James L. Holly, M.D.

Conversation with Dr. Wild Chief Medical Officer of Atlanta Region of CMS

April 28, 2015

Dr. Wild:

I am impressed with the rapidity and thoughtfulness of your response. I did not find your statement objectionable because I think that is where everyone is headed. While Medicare Advantage is a slightly different value-based program than the ACO model, it does eliminate the excessive use of resources, testing, etc. because of its capitated structure. This summer, SETMA will develop our own ACO. Because so many of our patients are MA, we have not had enough FFS Medicare to qualify for our ACO. Without our growth that should not be resolved.

SETMA (www.jameslhollymd.com) has been involved in MA and its predecessors since 1996. We began learning early that fee-for-service drives utilization patterns sometimes inappropriate. In 1997, SETMA was making $50,000 a month profit from our in-house, medium-complex, now Joint Commission accredited, in-house laboratory. It because obvious to us in October, 1997, that we had to cut costs which initially meant cutting revenue.

We went to the MSO which managed our HMO and asked that our laboratory services be capitated with an outside reference laboratory. This was a direct and immediately drop in annual PROFIT of $600,000 but that and several other measures salvaged our managed care program. It was painful but now with a larger population being managed and with the tools and teams we have built, along with our successful deployment of stratified risk (HCC -- , http://www.jameslhollymd.com/epm-tools/Tutorial-HCC-RxHCC-Risk) we have replaced that revenue and more.

As second example of this process was when we realized that many of our patients – we treat an economically challenged group, were not getting excellent care because they could not afford their co-pays. 13 years ago, we went to the HMO and told them we wanted a primary care zero co-pay. They argued that if we did that, we would be inundated with inappropriate utilization by patients. We argued that we could manage that. In that 13 years we have had to address over utilization due to zero co-pay with zero patients. Through out analytics we have demonstrated that our outcome data with our zero-co-pay MA population is superior to our fee-for-service Medicare patients who still are responsible for their 20% of UCR charges. We have also demonstrated the elimination of ethnic disparities in diabetes and hypertension care.

Seven years ago, SETMA formed a 501-C Foundation to which the partners of SETMA, including Dr. Anwar, give $500,000 a year. That money is used to support the care of our patients who cannot afford their care. None of that money can profit SETMA – we treat those patients free -- but pays for specialty care when care will not be given without payment being made, for hospital care when the patient is uninsured and for procedure co-pays and medications when patients cannot afford either. We have particularly paid for a great deal of dental work seeing dramatic outcomes in health improvement and cost decrease when proper dental work is provided. The most dramatic example was a Medicare Fee-for-Service pay who was utilizing enormous resources in ambulatory and inpatient care. When the SETMA Foundation paid $10,400 to complete restore her oral and dental care, she "got well" and has not been hospitalized in the past seven years and is off all medications.

By the way, SETMA has paid for hip replacements and other surgeries for patients without insurance. The following hyperlinks are to some incredible stories about our patients. And, we can make sure that our patients have access to the medication they need. These stories come from our Patient-Centered Medical Home as to the following from our website:

The Story and the Ideals

- Paternalism or Partnership - the Dynamic of the PC-MH
- Learning From One's Mistakes
- Medical Home Poster Child
- Patient Centered Medical Home Poster Child: An Update after Five Years of Treatment in a Medical Home
- Evolution of Health Care
- Homicidal Threat to Reciprocal Caring
- Medical Home Pilgrimage - Stories

SETMA has invested our time and energy as well as our treasure into healthcare transformation including the following achievements.

SETMA's Recognitions and Accreditations

- **NCQA – PC-MH Tier III 2010-2016**
- **NCQA – Diabetes Recognition 2010–2016**
- **NCQA – Heart And Stroke Recognition 2010-2016**
- **NCQA – Distinction in Patient Experience Reporting 2014-2015**
- **AAAHC -- PC-MH 2010-2017**
- **AAAHC -- Ambulatory Care 2010-2017**
- **URAC -- PC-MH Advance Certification with EMR 2014-2017**
- **The Joint Commission – PC-MH 2014-2017**
- **The Joint Commission – Ambulatory Care 2014-2017**
- **The Joint Commission – Clinical Laboratory Services 2014-2016**
- **Texas Medical Foundation, CMS' Texas QIO –**

The Texas Practice Quality Improvement Award 2012-2014

We look forward to further dialogue with you as you desire.

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From: Wild, Richard E. (CMS/CQISCO) [
Sent: Tuesday, April 28, 2015 8:45 AM
To: James L. Holly
Cc: Syed Imtiaz Anwar
Subject: RE: My partner Dr. Anwar is attending the Las Vegas conference where you spoke -- he sent the quote from you which is below
Importance: High

Dear James (Larry) and Dr Anwar,

Thanks for your thoughtful note. Yes, I probably did say that comment pretty much as quoted, (in a quick response to a question due to time pressures yesterday during the Q and A). However, as Mark Twain once famously said, "the rumors of my death are premature".

