

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-15

Subject: Update on Payment Mechanisms for Physician-Led Team-Based Health Care

Presented by: Robert E. Hertzka, MD, Chair

Referred to: Reference Committee J
(Jeffrey P. Gold, MD, Chair)

1 At the 2013 Interim Meeting, the House of Delegates adopted as amended Council on Medical
2 Service Report 1, "Payment Mechanisms for Physician-Led Team-Based Health Care." The report
3 was amended to ask that the American Medical Association (AMA) "report back to the House on
4 issues, developments and AMA activity on payment mechanisms for physician-led team-based care
5 by the 2015 Interim Meeting" (Policy D-160.933). The Board of Trustees referred the requested
6 study to the Council on Medical Service for report back to the House at the 2015 Interim Meeting.

7
8 This report builds on the Council's previous reports on physician-led team-based care, including
9 one report focused on payment; outlines the transition of Medicare's payment system to include
10 value-based alternative payment models; acknowledges an increasing emphasis on team-based
11 payment; highlights examples of specialty-specific team-based innovative payment models;
12 summarizes AMA advocacy, activity and relevant policy; discusses avenues for AMA advocacy
13 and policy development; and presents policy recommendations.

14 15 BACKGROUND

16
17 Established by Council on Medical Service Report 1-I-13, "Payment Mechanisms for Physician-
18 Led Team-Based Health Care," AMA Policy H-160.908 advocates that payment models for
19 physician-led team-based care should be determined by physicians working collaboratively with
20 hospital and payer partners to design models best suited for their particular circumstances.
21 Physician team leaders should receive the payments from health insurers for services provided by
22 the team and establish payment disbursement mechanisms that take into consideration each team
23 member's contribution. The policy also states that an effective payment system for team-based care
24 should reflect the value, time, effort and intellectual capital provided by individual team members,
25 be adequate to attract team members of high caliber, and be sufficient to sustain the team over the
26 time frame that is needed.

27 28 REPEAL OF THE MEDICARE SUSTAINABLE GROWTH RATE (SGR) FORMULA

29
30 In April 2015, the AMA and other stakeholders were successful in lobbying to pass legislation
31 eliminating Medicare's SGR formula. The passage of H.R. 2, the "Medicare Access and CHIP
32 Reauthorization Act," (MACRA), is expected to potentially have great impact on the way
33 physicians practice medicine and receive payments for services provided.

1 *Alternative Payment Models (APMs)*

2
3 Medicare fee-for-service payments will be retained under MACRA, although physicians are
4 encouraged to participate in value-based Alternative Payment Models (APMs) through “alternative
5 payment entities” in order to receive APM bonus payments. An “alternative payment entity” either:
6 (a) bears financial risk under an APM for monetary losses that are in excess of a nominal amount;
7 or (b) is a medical home expanded under the Centers for Medicare & Medicaid Services (CMS)
8 Innovation Center’s authority. Physicians participating in APMs will receive annual bonus
9 payments equal to five percent of their covered Medicare professional services provided during
10 2019 through 2024. To be eligible for these payments, physicians’ level of participation in the
11 qualified APMs must reach certain threshold levels, starting with 25 percent of revenues in 2019 –
12 2020 and growing to 75 percent by 2023. Physician participation in APMs is voluntary.

13
14 APMs are designed to improve care coordination and professional collaboration, which foster
15 team-based care. Under fee-for-service Medicare, team-based health care services are currently not
16 billable. The option to participate in an APM allows physicians the opportunity to provide team-
17 based care and receive payments for such services. For example, in an APM a surgeon who
18 removes a patient’s cancer and the surgeon who provides the reconstructive surgery could both
19 receive payment when collaboratively working to avoid repeat operations.

20
21 *Merit-based Incentive Payment Systems (MIPS)*

22
23 Under MACRA, the current fee-for-service payment incentive programs – Meaningful Use,
24 Physician Quality Reporting System and Value-Based Modifier – will be replaced with the new
25 Merit-Based Incentive Payment System (MIPS) starting in 2019. MIPS will include measures from
26 these programs as well as a new “clinical practice improvement activities” area that has not yet
27 been developed. CMS has more flexibility to tailor MIPS to the needs of individual specialties.
28 MACRA exempts physicians with low Medicare volume from MIPS and gives special
29 considerations for practices that are small, rural or in underserved areas. Our AMA advocated for
30 these provisions.

