American Hospital Association®

Delivery System Reform Programs

Background

Many hospitals, health systems and payers are adopting delivery system reforms with the goal of better aligning provider incentives to improve care coordination and quality, and reduce costs. These reforms include forming accountable care organizations (ACOs), bundling services into 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.

The federal government also is working with hospital and health systems to pursue these models, with many of these activities being coordinated within the Center for Medicare & Medicaid Innovation (CMMI). The CMMI was created by the Affordable Care Act (ACA) and is intended 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.

AHA View

Our fragmented health care system is rapidly transforming into a more integrated delivery system where 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. As such, we urge 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 to Congress on the approaches that warrant broader consideration. These programs should not be implemented automatically by law or regulation. The AHA's efforts around delivery system reform programs focus on areas described below.

CMMI Demonstration Projects. In selecting the models to test through the CMMI, the secretary of Health and Human Services (HHS) may give preference to models that improve the coordination, quality and efficiency of health care services furnished to beneficiaries, such as patient-centered medical homes. The Secretary also may limit testing of payment and service delivery models to targeted geographic areas. Payment models are evaluated based on the quality of care they incentivize, including patient-level outcomes and patient-centeredness, and the changes in Medicare spending they generate. The tested models are exempt from budget neutrality, and CMS has the discretion to terminate, modify or expand the scope or duration of the models as it sees fit. Beginning in 2012, and once every other year thereafter, the Secretary must submit a report to Congress on the progress of the CMMI.

In selecting innovations to fund under the CMMI, the Secretary has the authority to prioritize the following characteristics, among others:

- Programs that focus on providing telehealth, behavioral health, stroke and non-medical providers in medically underserved areas and facilities of the Indian Health Service;
- Programs that target beneficiaries with two or more chronic conditions; and
- Programs that link the public sector with private sector payers.

The current CMMI models fall into seven categories and are bulleted below.

Accountable Care	• Advanced Payment ACO model • Pioneer ACO model • Medicare Health Care Quality Demonstration • Rural Community Hospital Demonstration • Comprehensive End-stage Renal Disease Initiative • Nursing Home Value-based Purchasing Demonstration • Private, For-profit Demo Project for the Program of All-Inclusive Care for the Elderly (PACE) • Physician Group Practice Transition Demonstration (no longer active)
Bundled Payments for Care Improvement (BCPI)	• BPCI Model 1: Retrospective Acute Care Hospital Stay Only • BPCI Model 2: Retrospective Acute & Post-acute Care Episode • BPCI Model 3: Retrospective Post-acute Care Only • BPCI Model 4: Prospective Acute Care Hospital Stay Only • Medicare Acute Care Episode (ACE) Demonstration • Physician Hospital Collaboration Demonstration • Specialty Practitioner Payment Model Opportunities (under development) • Medicare Hospital Gainsharing Demonstration (no longer active)
Primary Care Transformation	• Comprehensive Primary Care Initiative • Federally Qualified Health Center Advanced Primary Care Practice Demonstration • Frontier Extended Stay Clinic Demonstration • Graduate Nurse Education Demonstration • Independence at Home Demonstration • Multi-payer Advanced Primary Care Practice • Medicare Coordinated Care Demonstration (no longer active)
Initiatives Focused on the Medicaid and Children's Health Insurance Program Population	• Medicaid Emergency Psychiatric Demonstration • Medicaid Incentives for the Prevention of Chronic Diseases Model • Strong Start for Mothers and Newborns Initiative: Effort to Reduce Early Elective Deliveries • Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care Models
Initiatives Focused on Dual Enrollees	• Financial Alignment Initiative for Medicare-Medicaid Enrollees • Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	• State Innovation Models Initiative: Model Design, Pre-testing and Testing Awards • Health Care Innovation Awards • Maryland All-payer Model • Medicare Intravenous Immune Globulin (IVIG) Demonstration • Frontier Community Health Integration Project Demonstration
Initiatives to Speed the Adoption of Best Practices	• Community-based Care Transitions Program • Innovation Advisors Program • Medicare Imaging Demonstration • Million Hearts • Partnership for Patients

Currently, all 50 states and the District of Columbia have at least one model being run at the state level, in addition to innovations being tested by health care facilities.

ACOs. ACOs are groups of doctors, hospitals and other health care providers who voluntarily come together to better coordinate care to improve quality and reduce cost. Some hospitals have been participating in similar arrangements with private payers for several years. According to CMS, more than 360 Medicare ACOs have been established to date, serving more than 5.3 million beneficiaries. Notably, more than half of ACOs are physician-led organizations that serve fewer than 10,000 beneficiaries. Approximately one in five ACOs include community health centers, rural health clinics and critical access hospitals that serve low-income and rural communities.

