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How Physician-Focused APMs Aim to Overcome Challenges

Dr. Birnholz:
Alternative Payment Models, or APMs, have burst onto the healthcare scene alongside the induction of MACRA for introducing novel ways to reduce medical costs while improving quality of care, but it's been slow-going to date, as problems of standardization, high Medicare costs, physician confusion and a host of other issues threaten to undermine adoption of APMs. However, a recent trend toward physician-focused payment models is seeking to address these issues, and this will become the subject of today's discussion.

This is "Inside Medicare's New Payment System" on ReachMD, and I'm Dr. Matt Birnholz. Joining me is Harold D. Miller, President and CEO of the Center for Healthcare Quality and Payment Reform. We'll be discussing what physicians need to know about physician-focused payment models to more successfully navigate healthcare reform in practice.

Mr. Miller, welcome to the program.

Mr. Miller:
Thanks Matt, nice to be here.

Dr. Birnholz:
Great to have you with us. So, to help get us grounded on today's topic, how do we, or at least how should we, define alternative payment models?

Mr. Miller:
Well, an alternative payment model, which everybody refers to as an APM, is actually a very flexible outcome-oriented concept. Congress defined an APM as any method of paying for healthcare that achieves 1 of 3 results: lower spending without harming the quality of care, better quality of care without increase in spending, or both lower spending and better quality. The challenge for anyone who wants to develop an APM is to achieve those results. Just because the payment model is different, that doesn't mean it's better. A payment model that reduces spending in ways that harm the quality of care, such as by preventing physicians from delivering services that patients need, isn't better, and it wouldn't count as an APM. And the reverse is also true. A payment model could improve the quality of care in very desirable ways, but if it causes spending to increase, then it isn't eligible to be an APM. One of the problems we're facing today is that Medicare and other payers have implemented a number of payment models that are different, and they're being labeled as APMs. However, they're not actually meeting the criteria for an APM because they're not reducing spending, or they can't show that quality is being maintained or improved. And under federal law, CMS can't continue using a payment model in Medicare if it doesn't meet the criteria that Congress established, so that's why there's a lot of interest in getting better APMs.

Dr. Birnholz:
And that provides a great segue then into introducing this concept of physician-focused APMs. So, what's different about this approach, and why are they coming onto the scene now?

Mr. Miller:
Well, a key reason why I and many other people believe that the APMs that have been created by Medicare and other payers aren't working very well is because they're not really very different than traditional fee-for-service payments. They haven't actually changed the way individual physicians have been paid in ways that enable those physicians to deliver better care at a lower cost. For example, for most physicians, the only APM Medicare has made available to them is the Medicare Shared Savings Program. In that program, physicians that form an Accountable Care Organization, or ACO, can receive a bonus from CMS if the average amount that Medicare spends on the physician's patients is lower than CMS projected it would have been otherwise. However, nothing actually changes about

the way the physicians are paid. Every physician still receives the exact same fees for the exact same services that they do today, and they don't get paid for services for which there is no fee. The results to date have been disappointing to the Medicare program and to the participating physicians. Medicare spending in the ACOs has actually been higher than what CMS projects it would have been otherwise. Many of the physicians who were involved in the ACOs have invested a lot of money in them, but they've gotten no return on those investments because of serious problems with the way the program is structured, and as a result, a number of physician groups have actually left the program.

A growing number of physician practices and medical specialty societies are developing much better models than this. Long before MACRA was passed, the AMA began educating physicians about APMs, and physicians from a wide range of specialties became excited about the opportunities to improve care for their patients under a well-designed APM. The AMA held seminars all over the country, and just in the past year it held 2 workshops where dozens of physicians who were working on APMs came together to share their ideas. And thanks to all this work that's occurred over several years, innovative, physician-focused APMs have been developed in primary care, in oncology, cardiology, gastroenterology, allergy and immunology, rheumatology, neurology, emergency medicine and many other specialties. The challenge now is to get CMS and other payers to implement these APMs so that physicians can use them to deliver better care at lower costs for the kinds of patients that they treat.

Dr. Birnholz:
And it's encouraging news in terms of what's been put out there speculatively and what some of the returns have been as far as being able to create a positive outlook, but given what you've just talked about for the challenges that APMs have been facing to this point, I'm sure a number of our listeners are wondering what measures or evidence out there would give you confidence that physician-focused models would actually fare better.

Mr. Miller:
Well, it's a good question. We know it's possible for physicians to significantly improve the quality of care for patients while reducing the cost of care because there are many projects where they've already done it. There are many projects where physicians were able to deliver care differently, but it was only because they had a grant from Medicare or from a charitable foundation that enabled the doctors to pay for things that aren't paid for under fee-for-service. For example, there are many projects that have shown that enabling physicians to hire a nurse care manager to help chronic-disease patients manage their conditions, or enabling the physicians to deliver palliative care services in addition to treatment, or enabling physicians to deliver more services to patients in their own home, will actually improve the quality of care for the patients while also saving money. Unfortunately, without physician-focused payment models to sustain these projects when the grants come to an end, the improved services have to stop, the costs go back up, and the patients suffer.

Dr. Birnholz:
Let's switch gears for a minute and spend some time on a related track, because I think it's an important part of this conversation, and that's to focus on a special federal advisory group that evaluates these alternative payment models, which I actually believe you, yourself, are an original member of. It's called PTAC. What can you tell us about this particular committee and its role in payment reform?

