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Alternative Payment Models for Healthcare Delivery
What is it and Why does it matter?
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Change is not surprising in human experience. We are humorously told that as Adam and Eve left the Garden, Adam said, "Well, Eve, things are changing!" And, it has been that way ever since. In a January 26, 2015 meeting Health and Human Services Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

In that announcement, the Secretary set goals "of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models (APM), such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for APMs and value-based payments."

In her address, The Secretary reviewed principles contained in the Affordable Care Act which included "a number of new payment models that move even further toward rewarding quality. These models include ACOs, primary care medical homes, and new models of bundling payments for episodes of care. In these APMs, health care providers are accountable for the quality and cost of the care they deliver to patients. Providers have a financial incentive to coordinate care for their patients – who are therefore less likely to have duplicative or unnecessary x-rays, screenings and tests. An ACO, for example, is a group of doctors, hospitals and health care providers that work together to provide higher-quality coordinated care to their patients, while helping to slow health care cost growth. In addition, through the widespread use of health information technology, the health care data needed to track these efforts is now available."

How does this new APM differ from the way healthcare providers have been being paid since Medicare was implemented in 1965? Most health care providers today receive a payment for

each individual service, such as a physician visit, surgery, or blood test, and it does not matter whether these services help – or harm – the patient. In other words, providers are paid based on the volume of care, rather than the value of care provided to patients. APM's would continue the shift toward paying providers for what works – whether it is something as complex as preventing or treating disease, or something as straightforward as making sure a patient has time to ask questions.

In a January 27, 2016 *Health Affairs* Blog, the following appeared:

Three goals are central to a "payment reform conundrum." The goals are:

- To encourage providers to volunteer to participate in Alternative Payment Models;
- To encourage providers in APMs to bear the risk of a financial loss, not just share in savings;
- To reward provider efficiency, not just improvement relative to the provider's own past performance.

"There is no one solution to this conundrum. The likelihood of a satisfactory result will be increased, however, if policymakers look for options beyond the particulars of the APMs themselves. Changes in FFS and Medicare Advantage may be as important as APM design. One can imagine four policy "dials" that might be turned to higher "settings" than currently:

1. Make APMs mandatory
2. Make APMs and risk bearing more attractive
3. Make FFS less attractive
4. Strengthen incentives for Medicare beneficiaries to seek out low-cost/high-value providers

"CMS is doing its best to make APMs more attractive, but Congress should do more. How far Congress turns the third and fourth dials--making FFS less attractive and providing stronger incentives to beneficiaries--will determine whether needed progress is made on all three goals."

SETMA and the "new" Developments in Healthcare

In the early 1990s, "managed care" came to Southeast Texas. Poorly designed and placing a great burden on healthcare providers, increasing significantly the profit of healthcare plans and decreasing the medical practice revenues, the system failed. Out of the residue of that system came a few successful collaborations between healthcare providers, health maintenance organizations (HMOs), and medical service organizations (MSOs).

This system mimicked many of the principles of the new "alternative payment models," such as:

1. Rather than being paid piece by piece for each service physicians provided, a fixed, once-a-month fee was paid to the provider. If the patient was seen once a month, that fee was paid; if they patient was seen five times a month, the same, single, once-a-month fee was paid.
2. In addition, the provider was not paid more for "doing more," but could receive an additional payment at the end of a service period if the care delivered had resulted in improved care and cost savings.

3. The provider was at risk because if the care of a group of patients was more than what CMS paid the HMO, the excess cost had to be paid back out of future earnings.

Since 1996, SETMA has worked in that system with the majority of the patients we care for. It certainly is challenging because there is never any guarantee of success. However, the pressure of that risk had many benefits. The accountability pushed SETMA to:

1. Develop an electronic medical record system
2. Which made it possible both to improve the documentation of care and
3. To efficiently audit the quality of that care.

It pushed SETMA to design:

1. A "team approach" to healthcare delivery as the demands upon healthcare providers increased to where no one person could perform all of the tasks which were needed.
2. To begin auditing provider performance so SETMA could know if we were improving care continually.
3. Ten principles of how to design a system which will support the above.
4. A Patient-Centered Medical Home accredited by National Committee for Quality Assurance, the Accreditation Association of Ambulatory Health Care, URAC and the Joint Commission.

While SETMA began in 1999 using analytics to measure the quality of our care, it was 2009, when we began publicly reporting by provider name of our performance on over 300 quality metrics. This was possible only because one of the major transitions from fee-for-service payments to capitated monthly payments led to the transition from EMR to electronic patient management with disease management tools, clinical decision support and automation of tasks to reduce the time and energy it took to perform complex but critical task. One of those tasks which took 45 minutes was reduced to one second with the use of electronics and automated data aggregation. Algorithms, automation and team collaboration made these complex systems redesign possible, profitable and made their use sustainable.

Inquiry abut Alternative Payment Models

The interest in this subject is extensive. On January 28th, SETMA received the following inquiry:

> "My organization (Audacious Inquiry) has been contracted by the Office of the National Coordinator for Health IT (ONC) to develop a report on the health IT infrastructure required for scaling Delivery System Reform. The focus of the project is to evaluate and determine the near-, mid-, and long-term health IT infrastructure components that are necessary to support widespread participation in alternative payment models.
>
> "The report will be based on a literature review, interviews with clinical subject-matter experts, health IT vendors, and payer organizations in addition to CMS. You have been identified as a valuable contributor on this topic, and we would greatly appreciate your viewpoint on this subject. Given the rapid momentum behind many of these delivery system reform initiatives, we have a

tight timeframe in which to gather feedback from the field. Please let me know what your availability is for a virtual meeting. Because this is such a large topic area we are targeting 90 minutes for the interviews."

In accepting this invitation, SETMA sent the following to Audacious Inquiry:

The following links are to articles and questions and answer to value-based payment models and Alternative Payment Models:

- Letters – "Health IT to Support ACO and Group Reporting"
- Letters - Value-Based Payment Models, Questions for the Industry, Health Leader Media, Answers by James L. Holly, MD April 15, 2015
- Letters - Value-Based Payment Models, Questions for the Industry, Health Leader Media, Answers by James L. Holly, MD April 15, 2015
- Letters - Response to Dr. Holly's Presentation to Health Leaders Media's RevenueCycle Conference for Hospital Vice Presidents of Revenue Cycle, Austin, Texas, March 26. 2015' 8-9 PM
- Letters - SETMA's Solution for CMS and ONC Meeting on Health IT to support ACO April 23, 2015
- Letters - Chris Cheney -- SETMA and Value-based payment model curve

The following links are to a Transformation Library which SETMA created for CMS' Transforming Clinical Practice Initiative:

- Your Life Your Health - CMS Transforming Clinical Practice Initiative SETMA's Offer to CMS
- Transforming Your Practice
- Transforming Your Practice - Introduction to SETMA's TCPI Library

No one will say that Alternative Payment Models are easy, but they are the future. In order to participate in that future successfully, healthcare providers will need to embrace them and remodel practices to meet the needs and demands of them. Ask your healthcare provider if he/she is prepared to participate in APMs.