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What Are Physician-Focused Payment Models?

Dr. Matt Birnholz (Host):
The new Quality Payment Program created by the Medicare Access and CHIP Reauthorization Act, or MACRA, has generated a lot of questions from the physician community regarding how to participate, and what that participation will mean for benefitting practices. On today's program, we'll investigate physician-focused alternative payment models, or APMs and their emerging role in this new Quality Payment Program. You're listening to Inside Medicare's New Payment System, and I'm Dr. Matt Birnholz. Joining me to discuss APMs is Sandy Marks, Assistant Director of Federal Affairs at the American Medical Association.

Sandy, welcome to the program.

Sandy Marks:
Thank you for having me.

Dr. Birnholz:
It's great to have you with us. So, to start, let's first review the basics of APMs. What specifically are they intended to do for physicians?

Sandy Marks:
Well, alternative payment models, or APMs, can provide physicians with more flexibility than the fee-for-service program. They can support non-face-to-face services that are not paid for under the fee schedule, and they can also provide flexibility by paying for episodes of care with a bundled-payment, instead of each service separately. In addition, they can allow physicians to earn extra payments, such as monthly care management payments, and a share of the cost savings that they help to generate.

Dr. Birnholz:
So, the share of cost savings that brings up the idea of incentives or bonuses with savings, what are these incentives and bonuses that we've been hearing about?

Sandy Marks:
Well, this new Medicare Quality Payment Program provides bonus payments annually for 6 years for physicians who participate in APMs, and it provides bonuses of 5% each year in a lump sum. To qualify, the APMs have to require their participants to use electronic health records, tie payments to quality measures in some way, and repay a portion of the difference if they miss their savings targets. Also, the physicians who participate in the APM need to reach certain levels of participation. So, in the first 2 years, which is 2017 and '18, at least 25% of the physicians' Medicare revenues must come through the APM in order for them to quality for the 5% bonuses. These thresholds increase over time, but in the future years, they can be met with a combination of APMs supported by Medicare and those offered by other payers. APM participants are also going to be exempt from the new quality reporting program called MIPS, so that's another important incentive for people. And if physicians who are participating in the APMs don't quality for the APM bonus payments, they can still use their APM participation to improve their MIPS score.

Dr. Birnholz:
And just to clarify, Sandy, there are three different types of APMs, is that right? Can you give us a brief rundown on the different types?

Sandy Marks:
Well, there are three main types available in Medicare today: medical homes, bundled-payments, and Accountable Care Organizations, or ACOs. But MACRA promotes the development of a wider array of APMs that can allow more physicians to participate in them, and it created an advisory committee specifically for that purpose, to review proposals that stakeholder organizations submit for physician-focused APMs, and these can come from groups like medical societies or even practices.

Dr. Birnholz:
Well, let's focus on one of those societies, a major stakeholder group, and that's your base of operations. What has the AMA, in particular, been doing to help physicians understand and participate in APMs?

Sandy Marks:
The legislation initially passed in 2015. So, for the past couple of years, we've been reviewing and discussing with the Senate for Medicare Services that runs Medicare, what the details would be for implementing the new program and what the regulations would be. So we reviewed the proposed policies for APMs in detail and successfully urged CMS to make some improvements when it issued the final regulations. One of the most important of these improvements is that CMS lowered the minimum requirement for APMs to repay financial losses by allowing those losses to be linked to the practice's revenues, instead of the total Medicare spending on the APMs' patients. And that was important because spending on physician services or physician revenues are only a small percent of the total cost of care. So, that change alone is going to probably expand the number of qualified APMs in which physicians can participate.

Dr. Birnholz:
So Sandy, that' s great information, and I'd love to get an idea of some real world cases that can help illustrate what you've been talking about. Can you share with us how some physicians have put this into practice?