Mr. Miller:
Medicare and other payers have traditionally used what I refer to as a top-down approach for designing APMs, and it's resulted in payment models that don't work well for the physicians who are delivering care or for their patients. When Congress passed MACRA, the Medicare Access and CHIP Reauthorization Act, it created a new bottom-up approach in which physicians could actually develop the APM designs that made sense to them and then submit those designs to the Federal government to be reviewed and hopefully implemented. To facilitate that, Congress created a new entity, an 11-member Physician-Focused Payment Model Technical Advisory Committee, which is a very long name, and so everybody calls it the PTAC for short. PTAC is a really unique entity. Its job is to make recommendations to the Secretary of Health and Human Services about whether to implement proposals for payment models that physicians develop. However, PTAC isn't appointed by the Secretary of HHS. The 11 members are appointed by the independent Government Accountability Office. So, the group has the ability to make independent objective recommendations, and I was honored to be appointed by the Comptroller General as one of the original 11 members of PTAC.

Dr. Birnholz:
Congratulations to you on that, by the way.

Mr. Miller:
Oh, thanks.

Dr. Birnholz:

And how many physician-focused APM proposals has PTAC received to this point?

Mr. Miller:
We've really been pleased at the response. PTAC started accepting proposals in December 2016, 18 months ago. Since then, we've received 25 complete proposals. We've completed our reviews of 18 of those proposals, and we recommended that HHS implement 10 of the models. All of the physician-focused payment models we recommended would address important opportunities to improve care and reduce costs that just aren't possible under either the current fee-for-service payment system or under the existing APMs that Medicare has implemented. For example, 2 of the proposals that we approved would enable a significant subset of the patients who currently have to go to a hospital to receive hospital-level care to get that same level of care in their own homes instead—called Hospital at Home. Similar programs have successfully operated at a large scale in Australia and other countries for many years, and there have been multiple evaluations showing the services both save money and improve patient outcomes. We recommended 2 proposals that would enable patients to receive palliative care services while they're still receiving treatment without having to be in a hospice program. Studies have shown that these kinds of services could significantly reduce spending and improve the quality of life for thousands of patients that have advanced illnesses. Another proposal that PTAC recommended would pay a bundled payment to a team of physicians who are managing a patient's health problem, regardless of where the care is delivered, either inside or outside the hospital. Although CMS has implemented a bundled-payment program in Medicare, it's been limited to patients who are admitted to the hospital for treatment of their health problem, and that ignores the savings opportunities by being able to treat patients outside of a hospital, and it could even encourage overuse of inpatient care.

Dr. Birnholz:
So, I suppose in that classic bench-to-bedside tradition of questions, my next million-dollar question is whether physicians are currently participating in these models that were approved by the advisory committee.

Mr. Miller:
Unfortunately, no, because they haven't had the opportunity to do so. We've been really very disappointed that CMS, Medicare, at least to date, hasn't been willing to implement any of the physician-focused payment models that the PTAC has recommended.

Dr. Birnholz:
That definitely sounds like a big disconnect, to put it lightly, but where do you think that's stemming from?

Mr. Miller:
Well, it's disappointing, but we're not sure exactly where the disconnect is coming from. CMS hasn't even responded to most of our recommendations, even though Congress required them in MACRA to do so and to do so publicly. My sense is that they are continuing to hope for one single payment model that will somehow guarantee Medicare a large amount of savings, and they see the models that we recommended as having too little impact.

Dr. Birnholz:
So, despite that obvious setback getting these recommended models in motion, do you think that these can still have a big impact if introduced and embraced by physicians?

Mr. Miller:
The impact of the APMs that Medicare has implemented so far has been so small that it wouldn't be hard to have a bigger impact! But seriously, I think the only way to have a big impact on Medicare spending is going to be through multiple payment models. And the reason is simple: most Medicare spending doesn't pay for just one thing. Patients have a variety of different issues and concerns. They have cancer. They have heart disease. They have arthritis. They have strokes. They have many, many different kinds of problems, and they receive care from different types of physicians for those different conditions. They receive different types of services. And the opportunities to improve care and reduce costs differ for different health conditions and different services. There's just no way that one generic alternative payment model could address that, and there's certainly no way, I believe, that any one model could be truly physician-focused or patient-focused.

Dr. Birnholz:
It's a very intuitive point that I think often gets lost in this whole conversation about health reform—the idea that patients are more complex than singular conditions. What about the payers other than Medicare? Are they doing something to help implement physician-focused payment models?

Mr. Miller:
Some of them are. For example, the first payment model that the PTAC recommended was developed by a gastroenterology group in Illinois, and they knew it could work when they brought it to PTAC because Illinois Blue Cross Blue Shield had already been paying

them that way for the patients that the Blue Cross plan insured. Although the proposal was focused on Crohn's disease patients, because that's one of the chronic conditions that gastroenterologists treat, Medicare could easily implement a similar approach with many other specialties for the chronic conditions those specialists treat, and that would have the potential for significant total savings for Medicare and better outcomes for many Medicare beneficiaries. In general, though, what I've seen is that most private health plans won't make changes in the way they pay unless Medicare also makes the change, because Medicare is such a big part of most physicians' practices.

Dr. Birnholz:
So, Mr. Miller, my last question to you, as a sort of capstone to this issue: Looking ahead, would you say you're feeling optimistic or pessimistic about what's to come for reforming the payment system after everything we've just discussed?

Mr. Miller:
Well, I'm optimistic, and it's because I've seen what physicians can do to improve care and control spending when they're given the resources and flexibility that they need. Physicians have demonstrated through the PTAC process and otherwise that they have good ideas for how to change the payment system and ways that will achieve those goals. We just need to let them implement those ideas.

Dr. Birnholz:
Mr. Miller, a pleasure to have you on the program today.

Mr. Miller:
Thanks for your interest in the issue.

Dr. Birnholz:
This is ReachMD, and I'm Dr. Matt Birnholz. To download this podcast or others in this series, visit ReachMD.com/AMA. We welcome your comments and feedback, and thanks for listening.