Since our payments for quality and value will still be superimposed on the fee for service billing system matrix in the near term in most payment models, perhaps a more nuanced (but not so easily quotable) answer would be as follows:

> "With payments increasingly tied to quality and value, a volume based fee for service model which does not focus on providing
> quality outcomes and value based care will have significantly diminishing returns as payment systems focus more on population
> based payment models, quality, patient centered care, and value".

How does that sound? It's a more accurate statement that I am more comfortable with.

Thank you for corresponding with me. I have to constantly remind myself that short, overbroad statements are highly quotable, have a high impact, but may not be totally accurate. Your kind note to me drove that home.

Sincerely,

Richard E. Wild, MD, JD, MBA, FACEP
Chief Medical Officer, Atlanta Regional Office
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Atlanta, GA 30303

From: James L. Holly
Sent: Tuesday, April 28, 2015 8:25 AM
To: Wild, Richard E. (CMS/CQISCO)
Cc: Syed Imtiaz Anwar
Subject: My partner Dr. Anwar is attending the Las Vegas conference where you spoke -- he sent the quote from you which is below

Dr. Wild: My partner, Dr. Anwar, heard you speak yesterday. The following is my note based on your comments. I hope to meet you. It sounds like we have a lot in common. 40% of our practice is full-risk, capitated. James L. Holly, MD Adjunct Professor Family & Community Medicine University of Texas Health Science Center San Antonio School of Medicine

To SETMA's Staff:

Dr. Anwar is attending a conference in Las Vegas on Reducing Hospital Readmissions. Yesterday, April 27, he sent a note with a quote from one of the presentations given by Dr. Wilde, Chief Medical Officer (CMS) of Centers for Medicare and Medicaid Services (CMS), in which Dr. Wilde said**: "Fee for service is dead. If you have a business plan that is based on fee for service then you need a different plan or start doing something else."**

The transformation of payment methods for healthcare is being referred to as "Revenue Cycle Management". As I noted yesterday, I was asked to given an address to Chief Financial Officers of healthcare organizations in Austin earlier this month. The attached articles address **Value-Based Payment Reform**. The articles are drawn from my responses to two sets of questions sent to me by the Chief Financial Editor of the *Health Leaders Media*. He wrote an article about the Austin Conference and is preparing a major, cover presentation for May or June of *Health Leaders Media*. The Editor send me a response to my Austin presentation which can be read at: http://www.jameslhollymd.com/Letters/response-to-dr-hollys-presentation-to-health-leaders- media, After reviewing my answers to his questions and after our telephone interview, the Editor said: **"It is as I suspected, Dr. Holly: You and SETMA are ahead of the value-based payment model curve. Is there any area of healthcare reform you have left unexplored? You are an impressive reformist figure, with unique depth of experience. Eager to talk next week, Chris."** (emphasis added)

The two list of questions the Editor sent and my answers can be reviewed at the following hyperlinks:

- Value-based Payment models, Last Group of Questions: http://www.jameslhollymd.com/Letters/value-based-payment-models-questions- for-the-industry-health-leader-media

    1. Why is capitation with fixed monthly payments a viable value-based payment model?

2. Does capitation give physician practices a transformational edge by allowing flexibility to redesign care crafted to the local market?
3. How can you use PCMH to generate value-based payment opportunities and revenue gains?
4. Does EMR-based tracking of quality metrics help support advancement and adoption of evidence-based medicine?
5. Mindset shift: A value-based healthcare industry will be financially lean relative to the healthcare industry's longtime volume-based business model. How do you convince physicians to embrace value-based care and payment vs. volume-based care and payment?

- Value-Based Payment Models, Questions for the Industry, HealthLeaders Media, Answers by James L. Holly, MD, April 2015 http://www.jameslhollymd.com/Letters/pdfs/value-based-payment-models-questions- for-the-industry.pdf

Eight questions about value-based payment models:

1. What are the key factors for physician practices to consider when weighing involvement in value-based payment models?
2. Industry-wide, gauge the trend for physician-practice uptake of value-based payment models?
3. How do you organize physician practices to embrace value-based payment models? At physician practices, are there particularly daunting hurdles to adoption of value-based payment models?
4. At SETMA, how have your clinical models of care changed to match value-based payment models?
5. At SETMA, have value-based payment models driven down service volume? If utilization rates have declined, what impact has that had on the practice? If there has been a negative impact, did you find ways to offset that impact?
6. At SETMA, what are the prime ways you are using data in conjunction with value-based payment models?
7. How does changing from "volume" to "value" payment models affect measurement of patient experience of care?
8. What are the essentials of value-based payment reform?

In the context of SETMA's recent discussion about costs and fees in relationship to laboratory charges, this review of value-based payment reform and particularly the CMO of CMS' statement are important for us to consider. Remember the CMO's statement: **"Fee for service is dead. If you have a business plan that is based on fee for service then you need a different plan or start doing something else."**

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