Sandy Marks:
Yes. There are several examples already of pilot programs. A doctor in Colorado, Dr. Jennifer Wiler, an emergency physician, got a CMS Innovation Award that she used to support patient education, care coordination, and post discharge services for her emergency department patients. And this model was able to reduce emergency visits 41% by patients who had been coming to the emergency department more than three times a year, and 80% of those patients now have a regular primary care physician. Another example is in Illinois. A gastroenterologist, Dr. Larry Kosinski, developed a specialty medical home for patients with Crohn's disease, with support from Illinois Blue Cross and Blue Shield.

Dr. Birnholz:
Actually, Sandy, I have to interject. I love that you mentioned this example off the bat, because I had the opportunity to interview Dr. Larry Kosinski about SonarMD, I believe, is that right?

Sandy Marks:
Right. Yes. He called it "sonar" because he said his Crohn's patients were like submarines with no payment for phone or email outreach, the patients were under water, where he had no idea when there was a problem and could not help them manage it. SonarMD has cut hospital admissions in half, and was among the first proposal submitted to the Physician-Focused Payment Model Technical Advisory Committee for review. And then, among surgeons, Dr. Stephen Zabinski, in New Jersey, has a total joint replacement model that supports intensive preoperative care for patients, focused on risks that they're able to modify before they have surgery; things like their body mass index, diabetes control, and smoking, and that prehab improves their surgical outcomes and makes their postop rehab faster and less costly. So there are a few.

Dr. Birnholz:
A great few. It's wonderful diversity in those examples that you've just provided us at the clinical practice level. Now, what about the society or association level?

Sandy Marks:
Well, medical societies and associations of all sizes are also developing and piloting these physician-focused APMs. So, I'll give you a few examples, although there are really a large number in the pipeline. The Wisconsin and Florida chapters of the American College of Cardiology got an award from CMS for a model they call SMARTCare, and that uses point-of-care decision tools and registries to improve the appropriateness of tests and procedures for patients with stable ischemic heart disease and reduce their risk of heart attacks. The American College of Surgeons is leading a bundled-payment approach that can be applied to hundreds of episodes that are done by many different teams of physicians, including surgeons, anesthesiologists, pathologists, hospitalists, and others, and the College's proposal is among the first that was submitted to the Physician-Focused Payment Model Committee for review. But, you don't have to be a big society to do this, a smaller society, the Society of Gynecologic Oncology, has been working on APMs for treating ovarian and endometrial cancer that involve team-based development of treatment plans and can reduce the number of repeat operations, improve outcomes, and improve patient and physician-shared decision-making about their care over the entire course of the disease. Finally, the American Academy of Neurology is working on APMs for epilepsy and also for headaches to improve diagnostic accuracy, ensure patients are getting the best medication, and improve medication adherence. The models involve monthly payments that replace the payments they currently receive for office visits. And several other specialties are also working on models that involve a very similar approach to this one.

Dr. Birnholz:
Well, thanks Sandy, that's another great sampling from the society level. Before we wrap up our discussion, are there any parting comments you want to summarize or reiterate for our audience regarding APMs?

Sandy Marks:
Well, I think it's clear that physician-focused APMs have real potential to change the way that physicians manage serious conditions in ways that can improve outcomes for patients. They can also lower growth in healthcare costs and improve the financial sustainability of the physician practices. There are a lot of specialties working on this and physicians who are interested in APMs should contact their own specialty society to find out if there are APMs under development that would apply to their own patients. The AMA has also developed a free online tool. We call it the Payment Model Evaluator which allows any physician or practice manager to answer 12 questions, to evaluate if they qualify for one of the MACRA APMs.

Dr. Birnholz:
And Sandy, where can people find that and other tools and resources?

Sandy Marks:
Well, we have actually quite a number of AMA resources on MACRA and they're all available at AMA-ASSN.org/Medicare-payment.

Dr. Birnholz:
With that, I very much want to thank my guest, Sandy Marks, Assistant Director of Federal Affairs at the American Medical Association. We've been talking about Alternative Payment Models, or APMs, as an important new determinant of physician reimbursement within Medicare's new payment system.

To access this interview and other related content, visit ReachMD.com or download the ReachMD app. I'm Dr. Matt Birnholz, as always, inviting you to Be Part of the Knowledge.