American Hospital Association

Delivery System Reform Programs

Background

Several payers, hospitals and health systems are adopting delivery system reforms to better align provider incentives to improve care coordination and quality, and reduce costs. These reforms include forming accountable care organizations (ACOs), bundling services into discrete episodes of care and testing payment alternatives for vulnerable populations. Private payers and large employers are working with hospitals and health systems to pursue these models. On the federal level, many of these activities are being coordinated within the Center for Medicare & Medicaid Innovation (CMMI), which was created by the *Patient Protection and Affordable Care Act* (ACA). Given the level of funding available to pursue experimental payment models, $1 billion a year for each of the next 10 years, the CMMI is intended to serve as a highly effective vehicle for transforming the delivery and payment of health care services.

AHA View

Our fragmented health care system is rapidly transforming to a delivery system where care is more integrated, providers are at more financial risk, and all elements of the system are more accountable to the public. The AHA is working to ensure that changes to health care delivery are implemented responsibly and improve care for patients and communities. The AHA urges the Centers for Medicare & Medicaid Services (CMS) to establish a reliable evaluation system to assess the impact of all delivery system reform programs and report back to Congress on the approaches that warrant broader consideration. These programs should not be automatically implemented by law or regulation. A variety of projects with proper evaluation can determine what best serves patients' needs. The AHA's efforts around delivery system reform programs focus on the following:

Accountable Care Organizations. When CMS initially released its proposed rule governing the creation of ACOs under the Medicare Shared Savings Program, the hospital field was very concerned that the agency had created a program that was neither financially attractive nor operationally viable. At the AHA's urging, CMS made extensive revisions in the final regulation to improve the program. Most significantly, the final rule allows all participants to share in first-dollar savings and eliminates down-side risk for ACOs participating in one option of the program. (The proposed rule would have subjected track one ACOs to down-side risk in the third year of the program.) CMS also said it will not withhold any portion of an ACO's earned bonus, as proposed, and appropriately eliminated indirect medical education and disproportionate share payments from the calculation of spending estimates. In addition, CMS reduced the number of quality measures to be reported to 33 from 65 and did not finalize any meaningful use requirements for the ACO program.

In conjunction with the rule, the Department of Justice and the Federal Trade Commission issued a final Statement of Antitrust Enforcement Regarding Accountable Care Organizations, abandoning their proposed mandatory antitrust

review before hospitals could even apply for the ACO program and replacing it with guidance applicable to all ACOs. The guidance said the agencies will "vigilantly" monitor complaints about anti-competitive behavior and all ACOs' competitive conduct will be evaluated under the "rule of reason," which takes pro-competitive benefits into account. In addition, CMS and the Department of Health and Human Services' Office of Inspector General issued an interim final rule with comment period that created five waivers that go beyond the limited protections offered in the proposed rule to provide protection from fraud and abuse laws for hospitals and other providers considering participation in an ACO.

In addition, the changes the AHA advocated for in the ACO program also apply to the CMMI's Pioneer ACO program. The Pioneer program allows providers to become Medicare ACOs who also have ACO arrangements with one or more private payers. The CMMI has awarded 32 Pioneer projects.

Bundled Payments. Bundling payments to cover a set of clinical services has the potential to create consistent, efficient high-quality care. The ACA takes a national, voluntary pilot project approach to test different models of bundling to determine what works and does not work before broad adoption. In preparation for the pilot, many hospitals and health systems have engaged in an early CMMI project referred to as the Bundled Payments Care Initiative (BPCI). Participants may select one of four different models that range from inpatient-only services to those services that span across the full care continuum, including post-acute care.

The AHA is conducting an extensive data analysis to develop key policy positions on what should and should not be included in the national bundling pilot. Chief among the analyses are:

- Testing the impact of varying the post-discharge episode length at 15, 30 and 60 days post-discharge;
- Analyzing typical services (including post-acute care) utilized and patient care pathways (such as discharge to home or discharge to an inpatient rehabilitation facility) within an episode; and
- Examining readmission rates within an episode.

This analysis also will be used to educate AHA members about bundled payments and assist BPCI participants.

State Demonstrations. States, in particular state Medicaid agencies, often are a valuable testing ground for delivery system reform. Under both the CMMI and CMS's Federal Coordinated Health Office, several states have been funded to target care coordination programs for dual-eligible beneficiaries – low-income seniors and younger persons with disabilities who are enrolled in both the

Medicare and Medicaid programs. Dual-eligible beneficiaries account for 16 percent of Medicare enrollees and 27 percent of Medicare spending; in Medicaid, dual-eligible beneficiaries account for 15 percent of enrollees and 39 percent of costs. CMS has awarded $1 million planning grants to 15 states. The grants create a partnership between CMS and states to explore alternative payment approaches, including fee-for-service and capitated payments for dual-eligible beneficiaries. While the AHA is monitoring the progress states are making under these grants and corresponding with the respective state hospital associations, we are concerned that for example, these demonstrations may inappropriately place beneficiaries in the Medicaid program. In addition, on the topic of caring for dual-eligible beneficiaries, earlier this year the AHA Committee on Research released a report, "Caring for Vulnerable Populations," which highlights best practices and makes recommendations for coordinating care for the dual-eligible population.