Physicians show the way for Medicare's Alternative Payment Models

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Alternative Payment Models (APMs) are one of the payment pathways of Medicare's Quality Payment Program (QPP). APMs that are recognized in the QPP include Comprehensive Primary Care Plus, which is a patient-centered medical home model, and Medicare accountable care organizations. Other innovative models are being developed for specialty practices, as *AMA Wire*® stories explained in 2017.

Work is ongoing to develop APMs. Specialty societies have been active in developing APM proposals for the physicians they represent. The AMA has also been active in developing resources that can assist them on this journey.

Several APM proposals developed by specialists have already been recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and others are under review by the committee. An APM for patients with Crohn's disease or ulcerative colitis was the first approved by the PTAC. It grew out of data from a private payer showing that, of the more than 50 percent of Crohn's patients hospitalized with complications of their disease, less than one-third had seen any physician within the 30 days preceding their hospital admission.

Under the model, called SonarMD, participating gastroenterologists receive funding support for proactive outreach to patients by nurse care managers. Each patient receives a "ping" via text message, email or phone each month with a few structured questions. The nurses are able to use the patients' responses to these questions, called Sonar scores, to alert the gastroenterologists if they need to see the patient or adjust their medication regimen. The Sonar model has cut the rate of hospitalizations in half.

Two APM workshops for physicians that were convened by the AMA this year helped to highlight the work underway at many specialty societies to develop physician-focused APM proposals.

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Increased opportunity and flexibility sought. The AMA also welcomed a proposed new direction for the Center for Medicare and Medicaid Innovation that had the expressed goal of increasing opportunities for APM participation.

The AMA is working with CMS to secure more advanced APMs for physicians. In the comment letter on this new direction, the AMA called for CMS to adopt APMs that support more accurate diagnoses, treatment planning, care coordination, and outreach to high-risk patients to ensure they get preventive services. The highest priority should be expanding and accelerating the availability of APMs in which specialists can participate.

"Future proofing" medical practices' investments. In an *AMA Wire* Leadership Viewpoints column, AMA President David O. Barbe, MD, MHA, described how CMS is incentivizing participation in APMs as "an opportunity to improve care and reduce spending for payers and patients."

"A growing number of medical specialty societies are working in partnership with their members to develop APM proposals that Medicare and other payers can implement under MACRA," Dr. Barbe wrote. "Taking purposeful steps to align our current practice-improvement efforts under MIPS with the eventual demands of APMs is a great way to future-proof our investments."

CMS takes steps to make Medicare ACO program more attractive. These steps included limiting downside financial risk for physicians participating in the new ACO Track 1+ while allowing them to collect the lump-sum bonus that formerly only allowed for riskier plans.

"The AMA supports CMS as it expands the models that can qualify as advanced APMs, allowing more practices to be eligible for 5 percent Medicare bonus payments," former AMA President Andrew W. Gurman, MD, said in a statement. "We hope that CMS will continue to expand the list of advanced APMs in the future so new delivery and payment arrangements can be supported and promoted."

In addition to the bonus and comparatively reduced risk, other elements of the Medicare ACO model Track 1+ include:

- A limit on the 30 percent loss-sharing rate, based on 8 percent of Medicare fee-for-service payments or 4 percent of the ACO's updated historical benchmark. Which cap applies is determined by the ACO's composition.
- Prospective beneficiary assignment, which allows the ACO to know which patients it will be accountable for in measuring performance.
- A process to apply for waivers from Medicare's skilled nursing facility (SNF) three-day stay rule, which mandates a patient stay of at least three consecutive days as a requirement for SNF coverage.
- A participation limit of three years.

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