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Navigating Alternative Payment Models

Understanding APM Design and Suitability for Provider Organizations

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ORANGE PAPER

Navigating APMs

The US healthcare industry is undergoing a seismic shift to emphasize value over volume. The federal government, states, and private payers are collectively pushing healthcare providers to move from a fee-for-service reimbursement model to value-based payments (VBP), with payment tied to cost and quality outcomes. As a result, providers are under substantial pressure to participate in Alternative Payment Models (APMs). However, there is considerable uncertainty about how these models function and which specific APMs make sense for individual providers.

In the 2015 bipartisan MACRA legislation, Congress approved incentives for providers to participate in Advanced APMs. Additionally, the Centers for Medicare and Medicaid Services (CMS) has set a goal of 50% of Medicare payments through Advanced APMs. And the Federal government is not alone on this. Numerous states, such as New York, have set targets for transitioning to VBP in their Medicaid programs and have created incentives and penalties for meeting these goals. Commercial payers such as Aetna, Anthem, and Cigna have also made similar commitments and are focused on aligning on common approaches with CMS and other payers.

ADVANCED APMS

- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Medicare Shared Savings Program – Tracks 1+, 2, and 3
- Bundled Payment for Care Improvement – Advanced Model
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive ESRD Care (CEC)
- Vermont All-Payer ACO Model

What is an APM?

At the most basic level, APMs are designed to provide financial incentives for performance based on measurements of cost and quality. CMS has specified that "Advanced" APMs must meet specified criteria including:

- More than a nominal amount of financial risk;
- Payment adjusted based on quality measures similar to those used in the MIPS program; and
- Require use of certified EHRs

As of February 2018, CMS identified 11 models that meet these criteria, including the Medicare Shared Savings Program (Tracks 1+, 2, and 3)[1], Next Generation Accountable Care Organization (ACO), and the recently introduced advanced version of the Bundled Payments for Care Improvement Program (BPCI-A). Additionally, providers can expect additional APMs to be introduced soon, as MACRA also created a Physician-Focused Payment Model Technical Advisory Committee (PTAC) to make recommendations to HHS on proposals for APMs submitted by individuals and stakeholder entities, such as medical societies and provider organizations.

A key challenge for providers is understanding these programs to evaluate whether to participate and which APM is best aligned to their organization. However, most APMs are quite complicated with varying design elements - complex rules and methodologies - that dictate performance and success under these models (see Figure 1). Whether a provider is evaluating its initial foray into APMs or is already participating in APMs and considering shifting to a more advanced model, a thoughtful assessment of these key variables is necessary to make this critical strategic decision.

1. At the time of this writing, CMS is finalizing a proposed rule, "Pathways to Success", to overhaul the ACO program, reduce the number of tracks available, and phase out upside-only risk models

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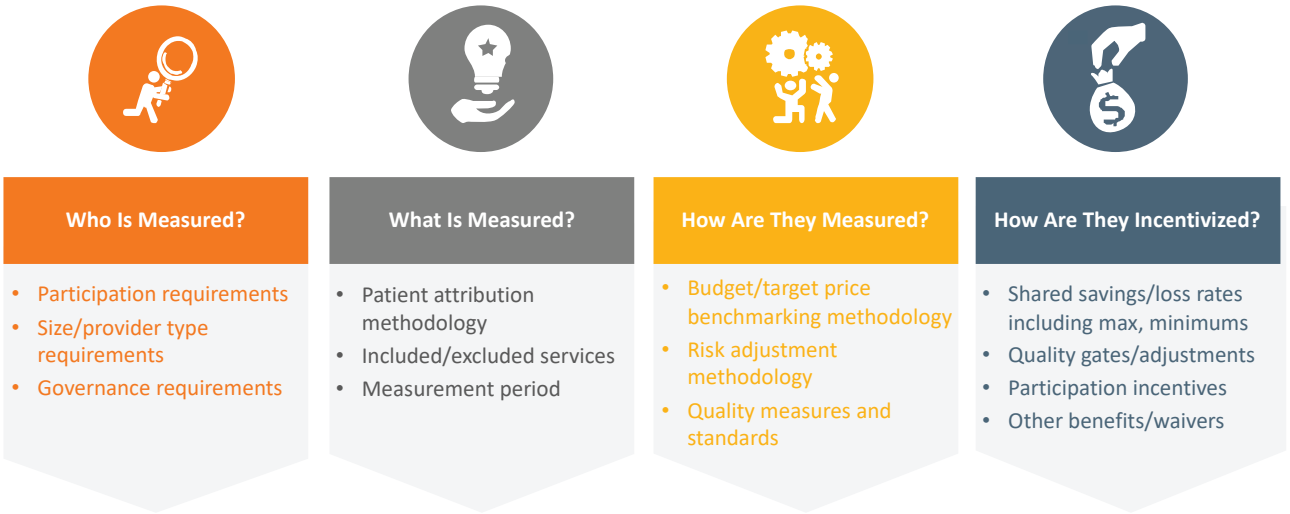
Figure 1: APM Design Elements



How do APMs Work?

A simple framework helps illuminate the key categories of design elements that define an APM:

1. Who is Measured?

APM models vary substantially in the rules governing which entities can participate and which entity is ultimately held accountable for outcomes. For example, an ACO in the MSSP can be made up of nearly any combination of provider types, yet it must include clinicians providing primary care services to at least 5,000 Medicare beneficiaries. In a bundled payment model, such as BPCI-A, participants must be clinical episode initiators (typically hospitals) or otherwise serve as convening organizations that manage risk among all participants.

