Three Key Decisions to Direct Your APM Adoption Strategy

written by Theresa Hush | July 14, 2022

How you ramp-up to full-scale APMs is crucial. Even if your multi-specialty group or health system receives some value-based payments with downside risk, your success hinges both on financial viability and retention of your clinicians and patients. If you delay APM adoption only after reviewing the potential on your bottom line, you'll need to pay more attention to the competition that is lapping at your foundations of your provider network and consumers.

Here are three key organizational decisions that will determine how your APM adoption proceeds:

> Should we own, enter into a joint venture, or participate in APM(s)?
> How much risk should we adopt, and with whom?
> How can our network strategy lead to APM success?

1. Maximize Your Risk-Reward APM Strategy Via Ownership, or Choose Participation

The huge advantage of value-based payment models is that they give you the opportunity to

ingest the “winnings” if you succeed. Unlike managed care models of the last go-round of HMOs and other payer-driven choices, you are in the driver’s seat under Value-Based Care—if you choose. You can organize an APM yourself, if your size and the infrastructure support it, or you can join with other provider organizations in your market to do so.

The difference between the two is that under a joint model, it may be more difficult to direct strategy and keep providers on board. Because the APM will distribute money, determine the flow of patients, and make the rules that govern your providers, a joint APM can create trust issues for clinicians and administrators.

A strong, centralized APM organization, either one or multiple entities, must create the buy-in necessary for everyone to act according to a central set of rules. Those rules must create growth and financial viability, so they should push the APM entity to play hard. That will translate eventually into a higher level of risk to increase marketability to payers and employers.

Whatever the initial setup, both single and joint ownership entities should move quickly to become the single APM contracting entity for all agreements with payers. Pre-existing relationships may dictate otherwise. There may be a Medicare APM and a variety of private insurer products that are separately negotiated. Or one group may have a Medicare Advantage plan. These flexible arrangements could easily erode the strength of the central APM entity to achieve goals, so settling them is important.

Your biggest determinant of a sole versus shared ownership is how big you are:

> If yours is a large health system with a good primary care base, your task of APM ownership through an ACO is the easier and natural course. If that base does not exist, you need to fill the geographic and reputational holes in your network or partner with other organizations.
> Smaller hospital-based systems, single-hospital-based groups, and primary care groups face bigger obstacles to single ACO ownership. Lack of expansive provider networks, insufficient infrastructure and data, competition and politics could dissuade your organization from independent ACO ownership. Joint ventures are the next viable option, or a smaller ACO, which may be a good option depending on your market position. The high investment in implementation and infrastructure is a hurdle.
> Multi-specialty groups come with a large range of APM-readiness, and if yours has the technology and market power along with a solid primary care base, the decision to go the ACO APM route may be optimal. Specialty-heavy groups should be wary of ACO participation, however, since Medicare’s attribution of patients puts specialty groups at a

> disadvantage of unanticipated patient costs. Unless your group is operating under separate legal practice names that could accommodate separate tax identification numbers, reconsider the options. Other APM possibilities for multi-specialty groups could be Primary Care First (future openings not known, and not currently available everywhere), Bundled Payments for Care Improvement (BPCI, limited and not currently open) and Specialty Care Models (even more limited and not open).

Your biggest ownership-related hurdle with all these options: timing. With most of the available Medicare options closed except the MSSP ACO, you can pursue that avenue, private insurer APM agreements, or participation in an existing APM entity.

2. Determine How Much Risk Is Safe for You, and With Whom

FFS reimbursement has a bull's eye on its back, as the market is quickly moving toward alternative risk-based reimbursement models. Even MSSP ACOs will eventually lose the option to have upside-only shared savings. Learning to manage outcomes and costs through data is your quickest path to be able to participate successfully under any ACO strategy. How to get there is a question, because evaluating your risk potential prior to APM application requires a full review of the expenditures of participants in the APM. Unfortunately, it's unlikely that you will have the data to do so. That requires historical claims data that includes costs outside your participation network.

So how do you decide with whom you will negotiate your alternative payment arrangements? That's hard, because if you choose to go small with a less influential payer, you will not get the momentum internally to address change, nor the data to proceed.

It may sound like a huge risk to instead try your biggest single payer, probably Medicare. But Medicare offers you the most secure base to start, if you are not tolerant to financial risk through the MSSP ACO. And if you are experienced and confident of your infrastructure and clinician engagement, start with MSSP ACO and transition to ACO REACH when it is available to you.

Under the MSSP ACO, you have a selection of both payment model type and level of risk. You can start at Level A, which involves no downside risk, but every year you progress up to at least the next level of downside risk. ACO REACH, which replaced Direct Contracting, offers population-based payments.

Alternative payment models with population-based payments offer the greatest financial

opportunity in your future VBC strategy, even if that is not now. CMS has already indicated a desire to experiment with specialty negotiations between the ACO and specialty clinicians. Under a global payment, this means that the ACO can focus on the substantial portion of specialty-driven services and costs. It can create financial rewards for specialists while improving patient access and services, communications between primaries and specialists, and enhancing data-sharing.

3. Craft Your Clinician Strategy to Ensure APM Success

Your providers are the entry point for patients, driver of patient services and costs, and ambassadors for your health system or group. With a lot of other organizations competing for them, your APM adoption plans will naturally focus on engaging them in the transition. Clinicians should be able to count on their own financial security under alternative payment models—whether they are employed or not—to support them both financially and administratively. There are signs that this has gradually improved in consolidated health systems, with the result that clinicians are becoming more open to alternative payment models.

Before your draft ACO or APM Participation List, establish your clinician strategy. It starts with relationship-building for a new future with changed roles, different reimbursements, and a redefined plan for use of resources. Even if you believe you've done this, the competition for your physicians requires a redo to build support for an APM transition.

Building trust with physicians must reach beyond obvious candidates in the hierarchy and include grass roots efforts throughout the organization. This starts with sharing information. You should create the mechanism to share as much clinical, strategic, and financial data with clinicians as feasible, but certainly start with insights about their own outcomes and clinically relevant data. If you have created the infrastructure to support an APM, your data should be able to compare episodic data with physicians, either through individual portals or, initially, through dedicated learning sessions. Their own patient data, which they will recognize and with which they'll have an emotional connection to patient histories, will do more to give them an understanding of key indicators than any aggregate report can do.

Part of your APM Adoption Strategy must also involve clinician compensation and support. Like the organization, there must be benefits to physicians for moving outcomes and addressing costs, and a plan for supporting them in their new role to guide patients. How they share in the success of payment models, or the losses, should be part of the inquiry process.

As for any business, practical realities dictate your transition to APMs: the models you will

adopt, how much risk you will accept, and who will participate in them. But these realities also illuminate the lead time you will need from when you decide to adopt APMs to their actual start-up. Beginning now to deal with the timeliness of decisions and laying groundwork with your clinicians will get you started with the essentials you need for your adoption strategies.

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