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reforming the delivery system

Last year's Affordable Care Act dealt primarily with the easy part of healthcare reform—reforming the health insurance market and expanding coverage. Both are important changes, but they are far from all that will be needed to address the problems facing the U.S. healthcare system.

The legislation also directly included some limited delivery system reforms, such as the provision for accountable care organizations (ACOs) and value-based purchasing provisions for hospitals in 2012 and nursing homes in 2013. Most of the potential delivery system reforms included in the legislation, however, are associated with various pilot projects and with initiatives that were to result from the legislatively established Center for Medicare and Medicaid Innovation (CMMI).

Now that it's been seven quarters since the legislation was passed and a year since CMMI was established, it seems appropriate to see how these delivery system reforms are progressing.

ACOs

Given how new the concept of ACOs was in 2009, it was interesting and perhaps surprising that this delivery system option was included directly in legislation, whereas most other strategies were to be tried first as pilots. The concept is simple enough: Groups of physicians or physicians and hospitals that are not formally integrated are encouraged to take a team approach to healthcare delivery to improve quality of care and reduce spending. None of these efforts required new legislation, but sharing the savings that might result did require new legislation. The challenge has been to specify the criteria for measuring improvements in quality and the growth in spending that would have occurred in the absence of the legislation.

As I indicated in an earlier column ("ACO Regs, Round 1," *hfm*, May 2011), the proposed rule issued in late March included several requirements that would have been difficult for most newly formed organizations to meet, and it ran the risk of producing the same result as was seen when provider-sponsored organizations were included in the 1997 Balanced Budget Act—that is, no response from the provider community despite a lot of hype while the legislation was being considered.

The final regulations released in late October have restored some of the previous interest in ACOs by no longer requiring ACOs to take downside risk in Year 3 (but giving those that do a larger share of the savings than those that do not), by not assigning seniors retrospectively to an ACO, by reducing the number of quality metrics that need to be reported from 65 to 35, and by sharing savings, starting with the first dollar of savings for those ACOs that exceed the minimum savings rate threshold. Whether these changes will be enough to reignite the previous level of interest expressed by the provider community will become clearer in 2012, when ACOs are scheduled to begin. Whether those providers that form ACOs will actually succeed in producing higher-quality care at lower rates of spending is another matter that only time will tell. Even if they do not, it is possible that ACOs will serve as a transition to a more traditional integrated group that enrolls patients in its system.

CMMI

Established with much fanfare (despite skepticism from some Republican commentators who questioned whether the federal government is a likely source of innovation), CMMI has been relatively quiet until the last few months. In fact, it has been so quiet that it has begun to provoke the

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ire of even some Democratic members of Congress. As an example, Sen. Max Baucus (D-Mont.) has publicly questioned the Centers for Medicare & Medicaid Services (CMS) as to when innovations regarding Medicare-Medicaid "dual eligibles" would begin.

Initiatives to date have mostly involved an aspect of ACOs or primary care, although, more recently, CMMI has released a bundled payment initiative and has announced an initiative to test whether advance payments to support organizational development will encourage groups to apply for the ACO program. In the summer, CMMI also announced a group of pioneer ACOs for more advanced organizations, with the intent of starting these models in early 2012. And there have been some multipayer collaborations announced to support primary care.

The bundled payment initiative provides four different models that will be tested by various types of providers. Which provider will receive the payment, how the payment will be determined, and how the payment will be distributed among the various providers differ by model, but in each case, a single payment will be made that covers an episode of care rather than payment for an individual service or type of care provided. Under three of the models, the payment bundling will be made retrospectively; under the fourth, the payment bundle will be defined prospectively.

In the first model, the episode is defined as the inpatient stay. Medicare will pay a discounted amount relative to the DRG that would otherwise be paid. Physicians will be paid separately for their services. Hospitals and physicians can share any savings that come from better coordination. In Model 2, the episode is the inpatient stay and post-acute care. The episode would end either 30 days or 90 days after hospital discharge. In Model 3, the episode begins with the hospital discharge and ends no sooner than 30 days after the hospital discharge. In both Models 2 and 3, the bundle includes physicians' services, the post-acute care provider, related readmissions, and any ancillary services provided during the episode. The target price will be discounted from the historical fee-for-service payments for the episode. Under the fourth model, the hospital will receive a single, prospectively determined bundle, which will include all services furnished during the inpatient stay, including those by physicians.

Letters of intent were due during the fourth quarter of 2011. Applications vary in their due dates but need to be submitted no later than mid-March of 2012.

Whether these models produce the desired results of better quality care at lower rates of spending will take several years to discern. More important, it will take years to see how CMS and the Department of Health and Human Services ultimately use the information to change and reconfigure the Medicare program.

What is most disappointing is that, to date, none of the bundled payment pilots focus on different ways to reimburse physicians. Therefore, not one of the models encourages the formation of multispecialty group practices, a known strategy that produces higher-quality care. Instead, the models assume that the hospital remains the dominant focus of the care delivery model—an assumption of dubious wisdom. ●

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