Eight Key Strategies for APM Contracting Right Now

written by Theresa Hush | October 6, 2022

Are you considering entering into APM contracts with private payers? Bravo! Teaming with commercial health plans and employers is a strong opportunity for growing patients through APM arrangements. Expanding your APM agreements into all payment types will be essential to back the incentives you build into your workforce for performance-based pay. But those contracts must align with your APM strategies and support your goals.

Our focus here is on APM contracts with health plans. Health plans may be eager to adopt these arrangements with you, if their analytics of your organization demonstrate good outcomes and reasonable costs. Population-based payments, which proved to keep many providers afloat during the pandemic, may help you financially and enable you to incrementally explore those benefits in a smaller number of patients.

Expanding your APM contracting to the private market should be a priority as soon as feasible. That said, there are many issues you should consider, both before and during the process of negotiations.

While employers have also greatly increased contracting with provider organizations, that's a topic for the future. Employer arrangements are often between one employer and one health system with specified services, and thus uniquely arranged. It's hard to assess their APM value in general, as they are too new and customized to have a track record.

Prepare for Private APMs, Because Failure is Public

Your pivot to private APMs should not be a feasibility test. The stakes of failure are too high for your market reputation, so be sure that you are ready. You must have data sufficiency and infrastructure as well as experience improving performance in patient outcomes and costs. For a private APM, part of that data sufficiency will require negotiation with the payer.

Experience is one reason why we suggested starting your first APM with Medicare, which has positioned APMs to be beneficial to providers:

> Proposed rules, if finalized, will help fund ACO efforts for new entrants.
> You may have more latitude to choose how much downside risk and how fast, and to level up when ready for population-based payments.
> Claims data always comes with the Medicare ACO option, and that data is critical to your ability to identify costs. With private payers, it's a negotiation.
> If you are a specialty organization and considering a specialty care APM, participation in one of Medicare's specialty care programs is a good foundation for similar private market initiatives.

But let's say you're ready. Let's get into your strategies for organizing and negotiating APM agreements.

Eight Strategies for Supporting APM Contracts with Health Plans

To negotiate successfully with health plans—meaning, you agree on terms that are mutually beneficial—you must clearly represent the best option for a successful APM, and you must specifically insert your own requirements into the agreement. You will find that not all your work is done negotiating externally; you'll also need to negotiate internally to identify your best product to sell to the health plan.

1. Examine your size and market positioning before finalizing your Contracting Entity (CE).

There are two significant issues to consider in the development of your CE. One is your size and marketing position. If you are small or not preferred, it may be difficult for you to achieve the best APM arrangements. If that's the case, consider your options of joining with other organizations. Consolidation has been a phenomenon in the market for years so that providers could gain an advantage in negotiations with payers. But here the issues are not solely financial, but also involve access to important tools, like data and safeguards.

2. Construct your CE carefully around APM accountability for costs and patient services.

Your CE composition must include participating physicians and practices who will share risk. Many ACOs were organized around local politics rather than accountable care. In pre-risk days, that helped the organization get started and attract other providers. But under risk, inclusion of specialty practices, in particular, makes it difficult to proceed with population-based payments, correctly align attribution to primary care providers, and examine referral costs.

Carefully consider whether you need specialty proceduralists to be included in the ACO contracting entity for private APMs, or whether you organize a narrower accountable network. Also examine how your organization's Tax IDs work for a risk-based APM business. Centralized data, infrastructure, and improvement programs can be built on a broad, clinically integrated network, with a smaller contracting network as a subset of that network. Separating the referral base could benefit both the APM and specialists by minimizing friction over risk, while enabling data sharing and initiatives with both components.

3. Specify the patient attribution methodology.

Medicare has an attribution algorithm that can negatively affect your costs if your ACO participation is multispecialty. Private payers have their own varying methods. Negotiate your ability to track attributed patients by accountable provider/organization, with a prospective date of attribution. Stipulating the methodology and transmittal of information in the agreement may protect you from costs accountability. Your organization will need dedicated staff to monitor and reach out to new patients.

4. Ask payers for patient-identified claims data that is all-inclusive.

If you cannot see the services that your patients use outside of your organization, there is almost no way for you to improve costs and outcomes. You need to know the diagnoses that were made elsewhere, and the treatment plan (with medications) to be able to help the patient improve. Claims data is so important that negotiating an APM contract with population-based payments without that is ill-advised. Select your health plan candidates appropriately, but you will still need to work through the many alternatives for overcoming historical hesitancy, privacy issues, and bureaucracy. Just know that some providers are getting this data, as are employers. Help the health plan understand what you will do with the data, how you will protect it, and how it will mutually benefit the arrangement.

5. Require all your providers to contribute EHR and practice management data to the APM entity, in return for inclusion in the CE.

You need clinical data and practice data, along with claims, to support all of your outcomes, cost, and health equity activities. In particular, this should include your specialists, even if they are not participating in the CE—hence the major advantage of a clinically integrated network and a subset contracting entity for the APM. There should be agreements with referral physicians that are mutually beneficial in collaborating on cost, spelling out referral and expected communication practices, and, where appropriate, reimbursement rates to specialists where the CE subcontracts.

6. Negotiate coverages and tools that you need for innovative and effective care, population health, and interventions.

These could include your priorities. Possibilities include coverage for supporting community mental health arrangements, digital health or physical therapy apps to support patient improvement without more expensive services, continuous glucose monitoring, diabetes self-management support, and so on. In addition, discuss common insurer practices around medications for obesity and other pharmaceuticals that could contribute to better patient care. Request funding for specific improvements and interventions.

7. On quality performance, negotiate quality measures and request use of your own APM reporting of performance.

Scored performance need be not generic and could help you enhance your own organization. You could also benefit by scoring on meaningful improvement trends, if you have clinical interventions to improve outcomes. Request use of your own APM reporting to avoid plan-calculated, claims-based data that may not accurately reflect patient performance on quality. You will be able to access more data sources to represent the patient status than claims can generate.

8. Consider prospective, population-based payments only if you have the data to model them for their financial effects and can identify and agree on outlier costs.

If you cannot undertake this analysis because you don't have the data or can't get it from the health plan, primary care-only payments may be considered if you have access to experience data from the plan (again with risk scores and outlier information). You must know the level of costs and patient risks to enact non-Fee-for-Service APM contracts. Even incentive plans are meaningless unless the health plan or your own data can provide you the solid evidence of historical and predictive costs.

There are myriad stop-loss agreements, exclusions, guarantees and other provisions that go into health plan agreements, and providers are so familiar with these that we're not addressing them here.

Moving into APMs in the private market is a key turning point. It's not an accident that these eight strategies equally address health plan requests and organizational transformation. From competitors to traditional providers—big ACO enablers and equity-backed practices—all have built their prowess by meeting these transformational goals. That's why they are gaining physicians and practices.

Your Catch-22 in the legacy health care world: until you achieve those same feats and create an APM entity that positions you for population-based payments, your savings will not be what they could be. Move quickly to overcome those obstacles, so that you can adopt population-based APM contracts before the market makes those decisions for you.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Jarosław Głogowski