Advanced Payment Models Toolkit

Including a Checklist to Consider when Joining



The CMS Quality Payment Program has two tracks: MIPS and joining an Advanced Alternative Payment Model (Advanced APM).

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.

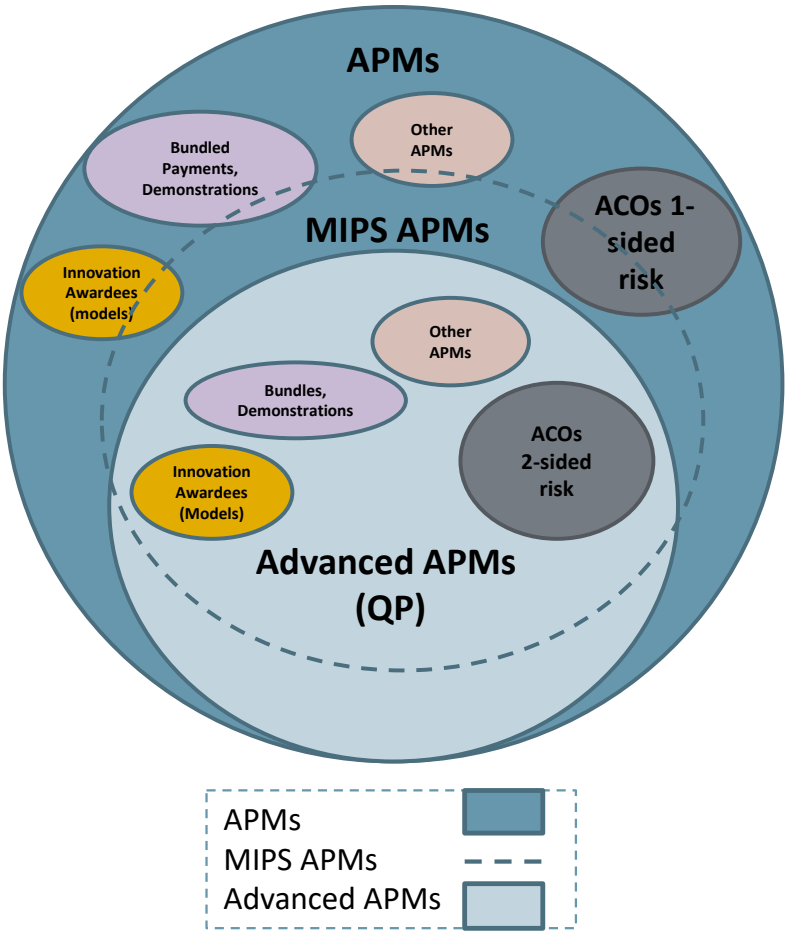
OR

Advanced APMs

Advanced Alternative Payment Models (Advanced APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

Clinicians can now look up APM Status by NPI at: https://qpp.cms.gov/participation-lookup



Alternative Payment Models (APMs) – APMs are programs that promote value over volume. APMS have incentive payments for higher quality and lower cost. APMs can apply to a specific clinical condition, a care episode or a population.

Advanced APMs – Advanced APMs are a subset of APMs that let practices earn more rewards in exchange for taking on higher risk related to patient outcomes. QPP does not change the design or incentive of any particular Advanced APMs; instead, it adds extra incentive – currently an additional 5%. Advanced APMs are excluded from MIPS reporting when participation thresholds are achieved.

MIPS APMs – MIPS APMs are subject to a different CMS scoring standard, which is designed for advanced and regular APMs. In the case of Advanced APMs, if an eligible clinician does not meet the threshold for enough payments or patients, the clinician will be scored according to the MIPS APM scoring standard. Other regular APMs can also be scored as MIPS APMs.

Accountable Organization (AO) – Accountable Organization are the entities that lead APMs. AO is an umbrella term we use for Accountable Care Organizations (ACOs), Convener Participants (CPs), and Direct Contracting Entities (DCEs). An AO is an organization that providers may join to participate in APMs. Many, but not all, APMs work through AOs rather than having direct provider participation.



Accountable Care Organization (ACO) – An ACO is a group of doctors, hospitals, and other health care providers who come together voluntarily through an accountable organization (AO) to give coordinated high-quality care to their patients. Medicare (Basic A-E and Enhanced tracks) and many other payers have developed ACO arrangements. The incentive is usually some kind of shared saving.

