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Accountable Care NEWS

Medicare Alternative Payment Models: Not Every Provider Has a Path Forward

by Angela Bowen, Natalie Burton and David Muhlestein

The Centers for Medicare and Medicaid Services (CMS) has shown significant support for the development of Alternative Payment Models (APMs). CMS' development and testing of 45 payment models has led to the adoption of similar models by other payers. Initial reports indicate that APMs could be key to producing healthcare delivery reform necessary for decreasing healthcare costs and increasing delivery quality. However, these models are only available to select provider types and some providers, such as emergency physicians and audiologists, have no Medicare APMs in which they can participate. To realize the full benefits of APMs, additional collaboration between CMS leadership and providers is needed to develop new models for providers who do not currently have access to them.

Debate Over APM Benefits

While many factors contribute to high healthcare costs, a traditional fee-for-service (FFS) payment system has been called "the single biggest obstacle to improving healthcare delivery."[1] Under FFS, providers receive payment for each service delivered, which can incentivize the delivery of non-essential services and decrease the attractiveness of preventive care.[1] FFS also does little to incentivize care coordination between providers; it does not emphasize payment for communication among providers, patient education and other high-value services.[2]

CMS has been at the forefront of testing and implementing new APMs that shift care delivery from FFS to value-based reimbursement arrangements.

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Value-Based Care: The Payers' Role

by Darryl Drevna

AMGA and its members are dedicated to moving the healthcare system to one based on the value of care provided. But for "value-based care" to be more than a buzzword in health policy circles, changes are needed in what is expected not only of providers, but also of payers. If the goal is to move away from a fee-for-service (FFS) system to one that bases payments on quality, outcomes and cost of care provided, reforms that are directed at only providers will be insufficient in achieving these objectives.

MACRA, which embodies Congress' intention to implement value-based payments for the Medicare program, is only the first step. As envisioned, the law was meant to transition providers away from FFS payments to those based on the quality and cost of care delivered. However, based on how CMS has implemented the law, it is clear that additional reforms are needed if value-based care is to be the standard model across both federal and commercial payers. Payers need to work with providers to create a value-based healthcare system.

MACRA Is Stuck in Neutral

Although MACRA is focused on one aspect of the Medicare program, the law has ramifications for the larger healthcare system and the effort to move to value. When CMS promulgated its initial rule for the Quality Payment Program (QPP), the agency created a transition period that allowed for minimal participation in the Merit-Based Incentive Payment System (MIPS) program. This transition period was intended to allow clinicians to familiarize themselves with the program's new requirements and data-reporting mechanisms.

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