31
32 *AMA Advocacy*

33
34 In response to the passage of MACRA, the AMA developed a Federation task force made up of
35 state and specialty societies to discuss the legislation and how physicians can successfully navigate
36 the new law. The AMA has also developed Federation workgroups on the MIPS and APMs with
37 the goal of determining innovations physicians are already engaged in, discussing implementation
38 issues with CMS, and developing relevant policy recommendations.

39
40 **TEAM-BASED PAYMENT**

41
42 CMS recognizes the value of team-based care and is considering payment refinements to improve
43 the accuracy of payments to physicians working in collaborative care practice arrangements. The
44 AMA is providing input on improving payment accuracy for primary care and care management,
45 including interprofessional services and consultations. In addition, the AMA Current Procedural
46 Terminology (CPT[®]) Editorial Panel and the Relative Value Scale (RVS) Update Committee
47 (RUC) are working with specialty societies on specific coding and valuation issues for
48 collaborative care payments.

1 SPECIALTY-SPECIFIC TEAM-BASED ALTERNATIVE PAYMENT MODELS

2
3 The recent emphasis on APMs focuses mainly on delivering primary care services and
4 hospital-based procedures. The primary care medical home model is a well-established
5 team-based delivery model with a payment structure emphasizing value instead of volume.
6 There has been rapid growth in accountable care organizations and many physicians now
7 participate in this shared savings model. While many specialties are interested in developing
8 APMs, at this time Medicare does not approve specialty models on a wide scale. Following are
9 four examples of innovative payment models developed by non-primary care specialties:

10
11 *Integrated Physical and Behavioral Health Care – Global Budget Payments*

12
13 The Sustaining integrated Healthcare Across Primary care Efforts (SHAPE) initiative in Colorado
14 is evaluating the use of a global budget payment model for the integration of physical and
15 behavioral health care. SHAPE's global budget payment model allocates payments based on each
16 practice's cost, panel size, panel complexity, and program design. The model includes shared risk
17 and quality targets between a practice and payer. A comparison of the costs and outcomes in
18 integrated practices using a global budget payment model and integrated practices using traditional
19 payments will be published in late 2015.^{1,2}

20
21 *Oncology – Patient-Centered Oncology Payment (PCOP)*

22
23 PCOP is an innovative payment model designed by the American Society of Clinical Oncology
24 (ASCO) to support higher quality cancer care at a lower cost. Practices are accountable for
25 delivering high-quality care, such as following evidence-based use criteria for drugs, helping
26 patients avoid and manage complications of treatment, and support patients' advanced care needs.
27 Payments provide sufficient resources and flexibility for oncology practices to tailor health care
28 services to meet each patient's unique needs.³

29
30 *Transplant Surgery – Tiered Payments*

31
32 The transplant community has used a tiering system for at least 20 years to pay providers involved
33 in an episode of care. First or second tier providers are involved in 5 - 95 percent or more of the
34 cases and receive a prospective payment based on an agreed upon percentage of each case's total
35 payment according to historical payment data. Third tier providers are involved in less than five
36 percent of the cases and are paid from funds set aside according to a pre-negotiated rate. For cases
37 that do not necessitate third tier providers, the funds set aside are distributed to the first and second
38 tier providers.⁴

39
40 *American Society of Anesthesiologists (ASA) – Various Payments*

41
42 The ASA has been developing the Perioperative Surgical Home (PSH) model of care for nearly
43 four years as a cost-effective pathway to provide perioperative services. The PSH provides acute
44 episode care that contributes to overall population health management, cost savings and improved
45 quality of care. ASA is exploring feasible payment models given the challenges of providing
46 perioperative services.⁵

