Prior to the implementation of the Patient Protection and Affordable Care Act (ACA) in 2011, payments through the Medicare system were tied to the volume of patients seen, procedures performed, and tests run, even if these procedures did not advance the patient’s care. In an effort to achieve a “better healthcare system,” the U.S. Department of Health and Human Services (HHS) identified three interdependent areas that, through pioneering and cutting-edge reforms, have the potential to improve patient care across the U.S. These three areas include: using flexible incentives to motivate high value care from hospitals, physicians, and other providers; delivering care through effective coordination, teamwork, and integration; and, accelerating the availability and utilizing the power of information to improve patient and provider decision making. Since the implementation of the ACA, several programs have been established to help further these goals such as:

1. Electronic Health Records and Meaningful Use programs;
2. The Patient Centered Outcomes Research Institute (PCORI);
3. National programs to reduce readmissions through transitional care and educate hospitals on addressing high priority risks to patient safety; and,
4. The development and testing of new and alternative payment models including Accountable Care Organizations (ACOs), the Bundled Payment for Care Improvement Initiative, and new models for specialty and chronic care.

In furtherance of this desire to establish a “better healthcare system,” on January 26, 2015, HHS announced an initiative to transfer a large share of Medicare payments from the current fee-for-service model, paying for value rather than volume by incentivizing better outcomes and lower costs by rewarding quality and efficient care. This monumental announcement was the first time HHS set specific goals for alternative payment models and value based models in the 50 year history of the Medicare program. HHS plans to use internal metrics to track the progress of these goals and utilize population health statistics, currently measured and reported through Healthy People 2020, to track quality of care improvements in the U.S.

To explain variations between provider payment models, HHS adopted a Centers for Medicare and Medicaid Services (CMS) framework that categorizes healthcare reimbursement by the type of justification for the payment. Specifically:

1. Category 1 describes a fee-for-service payment with no link to quality or efficiency;
2. Category 2 describes a fee-for-service payment with a link to quality or efficiency of health care delivery system;
3. Category 3 describes an alternative payment model built on the fee-for-service architecture where payments are still triggered by delivery of services but there is an opportunity for shared savings when high quality, cost effective care is provided; and, 
4. Category 4 describes a population-based payment that is not linked to volume of services but instead is associated with the volume necessary to provide quality and efficient healthcare to a group of beneficiaries for a long period of time.

While categories 2 through 4 have a quality component related to payment and are considered a form of value based purchasing, transitioning from Category 1 (e.g. the current reimbursement model) to Category 4 (e.g. the ideal goal for reimbursement models) would require a greater focus on population health management, a transition from responding to the acute needs of an individual patient to anticipating and shaping patterns of care across subgroups. Population health management should:

1. Improve the overall patient experience;
2. Improve access to care;
3. Promote patient engagement and allow patients to take responsibility in the management of their individual health;
4. Lower the cost of care through an integrated delivery approach; and,
5. Reduce the frequency of individual health crises.
Under this recently released plan, HHS anticipates 30% of its Medicare reimbursement payments will be classified under an alternative payment model (e.g. categories 3 and 4 of payment framework) by the end of 2016 and 50% by the end of 2018. While this percentage may seem high, by the end of 2014, HHS already had 20% of its Medicare reimbursement payments classified under an alternative payment model. Additionally, HHS anticipates 85% of its Medicare reimbursement payments to have a quality or value component (e.g. falling in categories 2 through 4) by 2016 and 90% by 2018. Further, while these goals have been identified separately, any advancements made towards increasing the percentage of alternative payment models will help towards achieving the overall goal of aligning payments with a quality or value component.

HHS established the Health Care Payment Learning and Action Network (HCPLAN) to help with the necessary system transitions to ensure the work performed in one sector is aligned with the progress of another sector, reduce unnecessary duplication of work, and reduce the amount of confusion these changes may cause. HCPLAN will focus on the operational components necessary to successfully implement quality based care measures throughout the system as a whole and not just for the population covered by Medicare payments. Additionally, HCPLAN is responsible for fostering collaboration between HHS, consumers, providers, state and federal partners, private payers, and large employers to help transition advanced payment models, categories 3 and 4, into the market.

HHS Secretary Sylvia Burwell stated that, even with all of the improvements made so far, that many people today are still not receiving quality care as evidenced by one out of every ten hospitalized patients experiencing an adverse event during their episode of care. HHS envisions that by releasing these goals and using payment incentives to foster quality care, it will be able to accelerate the pace of improvements and advance change in a sustainable and permanent manner.
Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Institute of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: “Accountable Care Organizations: Value Metrics and Capital Formation” [2013 - Taylor & Francis, a division of CRC Press], “The Adviser’s Guide to Healthcare” – Vols. I, II & III [2010 – AICPA], and “The U.S. Healthcare Certificate of Need Sourcebook” [2005 - Beard Books]. His most recent book, entitled “Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services” was published by John Wiley & Sons in 2014.

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious “Shooshan Prize in Business Valuation” conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS).

Mr. Zigrang is the author of the soon-to-be released “Adviser’s Guide to Healthcare – 2nd Edition” (AICPA, 2014), numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: The Accountant’s Business Manual (AICPA); Valuing Professional Practices and Licenses (Aspen Publishers); Valuation Strategies: Business Appraisal Practice; and, NACVA QuickRead. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the Physicians Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).

Mr. Chwarzinski holds a Master’s Degree in Economics from the University of Missouri – St. Louis, as well as a, Master’s Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. Mr. Chwarzinski’s areas of expertise include advanced statistical analysis, econometric modeling, and economic and financial analysis.

Ms. Bailey is a member of the Missouri and Illinois Bars (HCC), where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey is a member of the Missouri Bar and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as Fall Managing Editor for the Journal of Health Law and Policy.

Mr. Hill is a member of the Missouri Bar and holds a J.D. and Health Law Certificate from Saint Louis University School of Law.