In January 2015, Health and Human Services Secretary Sylvia Mathews Burwell announced the Administration’s ambitious goal of shifting 30 percent of traditional Medicare Fee-for-Service (FFS) reimbursement to alternative payment models by the end of 2016, and 50 percent by the end of 2018. AAMC-member teaching hospitals have been very involved in Medicare alternative payment models. The AAMC believes that for these models to continue their success, they should include appropriate risk adjustment methodologies to ensure that providers, such as teaching hospitals and physicians, that treat the most complex individuals are not unfairly penalized. The methodologies also should incentivize providers for elements they can control, rather than penalizing providers for the factors they cannot influence. This point is especially crucial for academic medical centers (AMCs), which often care for the most complex and vulnerable patients. Finally, the payment methodologies should exclude Medicare mission-related payments so that savings calculations appropriately reward the reduction of unnecessary services.

The first of these models, Bundled Payments for Care Improvement (BPCI), was introduced in 2012. AMCs were among the early entrants in this program. The launch of the mandatory joint replacement bundled payment program, Comprehensive Care for Joint Replacement (CJR) on April 1, 2016, and the Oncology Care Model (OCM) on July 1, 2016, will both drastically increase the number of providers in risk-based payment models. Finally, in July 2016, the Centers for Medicare and Medicaid Services (CMS) announced three new bundled payment models in the proposed rule, Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR). Providers in these models all face a need for enhanced data analytics, education regarding new gainsharing opportunities and complex payment policies, and assurance that their needs will be reflected through effective advocacy. Planning and implementing an alternative payment model requires involvement from both administrative and clinical leadership, as well as significant time and resources. In many instances, CMS has not provided adequate time or support for these endeavors.

Since 2012, the AAMC has served as a facilitator convener in BPCI, and the number of convened group members has grown to 30 hospitals. In 2016, the AAMC also introduced collaboratives for hospitals participating in CJR and OCM. In these roles, the AAMC provides policy and data analytic support to hospitals implementing bundled payments, in addition to working with CMS to address policy concerns and shape the development of these models. The association also facilitates shared learnings between members.
A key component of many of these models is the establishment of spending “benchmarks” or “target prices” and the comparison of those amounts with actual spending levels. CMS has excluded the mission payments received by teaching hospitals (the indirect medical education [IME] and disproportionate share hospitals [DSH] adjustments) in the calculations for several of the ACO models. This decision is important because if these payments were included, ACO providers that had previously used teaching hospitals would have an incentive to begin sending their patients to other hospitals to generate savings. CMS has stated that removing IME and DSH payments from benchmark and performance year expenditures would allow Medicare to “more accurately reward actual decreases in unnecessary utilization of healthcare services, rather than decreases arising from changes in referral patterns.”

**AAMC Policy Recommendations**

The AAMC believes that a number of modifications could be made to APMs that would encourage long-term participation by providers and ensure high-value, high-quality care for patients. These include appropriate risk adjustment methodologies to ensure that providers, such as teaching hospitals and physicians, that treat the most complex individuals are not unfairly penalized. The methodologies also should incentivize providers for elements they can control rather than penalize providers for the factors they cannot influence. This point is especially crucial for AMCs, which often care for the most complex and vulnerable patients. Finally, the payment methodologies should exclude Medicare mission-related payments so that savings calculations appropriately reward the reduction of unnecessary services.

- **Treatment of direct graduate medical education (DGME), IME, and other Medicare add-on payments:** Add-on payments for DGME, IME adjustment, outlier payments, and DSH adjustment should be excluded from target price calculations as well as actual performance period payments. Such a policy ensures that providers are rewarded for changing how they practice rather than for changing referral patterns, which could be detrimental to patients.

- **Appropriate risk adjustment:** Payments and quality measures must be appropriately adjusted to reflect the higher complexity of patients treated by teaching hospitals and academic physicians.

- **SDS adjustment:** Payment and quality measures must be adjusted so as not to penalize providers for factors that are beyond their control.

- **Early and frequent access to Medicare claims data:** Medicare provides historical and performance period claims data to participants in the various models. Participants use these data to identify clinical and financial areas of risk and opportunity and to inform their overall implementation strategy.

- **Accurate and predictable target prices:** Medicare must employ target price methodologies that limit variation in target across time and ensure that providers are assigned targets that present accurate and fair benchmarks for financial performance.

- **Adequate transition to downside risk:** Providers require considerable time to plan and implement alternative payment models. Many BPCI participants, who voluntarily entered this model, spent at least a year preparing for the risk phase. Medicare must provide participants—especially those in mandatory models—with a gradual ramp to accepting downside risk. This end can be achieved by including an upside-only phase and by using higher target prices.

- **Waivers:** Waivers of certain Medicare payment rules and fraud and abuse rules are necessary to successfully implement alternative payment models.

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**Web Resource**

**AAMC Information on Alternative Payments**  
https://www.aamc.org/initiatives/bundling