Questions You Should Ask (or Should Have) About Medicare's Alternative Payment Models

written by Theresa Hush | November 11, 2015

Are you prepared for your risk or reward under Medicare payment reforms? It's hard to give up current revenues that reward volume, sooner than absolutely necessary. That's the dilemma facing all providers who realize that Medicare is serious about moving 50 percent of its provider reimbursement to Alternative Payment Models (APMs) by the end of 2018.

While some providers have rushed into the new system while Medicare still allows for failure to meet targets, others are waiting (including many higher cost academic medical centers). Here's what to ask before plunging in—and if you're already in, how to right the ship.

The APM

The APMs include Accountable Care Organizations (ACOs), Bundled Payments and Patient Centered Medical Homes (PCMH). There will likely be more, but these three incorporate three key components of health care delivery: Primary Care Management (PCMH), Specialty Care and Disease/Procedural Models (Bundled Payments), and an overarching all-care approach (ACOs).

These models, unlike current reimbursement, will eventually cap the money that providers get for care. They differ in structure, with the ACO being most complex and incorporating several designs of risk-reward.

Although providers straddle the current reality of fee-for-service and the future of alternative risk models, they need to understand that the alternative is not status quo. The Merit-Based

Incentive Based System (MIPS) imposes penalties on providers who fail to delivery quality or efficiency in patient care, and the system is less forgiving.

Medicare's desire for the transition has become very clear as the pieces of the new reimbursement structure are beginning to fall into place. Since the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Medicare has moved forward on transitioning to the new system. Rules are now finalized for all the components of the future Merit-Based Incentive Payment System—Meaningful Use through 2017, and the Medicare fee schedule, PQRS and Value-Based Payment Modifier through 2018. Meanwhile, the remaining details of the Alternative Payment Models (APMs) are slowly emerging.

Questions You Need to Ask

1. How much patient loyalty and in-network services do you have?

Why it's important:
Under an ACO, whether you can control costs will depend on whether your patients can and do get their services from you, or whether they are getting primary or specialty services elsewhere. That's probably why the ACOs with higher percentages of primary care physicians were more successful, on average, than other ACOs in saving costs.

For most Bundled Payment types, eventually you will need to have an arrangement with a hospital. Even if you are accepting risk only for professional services at this time, you can anticipate what's ahead and also have the data to make a wiser selection of the hospitals where you will perform the majority of your services.

As a PCMH, you need to be invested in understanding your per-beneficiary costs, as this is the direction that reimbursement will likely move. The key tools here are your practice's QRUR from CMS—you will be able to see important information not only about the services you provided, but also the total cost of care to patients attributed to you.

How to get answers:
Most organizations don't know how to evaluate this, because they don't have the total cost picture for their patients without Medicare claims data. But there are ways of getting that information:

> Look at your PQRS and other practice data to evaluate the gaps in services. This is where having a Registry evaluate your data and measures can be beneficial. If you see unexpected gaps in care, that's your clue that the services may be going elsewhere. Examine Medicare's QRUR for your practice(s). This will give you total cost information for

patients attributed to you, as well as indicate your trouble spots. The document is very revealing, because it also compares your results with other groups'.

2. Now or later: Is starting or participating in a risk model now essential to preparation?

Why It's Important:
Once you form or participate in an APM, it's hard to go back. Your data is immediately in the public eye, and if it isn't attractive in terms of quality or cost in the beginning, it is still visible to other providers and to patients. Failure to achieve targets, as well, may take a toll on your physician engagement or loyalty because they also have money on the line. Keep in mind that Medicare will make it very tempting to start as soon as possible, beginning with the 5 percent incentive for practitioners who do.