CMS, in collaboration with the CMMI, has developed three main ACO models: the Advanced Payment ACO Model (APM), the Medicare Shared Savings Program (MSSP), and the Pioneer ACO.

- APM. In order to assist participants with the high upfront costs associated with becoming an ACO, CMS created an APM whereby qualifying participants in the MSSP can receive upfront and monthly payments to invest in their ACO infrastructure. Advanced payments are recouped from the shared savings the ACO earns. The APM model was specifically designed for physician-based and rural providers whose ability to achieve success would be improved with additional access to capital. Currently, there are 35 ACOs participating in the APM.
- MSSP. Under the MSSP, ACO participants can choose to participate in one of two tracks. Track 1 is a "one-sided" model, which has no downside risk for participants. It was designed for less experienced ACOs and allows these organizations to share in the savings but not in the losses. Track 2 is a "two-sided model" in which participants share in both the savings and the losses.

According to CMS, as of March 2013, almost all MSSP participants (98 percent) were participating in Track 1, which is available only for the first three-year agreement period.

- Pioneer ACO. The Pioneer ACO model was created for those hospitals and other providers that have more experience with coordinating care across settings. The Pioneer ACO model differs from the MSSP in three key ways: (1) its shared savings payment arrangement has higher levels of savings and risk than in the MSSP; (2) if the ACO earns savings in the first two years it is eligible to move to a population-based payment model; and (3) it must have ACO-like payment arrangements with one or more private payers.

Interim financial results for the 114 ACOs that began work in 2012 show $128 million in savings for the Medicare program. However, only 29 of the 114 MSSP ACOs lowered expenditures enough to share in program savings. And two of these ACOs were excluded from shared savings because they failed to "successfully report" quality measures. Results for the Pioneer program are similar. According to CMS, of the 23 remaining Pioneer ACOs (the program started with 32), nine earned bonuses for achieving significantly lower spending growth while exceeding quality reporting requirements.

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 ACO and MSSP models. The programs place too much risk and burden on providers with too little opportunity for reward in the form of shared savings. While CMS made extensive revisions in its final regulations to make the program more financially attractive and operationally viable – such as allowing all participants to share in first-dollar savings, eliminating down-side risk for ACOs participating in one option of the program, removing a proposed withhold of an ACO's earned bonus, and reducing the number of quality measures to be reported – more modifications are necessary to attract additional participants.

The AHA will work with CMS as it makes modifications to the ACO programs. Some of these key changes include:

- improve the timeliness and accuracy of performance data;
- extend the Track 1 agreement period;
- set a uniform standard minimum savings rate (MSR), regardless of the number of attributed beneficiaries;
- create more achievable financial thresholds in the early years;
- implement technical adjustments to the benchmark to account for policy changes outside the provider's control;
- allow beneficiaries to "opt in" to the ACO programs;

- allow ACOs to vary beneficiary cost sharing; and
- simplify and align quality measures, and set the required thresholds prior to the performance year.

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

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. Currently, the largest effort is the CMS-CMMI Bundled Payments for Care Improvement (BPCI) initiative. CMS has identified 48 broad conditions for testing under the initiative. The associated diagnosis-related groups (DRGs) encompassed by these conditions account for about 70 percent of Medicare admissions. A total of 232 providers, including hospitals, physician group practices and post-acute care providers, are participating in the BPCI and had the option of starting their bundled payment model on either Oct. 1, 2013 or Jan. 1, 2014.

BPCI participants are testing four bundled payment models:

- Model 1 includes only inpatient hospitalization services for all Medicare-severity DRGs (MS-DRGs). Medicare will pay participants traditional fee-for-service payment rates, less a negotiated discount. In return, participants may enter into gainsharing arrangements with physicians.
- Model 2 includes the inpatient hospitalization, physician and post-acute services. Medicare will pay participants their "expected" Medicare payments, less a negotiated discount.
- Model 3 includes only post-acute services. Payments will be made as in Model 2.
- Model 4 includes the inpatient hospitalization, physician and related readmission services. Medicare will pay participants a prospectively determined amount.

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 expense to the Medicare program, 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
- Understanding care pathways including how readmissions and patient placement at discharge affect episode costs.

The AHA supports bundled payment, including a post-acute bundle, but much work is needed to ensure that bundling is workable for patients and providers. Last year, the AHA's Hospitals in Pursuit of Excellence initiative produced "Value-Based Contracting," a primer for hospitals and health care systems as they transition to value-based contracting arrangements. In 2014, the AHA will host an educational series on bundling and additional partnerships between general acute care hospitals and post-acute providers.