1 AMA ADVOCACY AND ACTIVITIES

2
3 *Professional Satisfaction and Practice Sustainability*

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5 Since 2013, the AMA strategic plan has included a focus on shaping payment and delivery models
6 to enhance physician satisfaction. CMS Report 1-I-13 reported that as part of this focus area, the
7 AMA collaborated with RAND Corporation to conduct in-depth field research on delivery and
8 payment models. The 2013 AMA-RAND study, “Factors Affecting Physician Professional
9 Satisfaction and their Implications for Patient Care, Health Systems, and Health Policy,” aimed to
10 better understand which payment models promote satisfaction and sustainability in different
11 practice settings, and to identify critical factors of success.⁶

12
13 In 2015, the AMA again collaborated with RAND Corporation to research the impact that various
14 payment models have on physician practices, their professional lives and the delivery of patient
15 care. The 2015 AMA-RAND study, “Effects of Health Care Payment Models on Physician Practice
16 in the United States,” aimed to describe the effects that alternative health care payment models
17 have on physicians and physician practices in the US.⁷

18
19 The results of the 2015 AMA-RAND study are guiding efforts to make improvements to current
20 and future payment innovations and help physician practices succeed in these new payment models
21 regardless of their mode of practice. The AMA is working with physicians, hospitals, commercial
22 payers, employers, and federal and state policymakers to ensure the success and sustainability of
23 payment models that improve patient care.

24
25 *AMA Innovators Committee*

26
27 In June 2011, the AMA formed the Innovators Committee, an advisory group of physicians with
28 experience in the development and management of innovative delivery and payment models. The
29 committee completed its charge by guiding the development of AMA resources to help physicians
30 enact innovations that improve patient care and increase their professional satisfaction and success.

31
32 Council Report 1-I-13 noted that in July 2012, the Innovators Committee released a whitepaper
33 entitled “Physician Payment Reform: Early Innovators Share What They Have Learned.” In April
34 2014, the Innovators Committee released another whitepaper entitled “Where Do I Fit In? Dividing
35 the Pie in New Payment Models.” These whitepapers illustrate how payments might be
36 appropriated to individual physicians and non-physician practitioners within a team.

37
38 RELEVANT AMA POLICY

39
40 The AMA will continue to monitor health care delivery and physician payment reform activities,
41 and provide resources to help physicians understand and participate in these initiatives. The AMA
42 will also continue to work with the Federation to identify, publicize and promote physician-led
43 payment and delivery reform programs that can serve as models for others working to improve
44 patient care and lower costs (Policy D-385.963).

45
46 In its work with CMS to shape the implementation of APMs, the AMA will advocate for physician
47 leadership and accountability to deliver high quality and value to patient care; diversity of
48 physician-led practice models; and opportunities for physicians to determine payment models that
49 work best for their patients, practices, specialties and regions. The AMA will advocate that APMs
50 consider physician readiness to assume up-side and down-side risk. The AMA will assist physician
51 practices by offering support and guidance to optimize the quantity and content of physician work

1 under APMs; address physicians' concerns about the operational details of APMs to improve their
2 effectiveness; provide resources for data management and analysis; and coordinate key components
3 of APMs across multiple payers, especially performance measures to help physician practices
4 respond constructively. (Policies H-390.844 and H-450.931).

5
6 AMA Policy H-385.915 calls on the AMA to promote the development of sustainable payment
7 models that could be used to fund the necessary services inherent in integrating behavioral health
8 care services into team-based primary care settings. In addition, independent physician practices
9 and small group practices are encouraged to consider opportunities to form health care teams such
10 as through independent practice associations, virtual networks or other networks of independent
11 providers (Policy H-160.912).

12 DISCUSSION

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15 Team-based payment models should reflect the diversity of physician practices and provide
16 opportunities for physicians to choose the payment mechanism or mechanisms that work best for
17 their patients, practices, specialties and regions. The option to participate in a Medicare APM
18 allows physicians to practice team-based care and receive payments for such services. To allow all
19 sizes of physician practices to have the opportunity to participate in a Medicare APM, the Council
20 recommends reaffirming Policy H-160.912, which encourages independent physician practices and
21 small group practices to consider forming health care teams such as through independent practice
22 associations, virtual networks or other networks of independent providers.

