

Leaving Fee-for-Service Behind by Embracing a Safety Model



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Historically, physicians have allowed the wave of CMS rules and regulations to crash over them, leaving behind frustration and attitude in its wake; the time is now that we take charge with a proactive approach to these changes. CMS is moving forward with an aggressive stance to alter the method of payment for Medicare. A recent *New England Journal of Medicine* article entitled “Setting Value-Based Payment Goals—HHS Efforts to Improve U.S. Health Care” by Department of HHS Secretary Sylvia Burwell, outlines 2 major goals: the first, a shift away from fee-for-service by having 30% of Medicare payments made via alternative models by 2016, and 50% by 2018¹; the second, is creating a link from the remaining fee-for-service payments to a value-based payment system. The emergent, and perhaps unknown, detail is that the measures that will ultimately determine quality and value are currently being measured.

Fortunately for those of us who have joined an MSSP ACO, the performance rules required to succeed are quite similar (details of the rules can be found in the Federal Registry).² To ensure that all ACOs have the chance to perform at a level that supports the highest value and quality over an entire population of beneficiaries, a practical approach must be put forward. This practical approach, however, does not require the immediate use of sophisticated clinical analytic registries, costly case managers, or an enormous admin-

istrative budget. What is required is a day 1 initiative to incorporate a handful of proactive processes and programs at the physician-patient level, which if done effectively will lay the groundwork for the subsequent use of big data analysis and integrative health information exchange systems.

Hopefully I have your attention by now, so here is my message: you do not need to have years of managed care experience. You also do not need to have experience in pay for performance and patient-centered medical homes, or expertise in medical informatics. What you do need is the belief that a primary care physician (PCP) can make the difference, and that the present model of care based on fee-for-service must evolve to highlight patient-centered needs. Once that change in behavior is made, adequate value-based payments will follow. If we help put power back into the hands of the PCP, then the focus on physician income can be expanded to include the pursuit of daily happiness, patient gratitude, and an overall environment focused on ensuring safety.

As an internal medicine practitioner, I never ran an office in which the pursuit of safety served as the primary baseline that my office must achieve; however, in the year 2015, this is the exact key to the transformation needed to ensure that PCPs have a central role in preserving Medicare, and to reap the rewards from CMS’ new models of payment. If the PCP were to take a reactive approach

to the changes in rules and regulations, it would result in the loss of independence via financial ruin, and replacement by alternative providers with far less experience, training, and insight.

Part of the current problem is that the PCP is unaware of patient value expectations, and we have not stopped to evaluate this failure. Physicians are now finding themselves being measured by metrics that are difficult to achieve because of outdated practice patterns and processes. For example, in a value survey of Medicare beneficiaries, over 95% responded “yes” to services we all agree are needed but are currently not common practice, such as:

- Would it be of value if your physician called you if you were admitted to the hospital?
- Would it be of value to you if your physician provided a summary or pertinent personal medical information to emergency rooms, hospitals, specialists, nursing facilities, etc?
- Would it be of value to you if your physician followed up with you 48 hours after he diagnosed and treated a condition which could get worse to confirm resolution of illness?

So if 95% of patients would want these services and consider them of value, then why don't we provide them? It may be because we don't get paid to do the extra work, but should physicians withhold safety for their patients just because of payment concerns? Additionally, what if a PCP is not working on Fridays and his/her answering machine directs patients to go to the emergency department? What if the PCP's daily schedule has no room for urgent care patients? Or what if the current office system has no process to check treatment progress, missed appointments, or patients at risk? What about practices where patients are sent to specialists or the emergency department without a process for the transitioning of care? It is my belief that if we pursue safety in an effort to become more accountable for our patients, then the payment concerns may not be a factor later on due to new payment models that reward safety. There are numerous examples of safety lacking in the office of the PCP, but the truth is that processes in the office need to evolve to better the practice and subsequently ensure continuous improvement of patient care.

The first step for approved MSSP ACOs—even before they receive the beneficiary list, utilization data, and part A and B expenses, purchase expensive clinical registries, and employ case managers—is to ensure that a proactive approach is in place so PCPs can prove they are performing at a uniform safety standard. This would solidify a foundation to provide relevance to all the reports generated for big data. After all, who would not want to go to the “safest” ACO, primary care physician office, hospital, skilled nursing facility, home health agency, specialist, or consultant? Who would not be willing

to pay for the services of those “safest” practices? Who would not agree that safety will reduce wasted healthcare expense while generating best outcomes and elevating patient experiences?

According to Charles G. Oakes, PhD: “Safety is the condition of a ‘steady state’ of an organization or place doing what it is supposed to do.”³ So in closing, I challenge each and every one of you in healthcare to first pursue patient safety as the metric when motivated to change the way one practices. The only problem is: does anyone know how to measure patient safety? Now, that is a discussion for another time.

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REFERENCES

1. Burwell SM. Setting value-based payment goals—HHS efforts to improve U.S. health care [published online January 26, 2015]. *The New England Journal of Medicine* website. <http://www.nejm.org/doi/full/10.1056/NEJMp1500445>.
2. Statutes/Regulations/Guidance. CMS website. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Statutes_Regulations_Guidance.html. Accessed February 27, 2015.
3. Oakes CG. Safety versus security in fire protection planning. American Institute of Architects website. <http://www.aia.org/practicing/groups/kc/AIAB079791>. Published May 2009. Accessed June 22, 2011.