How to get answers:
There are pros and cons to the early start, and it depends on your organizational culture:

Evaluate whether you need the "reality factor" to achieve change. Medicare's plan can "create the crisis" needed by many organizations to go forward. As one famous Chicago politician puts it, "Never let a crisis go to waste." Practicing under a risk-based model, organizing your data and giving provider feedback, and structuring governance and rules—these aren't just head-start actions, but help convince providers that they actually are acting under a different model of care. It requires a lot of energy for change; actually proceeding with an ACO, PCMH or Bundled Payment pilot helps coalesce the forces to make the transition.
Collect and examine the historical data. Many ACOs start without this step, as if it were the first step in implementation versus the first step in the decision process. You wouldn't take a personal financial risk without gathering the data, so why would do it here? This review will help you determine whether you should take the time to make some changes in your delivery of care to improve the likelihood of success.

3. What is your infrastructure for change?

Why it's important:
Again, many organizations consider how to alter infrastructure during implementation, after they have formed an ACO or proceeded with Bundled Payments. The issue is partly money, but also confusion about the technology and needs of the ACO. Not figuring this out in advance means that you spend a lot of valuable implementation time dealing with technical rather than care processes.

How to get answers:

Refocus your questions from “What vendor should I select?” to “What essential functionalities do I need?” In other words, go light—you don’t need to invest in the ultimate system when you are in an evolutionary stage. But you do need to gather data, identify patients by condition and risk, calculate quality and cost, and start diagnosing your problem spots. Start small and focus on these basics to figure out what works. It’s a learning process.

Look at your data, again from practice-based PQRS, QRUR, JCAHO, Meaningful Use reports, Medicare cost reports and other points of your history. These will help you establish the basic tools to answer the question of where you should focus your efforts, which will then define the infrastructure you need.

Look at all the possible infrastructure components, including different kinds of technology and services. There are many ways of mixing and matching technologies without duplication.

4. How should you establish your network (ACO)?

Why it’s important:

The rewards under an APM are anything but secure. Almost all organizations that started ACOs or participated in Bundled Payments opted for the lowest risk options to avoid losing money. And Medicare has been flexible by delaying downside risk. That’s lucky in the short term for ACOs, of which the vast majority did not achieve savings.

How to get answers:

Ensure that the ACO goes through a rigorous evaluation of its providers. Would you go into business with someone without really knowing where your fellow providers stand? Bundled Payments and PCMH, for now, are independent, but if you are building an ACO, that’s what you are creating—a financial partnership. Develop a Provider Assessment built around the QRUR, which defines the risk-adjusted, per-beneficiary cost and quality profile for every participating provider group. It doesn’t need to be oriented to exclude physicians, but to identify areas where interventions are needed by practices. Physicians should likewise be able to see detailed comparative information about the hospital’s statistics—length of stay, ambulatory sensitive admissions, readmissions, costs and morbidity/mortality rates.

Examine the patient choices. Gathering provider source data gives you the opportunity to evaluate patient visit data and determine patient retention and movement. It’s a clue about choices that patients are making about the network.

5. Should you establish an all-patient Clinical Integration plan?

Why it's important:
Pre-dating the ACOs and the consolidation in health care organizations, many health systems were focusing on "Clinical Integration" as a tool to establish broad payer-contracting networks based on quality and cost. In certain markets this remains very successful, but many efforts evaporated as providers focused on ACOs that could work for Medicare and potentially expand to commercial health plans, as well as revenue-impacted programs such as EMR adoption and PQRS reporting. Programs have become fragmented and coverage-specific, sometimes even to the point of using different technologies and networks. The result: expensive processes, difficult-to-achieve targets and, ultimately, ineffective plans.

How to get answers:

> Measure cost and quality metrics by coverage type and examine the differences. The best way to see your data is to use a Registry, especially a Clinical Data Registry, where you can benchmark your data against other providers as well as measure your performance internally. It is important is to see not only the aggregate data, but for your providers to be able to see individual patients and progress, which is the advantage Registry functionality gives you in Clinical Integration.
> Evaluate your outcomes over time across all patients and within subpopulations. If your outcomes are not improving, your approach is not sustainable under any risk model.
> Talk to your contracted health plans, and get comparative data from them. Are you participating in their most-purchased products? If not, Clinical Integration may be the method for refocusing on your results. It will also provide the vehicle for getting payer claims data to see out-of-your-network services and costs.
> Talk to your physicians. You may find that they are frustrated by layers of different program requirements and need to simplify and focus.

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