Convener Participant (CP) – A CP is an organization that brings together multiple downstream entities [must include either Acute Care Hospitals (ACHs) and/or Physician Group Practices (PGPs) under the Bundled Payments for Care Improvement (BCPI) Advanced model. The CP facilitates coordination among the downstream entities and bears and apportions financial risk (see: https://innovation.cms.gov/Files/x/bpci-advanced-faqs.pdf). In summary, Convener Participants (CPs) are accountable organizations under BPCI Advanced model.

Direct Contracting Entity (DCE) – DCE is a new option under the Primary Care First model. The Primary Care First model has five different options. The general Primary Care First option is built upon the principles of the established CPC+; providers can participate in this model directly (without an AO). Another is a special program for the seriously ill population - again, providers can participate directly (without an AO). Finally, there are three DCE model options where the provider does not participate directly but rather through an AO. The three DCE model options are called Professional, Global, and Geographic Population-Based Payment. See: https://innovation.cms.gov/Files/x/primary-cares-initiative-onepager.pdf for more info.

General Checklist When Considering AOs in Your Area*



Once you've identified the Accountable Organizations (AOs) in your area that participate in APMs, further review will help determine compatibility of the AO with your goals. While some information is available from the AOs web site, contacting the AO directly will help answer questions. Consider the checklist questions below in your discussion. Contracts need to be reviewed to confirm information (or have your lawyer review). The American Medical Association (AMA) has developed a checklist of questions for physicians to ask when negotiating ACO contracts.

Is the AO "open"?

- ▫ Is the AO accepting or seeking new participants? If you're a specialist, is the AO accepting new participants in your specialty?
- ▫ Are you already connected to AO participating providers through referral networks?

What is the AO participant financial, risk, and savings distribution model?

- ▫ What APM(s) does the AO participate in? One-sided? Two-sided? Bundles? Payers? (In 2019 Medicare has changed their ACO language from Tracks 1,2,3 to Basic and Enhanced levels based on risk)
- ▫ What are the specifics for each APM arrangement, including patient assignment or attribution?
- ▫ Are participants subject to "dues" or other up-front financial commitment?
- ▫ How are shared savings distributed? Are shared savings distributions based on participant-specific performance?
- ▫ For two-sided risk models: how are losses repaid? What are participant responsibilities?
- ▫ What is the maximum downside financial risk for participants?
- ▫ What are the AOs plans for taking on greater downside risk in future years?

What is the AO quality and performance strategy?

- ▫ What is the AO strategy for quality improvement and cost savings?
- ▫ What specific expectations, changes, or strategic initiatives does the AO require for participants? How is performance measured?
- ▫ What are the quality reporting requirements for participation?
- ▫ What are the EHR, technology, and interoperability requirements?
- ▫ What support services are provided by the AO? How are support services delivered? (E.g.: 1:1 in person coaching, remote support, webinars, etc…)

General Checklist When Considering AOs in Your Area*

- ▫ What type of analytics support is provided?
- ▫ Does the AO use any benefits waivers?
- ▫ What relationships does the AO have with Medicare and other payers? Are they pursuing others?

What is the AO's quality and performance track record?

- ▫ How long has the AO been operating under APMs? What is the size of the AO?
- ▫ What is AO performance record for quality and cost savings or losses? (these are publicly available)
- ▫ What is the AO participant retention rate?

What is the AO's participant experience?

- ▫ The AO may have participant survey data. You may also want to talk with colleagues who have been participating to get their impressions.

*The AMA also has an ACO checklist which explains some of these questions further if clarification is needed.

Consider Practice Readiness and Preparation: For primary care practices, please see the two checklists Comagine Health developed for Primary Care or Specialists to evaluate internal readiness (attached). Consider implementation or expansion of high-value service codes discussed in our Strengthening Primary Care initiative.

Primary Care Practice — APM General Readiness Checklist



Foundational elements of comprehensive primary care may help practices succeed regardless of whether they find that suitable APM contracting arrangements are available in their area.

The following are key general indicators of primary care practice readiness for APM participation. The capacity to perform on these indicators, and the experience of making the changes required, position practices for further changes in practice that may be expected or required under an APM.