23
24 The Council also recommends reaffirming Policy H-160.908, which advocates that payment
25 models for team-based care should be determined by individual physician practices working
26 collaboratively with hospital and payer partners to design payment models that are best suited for
27 their particular circumstances.

28
29 Established by Council on Medical Service Report 1-I-13, AMA Policy H-160.908 advocates that
30 physician team leaders should receive the payments from health insurers for services provided by
31 the team and establish payment disbursement mechanisms that take into consideration each team
32 member's contribution. To assist in this endeavor, the Council suggests encouraging public and
33 private health insurers to develop and offer a variety of value-based contracting options so that
34 physician practices can select payment models that best suit their delivery models.

35
36 Physicians are understandably concerned about taking on financial risk that cannot be determined
37 in advance. The Council suggests encouraging CMS to ensure that Medicare APMs do not require
38 physicians to assume responsibility for costs they cannot control because it could potentially create
39 an ethical conflict of interest. For example, non-compliant patients may require more services,
40 which could result in lower incentive payments to their physicians.

41
42 The recent emphasis on APMs focuses mainly on delivering primary care services and hospital-
43 based procedures. There has been rapid growth in accountable care organizations and many
44 physicians now participate in this shared savings model. Bundled payment programs developed to
45 date have focused almost exclusively on hospital episodes. While many specialties are interested in
46 developing APMs linked to patient conditions instead of being tied to a hospitalization, at this time
47 Medicare has not provided a pathway for approval and implementation of these types of models on
48 a wide scale. The Council suggests that the AMA continue to advocate to CMS that physicians in
49 all specialties and modes of practice must have at least one Medicare APM in which they can
50 feasibly participate.

1 MACRA establishes a Physician-Focused Payment Model Technical Advisory Committee (TAC)
2 to review proposed alternative payment models submitted by stakeholders and make
3 recommendations to the Secretary of the Department of Health and Human Services on whether the
4 models meet established criteria. The AMA nominated several individuals to serve on the TAC.
5 The Council suggests advocating to CMS that any review process of APMs proposed by
6 stakeholders be completed in a timely manner, include an administratively simple appeals process
7 and access to an ombudsman.

8
9 Finally, the Council recommends rescinding Policy D-160.933[2], which calls for the update that
10 has been accomplished by this report.

11
12 **RECOMMENDATIONS**

13
14 The Council on Medical Service recommends that the following be adopted and that the remainder
15 of the report be filed:

- 16
17 1. That our American Medical Association (AMA) reaffirm Policy H-160.912, which
18 encourages independent physician practices and small group practices to consider
19 opportunities to form health care teams such as through independent practice associations,
20 virtual networks or other networks of independent providers. (Reaffirm HOD policy)
21
- 22 2. That our AMA reaffirm Policy H-160.908, which advocates that payment models for
23 physician-led team-based care should be determined by physicians working collaboratively
24 with hospital and payer partners to design models best suited for their particular
25 circumstances. (Reaffirm HOD Policy)
26
- 27 3. That our AMA encourage public and private health insurers to develop and offer a variety
28 of value-based contracting options so that physician practices can select payment models
29 that best suit their delivery of care. (New HOD Policy)
30
- 31 4. That our AMA encourage the Centers for Medicare & Medicaid Services (CMS) to ensure
32 that Medicare Alternative Payment Models (APMs) do not require physicians to assume
33 responsibility for costs they cannot control because such a requirement could potentially
34 create an ethical conflict of interest. (New HOD Policy)
35
- 36 5. That our AMA continue to actively advocate to CMS that physicians in all specialties and
37 modes of practice must have at least one Medicare APM in which they can feasibly
38 participate. (New HOD Policy)
39
- 40 6. That our AMA advocate to CMS that any review process of alternative payment models
41 proposed by stakeholders be completed in a timely manner, include an administratively
42 simple appeals process and access to an ombudsman. (New HOD Policy)
43
- 44 7. That our AMA rescind Policy D-160.933[2], which was accomplished with this report.
45 (Rescind HOD Policy)

Fiscal Note: Less than \$500.

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