Key Considerations for Provider Organizations

1. Does your provider network include physicians with the **key specialties** required for the APM model?
2. Does the provider network have **sufficient size and scale**? Are external partners required?
3. Are your providers willing and **committed to accountability** for costs and quality?

2. What is the Scope of Accountability?

A critical aspect of an APM model is the scope of accountability, essentially which patients and which services over what time period will be included in determining performance. APMs utilize different attribution methodologies that define which patients are included and which are excluded. Additionally, models vary based on the overall scope of services included, such as a short-term clinical episode, or all medical services for the patient. For example, an ACO is held accountable for all medical care for its patients, who are attributed retrospectively or prospectively based on primary care visits. In BPCI-A, patients are attributed based on a "trigger" event, after which the provider is accountable for all care for a defined window of time following that procedure.

Key Considerations for Provider Organizations

1. Does your network breadth allow your organization to sufficiently **control and influence care** within the scope of accountability of the APM model?
2. Does the attribution methodology allow you to effectively **identify and manage patients**?

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3. How is Performance Determined?

All APMs measure performance against a cost and quality standard, however, the nuances of this design element are critically important to ensuring a sustainable business case for providers. Cost performance is typically measured against a pre-determined budget, which may be set based on a combination of historical cost, regional or peer costs, and a trend or discount factor, plus a risk-adjustment methodology to account for case mix. Quality performance may be measured through use of an assortment of measures collected from various sources including claims, registries, EHRs, or patient surveys, and targets are typically set based on peer benchmarks. As an example, an MSSP ACO is measured against a budget based on a blended 3-year average of historical costs plus a national trend factor[2] which is risk-adjusted using the CMS-HCC model and then scaled based on quality scores relative to national performance.

Key Considerations for Provider Organizations

1. Will the **benchmarking methodology** compare your results to past performance or regional market and which are you more **favorably positioned** against?
2. Does the **risk adjustment methodology** adequately eliminate insurance risk and account for the risk profile of your patient population?
3. Are the required **quality measures** relevant to and currently reported by your organization?

4. How are Incentives Structured?

The risk arrangement of the APM drives the ultimate bottom-line impact to the provider, dictating the amount of savings or losses (as determined by the budget benchmark) to be shared between the payer and provider. Most commonly, these amounts are determined retrospectively through comparison of actual costs incurred using FFS payments to the benchmarks discussed above, but in some cases are distributed prospectively, such as in a capitated model. These amounts may be adjusted up or down based on a quality scoring methodology.

Crucially, the incentive and risk-sharing design is the most sensitive to the composition of the APM participants, as the scale of the organization typically dictates its ability to assume financial risk and need for upfront incentives to enable the investment required. Some APM models account for this, such as the MSSP Track 1+[3], which is customized to limit the downside risk of physician-led ACOs not backed by a large hospital system. CPC+, a primary care medical home model, includes upfront payments for practices to build care management and IT capabilities. Additional important elements in this category include policies to limit insurance risk through stop-loss and minimum savings rates to account for actuarial uncertainty.

Key Considerations for Provider Organizations

1. Is the shared savings **upside opportunity meaningful** relative to your organization?
2. Does the **risk adjustment methodology** adequately eliminate insurance risk and account for the risk profile of your patient population?
3. Does the model include **other incentives** to offset required investments?

After developing a thorough understanding of available APMs from CMS and private payers, provider organizations should undertake a thoughtful review process to determine which models provide the best opportunity for gain and are appropriate for their organization, considering its scope of services, clinical specialties, patient population, investment ability, competitive landscape, and capacity for risk. Forward-thinking organizations should develop a clinical integration strategy to align clinicians, prepare the organization to adapt, and build the capabilities necessary to be successful in APMs. Providers that carefully undertake this process are the most likely to realize the ultimate goal of linking cost and quality outcomes to financial performance, better serving patients, and competing in a value-based world.

2. This methodology shifts over the course of the agreement and with subsequent agreements. Further details are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-guidance-and-specifications.html

3. See note above on CMS proposed rule, "Pathways to Success"

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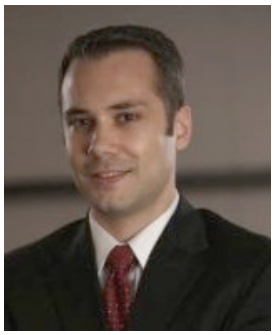
Meet the Author



Vince Volpe *Based in our New York City office, Vince has experience across the healthcare provider, payer, and managed care sector, including physician organizations, health systems, Medicare and Commercial health plans, and Medicaid managed care organizations. He has significant expertise in population health, value-based contracting, care management, and consumer/patient engagement. His recent experience includes the design and implementation of an accountable care organization (ACO), a value-based care strategy for a Medicaid MCO, retail health strategy for a multi-state health system, and a growth strategy for a post-acute and long-term care provider. Vince is a graduate of the Health and Pharmaceutical Management program at Columbia Business School, where he received his MBA.*

Optimity Advisors is committed to guiding healthcare providers, payers, employers and government agencies through their journey to value-based care. Our team of international experts has deep domain expertise and over 25 years of experience in supporting organizations to achieve results in integrated care and alternative payment models. We leverage our experience with strategy, design, implementation, and evaluation of new models of care in health systems across the US, Europe, and Middle East to help achieve the quadruple aim of better health outcomes, improved patient experience, lower cost, and improved provider wellbeing.

Thank you for your valuable time. For more information on our services, please contact:

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