Note that you may be ready for APM participation, even if there are some indicators you've not yet addressed.

Team-based primary care foundation:

- ▫ Annual Wellness Visits (AWV) or Welcome to Medicare: currently providing to at least 25% of your traditional Medicare population and (or) prepared to provide to 50% in the next year.
- ▫ Chronic Care Management (CCM): currently have at least 5% of your traditional Medicare population enrolled and prepared for at least 10% in the next year.
- ▫ Transitional Care Management (TCM): have capacity to provide TCM for traditional Medicare population (or providing through CCM program).
- ▫ Advance Care Planning: offered as part of AWV.
- ▫ Accurate Hierarchical Condition Category (HCC) risk coding: AWV and CCM processes capture comorbidities for comprehensive population health management.

High-impact population health management:

- ▫ Routine screening for diabetes (including in AWV); persons with pre-diabetes referred to Medicare Diabetes Prevention Program.
- ▫ Referral to Diabetes Self-Management Education programs.

EMR use:

- ▫ Practice uses certified EMR.
- ▫ Practice can report quality measures from EMR.
- ▫ Practice has taken steps to manage provider documentation burden.

In addition to these indicators, accountable care organizations may have their own participation requirements and expectations that practices should review.

Specialist — APM General Readiness Checklist

Specialists may have opportunities to participate in APMs such as shared savings programs or bundled payment/episode models. For specialists, successful APM participation may depend on being prepared to collaborate in new ways to produce high quality, efficient, evidence-based, and patient-centered care.

The following are general indicators of specialist readiness for APM participation.

In addition to these indicators, accountable care organizations or bundled payment convener organizations may have their own participation requirements and expectations that practices should review.

Prepared to implement strategies for reducing costs while maintaining or improving quality:

- ☐ Improve coordination and communications with primary care.
  - Examples of this include:
    - Direct scheduling and closing referral loops by providing results and patient summary of care record.
    - Acknowledging and working with/updating the patient care plan and share back with the primary care provider.
    - Connecting to a health information exchange for accessibility and transfer of patient records to avoid duplication and misinformation.
- ☐ Identify strategies for unnecessary costs, duplicated tests, low value services through improved coordination.
- ☐ Work with primary care providers to promote appropriate, high-quality referrals.
- ☐ Assess/improve patient education and engagement.

EMR use:

- ☐ Practice uses certified EMR.
- ☐ Practice can report quality measures from EMR.
- ☐ Practice has taken steps to manage provider documentation burden.



Resources

For further information about APMs, please view these helpful resources:

- CMS QPP website – Overview of APMs: https://qpp.cms.gov/apms/overview
- Health Care Payment Learning and Action Network's (HCP_LAN) APM Framework: http://hcp-lan.org/workproducts/apm-whitepaper.pdf
- List of CMS APMs: https://innovation.cms.gov/initiatives/index.html#views=models
- Center for Healthcare Quality & payment Reform's (CHQPR) Payment Reform Glossary: http://www.chqpr.org/downloads/PaymentReformGlossary.pdf
- New England Journal of Medicine (May 2018) - Opportunities for Risk-Taking Primary Care Providers: https://catalyst.nejm.org/opportunities-risk-based-primary-care-providers/
- Patient Centered Primary Care Collaborative (August 2018) - Advanced Primary Care: A Key Contributor to Successful ACOs: https://www.pcpcc.org/resource/evidence2018
- Health Care Payment Learning and Action Network (HCP LAN) - The LAN disseminates and diffuses knowledge and best practices for designing and implementing APMS: https://hcp-lan.org/
- Physician Payment Resource Center - American Medical Association resources to help with payment models – specific to Medicare and Commercial payers: https://www.ama-assn.org/practice-management/physician-payment-resource-center
- STEPS Forward - American Medical Association resources for implementing team-based care; includes online cost-savings calculator for practices: https://edhub.ama-assn.org/steps-forward/module/2702513
- AHRQ Creating Patient-centered Team-based Primary Care - Portion of the Agency for Healthcare Research and Quality's toolkit on Patient-centered medical homes: https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care
- NRHI SAN - Navigating the Transition to APMs: https://healthinsight.org/news-articles/1728-nrhi-san-navigating-the-transition-to-alternative-payment-models-apm

Need help? Contact us here.