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Patrick Conway, M.D.
Deputy Administrator for Innovation & Quality, Chief Medical Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Centers for Medicare & Medicaid Services' Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

Dear Dr. Conway:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) on Concepts for Regional Multi-Payer Prospective Budgets.

Our members are working to redesign the delivery system to provide better, more efficient, coordinated and seamless care for patients. **The AHA supports accelerating the development and use of alternative payment and delivery models that allow hospitals and health systems to achieve those goals. We appreciate CMS's efforts to examine an array of alternative payment models and we support the agency's efforts in exploring the feasibility of global budget payment programs in geographically defined communities. However, designing a global payment program to address the unique needs of various hospitals and health systems, including rural hospitals, is a challenging undertaking and we urge CMS to proceed in a thoughtful and deliberate manner.**

The AHA is currently exploring such a model as part of its Task Force on Ensuring Access in Vulnerable Communities, which is examining ways to ensure access to essential health care services in vulnerable rural and urban communities. The task force believes that global budget payment models, if appropriately structured, may provide the flexibility needed for hospitals in vulnerable communities to provide care in a manner that best fits a community's needs and circumstances. Global budgets also may provide financial certainty, potentially fair payments and incentives to contain health care cost growth and improve quality. The work of the task force is ongoing, and we look forward to sharing additional insights with CMS in the coming months. In the interim, we offer several overarching recommendations on global budgets.



The AHA's 2015 Committees on Research and Performance Improvement explored the redesign of a new care delivery system and identified seven key principles. The AHA supports the inclusion of these principles in any new delivery system, including the global budget payment model being examined by CMS. They are as follows:

1. *Design the care delivery system with the whole person at the center.* System design must start with the whole person, putting each patient's needs and ease of access to care before the needs and convenience of the system and its clinicians.
2. *Empower people and the care delivery system itself with information, technology and transparency to promote health.* Use technology and information to activate patients in their own care and to promote life-long health. For transformational health care delivery, patients who are highly "activated" will have better health outcomes.
3. *Build care management and coordination systems.* Develop effective care teams that provide quality care to patients through teamwork and delineated roles.
4. *Integrate behavioral health and social determinants of health with physical health.* The design of the health care system must include resources and services to provide support for behavioral health care, particularly diagnosis, treatment and prevention.
5. *Develop collaborative leadership.* A new care delivery system should include collaborative leadership structures with clinicians and administrators, and also focus on leadership diversity.
6. *Integrate care delivery into the community.* Participation with other organizations that offer vital community services and resources is essential if optimal health outcomes are to be achieved.
7. *Create safe and highly reliable health care organizations.* By creating a culture of high reliability, hospitals improve quality and patient safety.

In addition, to optimize the effectiveness of a global budget model, CMS should provide hospitals with the necessary tools to be successful under the program. We have several recommendations to help accomplish these goals:

- **Participation in the global budget should be voluntary and determined at a regional level.** CMS also should consider expanding the global budget model to include participation by additional health care providers (e.g., physicians). This could further align health care providers and increase accountability for the health care services offered within a community. In addition, any region choosing to participate must have population density necessary to sustain a global budget and, to the extent possible, should be permitted to select the types of services that will be included in the global budget.
- **The global budget model should be designed to account for different sizes and types of hospitals that are at very different points in the transformation process.** Hospitals and health systems have built care processes and policies around the current regulatory payment structures, and these systems will have to be changed if they are to achieve success in a global budget program. This is no small task. It will require significant investments of time, effort and finances. For example, hospitals and health systems will need to build upon their current infrastructure for health information technology, patient

and family education, care management and discharge planning. They also will need to align with other providers, both physicians and post-acute facilities, to achieve efficiencies under the model. This will entail forming new and different contractual relationships that build valuable partnerships and incentivize successful strategies.

- **The global budget model should include policies dedicated to critical access hospitals and small/rural hospitals.** While this RFI seeks general feedback on global budgets, CMS also has asked for specific feedback on the feasibility of rural hospital participation in global budgets. As indicated above, some hospitals already have taken significant steps toward achieving delivery system reform; however, rural hospitals may not be as far down this path. Specifically, due to small volumes, critical access hospitals and many small/rural hospitals have been unable to meaningfully participate in value-based payment programs or develop and sustain alternative payment models. While these hospitals would like to be part of a global budget conversation, they lack experience participating in alternative payment models and feel as though a global budget would likely be “too much, too soon.” As a result, the AHA urges CMS to consider payment policies that may bridge the gap between current fee-for-service or cost-based reimbursement models and a global budget model. For example, CMS could consider a transitional hybrid payment system that includes a fixed payment that continues to cover fixed costs, but also includes incentives to achieve better health and healthier communities.
- **Payments should promote predictability and stability.** The methodology that CMS uses to set global budget payment amounts should balance savings to the Medicare program with provider financial stability and patient access to care. Payments should be predictable, stable and sufficient to allow providers to build the infrastructure and capability to redesign care delivery. This includes payments that take into account the administrative costs or capital expenditures associated with participation in a global budget model, as well as risk adjustment and high-cost/high-risk utilizers. In addition, CMS should balance the risk versus reward equation in a way that encourages hospitals and health systems to take on additional risk but does not penalize them for the additional time and experience they must gather in order to fully participate in a global budget model. Doing this would help facilitate hospitals’ success under the program with regard to providing quality care to Medicare beneficiaries, achieving savings for the Medicare program, and also having an opportunity for reward that is commensurate with the risk they are assuming.
- **Providers need access to timely data and information.** Access to actionable information related to care, payment and cost will be essential to the success of a global budget model. For example, access to real-time data on patient utilization and spending for services across an episode of care will be necessary to actively manage care offered to patients. CMS will need to ensure open access to information from public and private payers to allow hospitals and health systems to make more informed decisions regarding their care delivery in the global budget model.

- **Waiver of fraud and abuse laws, as well as certain Medicare payment rules, is essential.** To allow hospitals to form the financial relationships necessary to succeed in a global budget model, it will be critical for CMS to issue waivers of the applicable fraud and abuse laws that inhibit care coordination. Specifically, CMS should waive the Physician Self-Referral Law and the Anti-kickback Statute with respect to financial arrangements formed by hospitals participating in a global budget model. These laws were designed for a different world of care delivery and payment and are not compatible with a global budget model.

Waivers of many existing Medicare payment rules also would be necessary to provide participating hospitals with maximum flexibility to identify and place beneficiaries in the clinical setting that best service their short- and long-term recovery goals. This includes, but is not limited to, the waiver of discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services, the skilled nursing facility “three-day rule,” and the inpatient rehabilitation facility “60% Rule.” These waivers are essential so that hospitals and health systems may coordinate care and ensure that it is provided in the right place at the right time.

- **CMS must address the interaction between the global budget model and existing alternative payment models.** The agency should ensure appropriate blending of different payment models to build upon the work that many hospitals and health systems have already taken to improve health care delivery. Hospitals and health systems have already invested resources to participate in existing Medicare alternative payment programs (e.g., the Medicare Shared Savings Program, Bundled Payments for Care Improvement Initiative and Comprehensive Care for Joint Replacement Model), and CMS should ensure that development of metrics for the global budget model will not work against those efforts. In addition, CMS should use its best efforts to streamline the metrics and quality measurement efforts in the global budget model with those already in existence for other alternative payment models.

Thank you for the opportunity to comment. If you have any questions, please feel free to contact me or Priya Bathija, senior associate director, policy development, at (202) 626-2678 or pbathija@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development