and payment of health care services by testing innovative payment and service

delivery models to reduce program expenditures while preserving or enhancing quality. Its budget is $10 billion for activities from fiscal years (FYs) 2011 through 2019, and $10 billion for each subsequent 10-year fiscal period beginning with FY 2020.

CMMI has focused its efforts around three core strategies: improving the way providers are paid; improving the way care is delivered; and increasing the availability of information to guide decision-making. Its initiatives fall into the following categories (including examples):

- Primary care transformation (Comprehensive Primary Care Initiative; Federally Qualified Health Center Advanced Primary Care Practice Demonstration)

- Accountable Care (Pioneer ACO, Advanced Payment ACO, Comprehensive End-Stage Renal Disease Care Model)

- BCPI

- Initiatives focused on Medicaid and the Children's Health Insurance Program (CHIP) populations (Strong Start for Mothers and Newborns)

- Initiatives focused on Medicare-Medicaid enrollees (Financial Alignment Initiative, Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents)

- Initiatives to speed the adoption of best practices (Partnership for Patients, Million Hearts)

- Initiatives to accelerate the development and testing of new payment and service delivery models (Health Care Innovation Awards, State Innovation Models)

All 50 states and the District of Columbia have at least one payment or delivery system reform model being run at the state level, in addition to innovations being tested by health care facilities. As of the end of FY 2014, CMMI had launched 22 payment and service delivery initiatives. The agency estimated that, as of that time, more than 60,000 providers were participating in these initiatives, furnishing care to more than 2.5 million Medicare, Medicaid and CHIP beneficiaries. The agency also has worked to engage other payers in testing these models in order to align financial incentives across payers when possible.

Engaging in Medicaid Delivery System Reform
Many state Medicaid programs are engaging in testing delivery system reform models. Though most states have turned to managed care for their Medicaid populations, a significant number also administer primary care case management programs. In addition, state Medicaid programs are implementing patient-centered medical homes, health homes for patients with chronic conditions and ACOs.

Seven states have used Section 1115 demonstration waivers to create delivery system reform incentive payment programs. These programs reallocate Medicaid supplemental funding pools that were previously used to reimburse hospitals for uncompensated care. Instead, the funds are used to make payments to hospitals to encourage them to implement delivery system and payment reform projects.

Enhancing the Health of Populations
As the U.S. health care system transforms, hospitals are expanding their work to support the Triple Aim by improving the health of their patients and surrounding communities. The ultimate goal is to improve the overall health of a given population while also reducing health disparities. Achieving improved population health will ultimately decrease medical costs.

Hospitals have long focused on providing high quality clinical care to their patients. More recently, they have invested in efforts that go beyond direct clinical care – such as care coordination and prevention – to improve outcomes for the populations they serve. In addition, hospitals are engaging in traditional public health initiatives to improve the overall health of their communities. For example, hospitals may provide free clinics, housing support for the homeless, meals on wheels to community residents, literacy programs or farmers' markets.

The AHA published two guides, "Managing Population Health: The Hospital's Role" and "The Role of Small and Rural Hospitals and Care Systems in Effective Population Health Partnerships," which outline how population health can serve as a strategic platform to improve health outcomes. Both are available at *www.hpoe.org*.