Creating Successful Alternative Payment Models

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ABSTRACT

The Medicare Access and CHIP Reauthorization Act of 2015 encourages development of physician-focused alternative payment models (APMs). This creates the most significant opportunity in 2 decades to meaningfully redefine how physicians are paid for their services. Whether this results in better care and lower spending, and whether it helps or harms physician practices, will depend heavily on how the HHS implements APMs. In this article, we draw on the experience of past and present payment reforms to suggest principles for successfully designing APMs.

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Five Principles for Successful APMs

1. Provide the Resources Needed to Deliver Higher-Value Care

An overarching goal of APMs is to slow the growth in healthcare expenditures. However, APMs, which blindly incent decreased utilization of services, can worsen access to care and health outcomes for patients.[1] Adding penalties based on quality can protect some patients, but harm others whose care needs fall between the many cracks in current quality measures.

A major weakness in the current fee-for-service (FFS) systems is lack of payment for many high-value services that could address patient needs at lower costs. For example, patient education and self-management support can help patients with chronic disease to avoid hospitalizations, but they are not adequately supported by payers. Similarly, supervised exercise therapy can achieve equal or better outcomes than surgery for many patients with diseases such as peripheral artery disease and joint osteoarthritis, but it is not adequately supported by the current payment systems. A successful APM will give physicians the flexibility and resources they need to deliver higher-value approaches to patient care.

2. Hold Physicians Accountable Only for the Aspects of Cost and Quality They Can Control

A second weakness of traditional FFS payment is that it neither rewards nor penalizes physicians based on the overall cost of treating a patient's problem or the outcomes achieved. In contrast, capitation payment systems reward physicians for avoiding high-need patients and penalize them for costs they cannot control. The reasons capitation systems were abandoned in the past was not a lack of adequate information technology or quality measures, but rather the inappropriate transfer of full insurance risk to physicians. Many current payment reforms that hold physicians accountable for all spending on their patients create the same problems under a different name.

There is a middle ground between FFS and full-risk global payments.[2] In many pilot programs, physicians have demonstrated the willingness and ability to reduce costs and improve quality for the services they both deliver and order if they have the resources needed to do so. A successful APM will hold physicians accountable for aspects of costs and quality they can control (eg, how many tests they order, which procedures they perform, how well they prevent avoidable complications), but not for the things they cannot (eg, the services ordered by other physicians for different health problems, increases in the prices of drugs they prescribe).

3. Improve Payment for Specialty Care, Primary Care, and Inpatient Procedures

Most payment reforms to date have taken 3 forms: primary care medical homes, bundled/episode payments for inpatient procedures, and accountable care organizations (ACOs). Although high-quality primary care, inpatient surgeries, and care coordination are essential to higher-value healthcare, the majority of services are delivered outside of inpatient settings and by specialists, not primary care physicians. Not every acute condition is something that good primary care can prevent, and the mere fact that services are more "coordinated" does not mean they are achieving the highest value.

Although a majority of healthcare spending is associated with a small proportion of patients who have multiple health problems or require very expensive services, most patients receive healthcare services for individual problems. Every patient deserves high-quality, affordable care, and for many patients, that care will be delivered by a specialist in an outpatient setting, not by a primary care physician, a hospital, or a care manager employed by an ACO.

In order to deliver higher-value care, the barriers that specialists face under the current payment system must be removed. Primary care medical homes and surgical episode payments are not readily adaptable to most types of specialty care,[3] and it is neither necessary nor desirable to force every patient to be part of a large ACO in order to receive better care. Appropriately designed APMs are needed in every specialty so that all patients can benefit from higher-value care.[4]

4. Allow Flexibility to Customize Service Delivery Approaches to Local Resources

The significant variation in care delivery within and across regions has been well documented. Much of this variation is avoidable and represents an important opportunity for physicians to improve quality and reduce costs under an APM. However, some of the variation reflects fundamental differences in the resources that communities have available to deliver care. A patient who has an acute stroke may be managed by an internist, neurologist, intensivist, or stroke specialist depending on where that patient lives; similarly, patients with back pain may be managed by internists, physiatrists, pain management specialists, or spine surgeons in different communities. Local regulations, workforce capacity, disease epidemiology, and patient expectations significantly impact how care must be delivered.

To be successful, APMs must allow flexibility in the types of services to be delivered and the types of providers who can deliver those services. Success should be measured based on outcomes, not on adherence to 1-size-fits-all standards for structure or processes, and performance benchmarks must reflect differences in the costs and outcomes that are achievable in rural areas, inner-city communities, and so on.

5. Minimize Administrative Burden

The complexity of current payment models and the systems used to administer them have significantly increased the costs of healthcare in the United States without corresponding improvements in outcomes. APMs represent an opportunity not only to improve care delivery, but to eliminate unnecessary administrative burdens. Just as care delivery should be redesigned to eliminate waste, no administrative requirements should be included in APMs unless the likely benefits will significantly exceed the costs.

Conclusions

By encouraging APMs, MACRA provides an unprecedented oppor-

tunity to encourage innovations in care delivery. However, just because a payment model is different does not mean it will be better. The success of APMs will depend heavily on how they are designed and implemented. We believe that these 5 principles can guide the development of APMs that enable better outcomes for patients at a more affordable cost and that physicians can enthusiastically support.

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