

TCPI APM Faculty Workshop: Deciphering the APM Journey for Primary Care

Thursday, June 27th, 2019 2:00 PM to 3:00 PM EDT

[Recording](#)

Event Summary and Key Takeaways

The June 27th event, the second in a series of TCPI National Faculty-led Office Hours around Alternative Payment Models (APMs), reviewed essential concepts of new APMs and defined and discussed contract characteristics and the necessary practice capabilities to ensure success.

Introduction

Karen Gallegos of the Development, Management, and Improvement (DMI) team opened the meeting by explaining the intent of the call and introducing two speakers, Dr. Sarah Chouinard, Chief Medical Officer (CMO) of Community Care of West Virginia and Allyson Gottsman from the Colorado Department of Health Care Policy & Financing.

Essential Concepts of APMs

Dr. Chouinard began by reviewing essential concepts of new APMs below:

- **Fee for service payments (FFS):** Described as payment based on coded claims, or volume-based payment model
- **Pay for performance:** In addition to being paid based on claims, a practice receives an additional payment if they reach a specific target
- **Quality Measures:** Defined clinical metrics for a targeted population and used to assess adherence of a clinician or practice
- **Attribution:** The way a payer identifies and assigns a certain group of patients to a practice
- **Accountable Care Organization (ACO)/Risk-bearing entity:** A group of healthcare providers who tie payments to quality and costs with a governance structure
- **Per Member Per Month (PMPM):** When a practice receives payments for a specific population based on the complexity of the patient, either on a quarterly or yearly basis
- **Total Cost of Care:** Aggregated cost of all medical services provided to attributed patients during a specified timeframe
- **Shared Savings:** An entity anticipates the cost of care for a patient populations and subtracts total costs to calculate the savings, which they share across the entity.
- **Prospective Payments:** An upfront payment to practices based on quality measure performance or a lump sum paid annually in anticipation of the total cost of care or episode
- **Back-end reconciliation:** Retrospective reconciliation of financial performance against established targets or a budget

Dr. Chouinard then outlined CMS' framework for APMs with a particular focus on Category 2. The contract characteristics under Category 2A include practices' continued receipt of payments for service and also include additional payments for care coordination, meaningful use of electronic health records (EHRs), reporting etc. Category 2B focuses on payment for performance usually based on the size of the population involved. With respect to practice capabilities, Dr. Chouinard communicated practices will not be held responsible for cost of care outside of their clinics.

Dr. Chouinard characterized Category 3 as that which starts to involve risk. Dr. Chouinard defined upside risk as additional money to gain when practices participate in a specific arrangement. Dr. Chouinard communicated a patient's behavior outside of the clinic in this case will impact how the practice receives payment. In Category 3a, if the practice meets targets, both they and the payer recoup leftover funds due to the transformation within the practice. Category 3b also involves upside risk and introduces downside risk, in which practices pay money back to payers if they do not meet targets. Ms. Gallegos emphasized Category 3b as an opportunity for not only negotiation between practice and payer, but also a partnership.

Category 4 represents a non-fee-for-service contract, which involves population-based payments. Category 4 focuses on paying practices to keep patients healthy at a low cost. Category 4 introduces risk assessment and coding, wrap around medical and non-medical services for high risk, in-depth team-based care, integrated care planning, and sophisticated data analysis.

Ms. Gallegos then highlighted the following four essential areas practices should evaluate when determining which contractual arrangements to enter:

1. **Know your patients:** Who is your target population, how will you identify them, and what barriers need to be addressed for better patient care?
2. **Know your data:** What are your cost drivers and what will it take to impact them? Are you meaningfully using your HER to track and manage your patients? How does your data align with payer data?
3. **Know your team:** How will you coordinate with other providers/ service providers?
4. **Know your contract:** How will you make and lose money? Is payment based solely on your performance or the collective performance of other providers? How will the burden of illness of your population be taken into account? Are there exclusions?

Question and Answer Session

Ms. Gallegos and Dr. Chouinard answered a few questions from the chat.

One participant asked if a payer that uses a PMPM model for care management will fall under Category 3a or 3b. Ms. Gallegos noted the practice would rest in Category 2 if they only pay a monthly or quarterly fee to manage care, due to infrastructure investments. However, if they have the potential for shared savings against a total cost of care, they would move into Category 3.

Another participant asked about the difference between APMs and advanced APMs. Ms. Gallegos said an APM represents any contract that does not include fee-for-service payments.

Advanced APMs denotes a CMS term that uses additional CMS criteria focused on certified health information technology.

Jacqueline Kreinik from CMS asked if Category 4 represents a wellness-based population program. Dr. Chouinard answered Category 4 focuses more on collaboration with a payer to keep patients completely well at a low cost. The payer provides practices with a certain amount of money they can spend to optimize patients' needs.

Morris Fogle from CMS asked if practices without a strong EHR system can succeed in an APM. Dr Chouinard stated a well-integrated EHR proves key to long term success. However, if a practice can track their patient population on attribution vs. empanelment, perform well on clinical quality measures, etc., they can still join and succeed in an APM.

A PTN Perspective

Ms. Gottsman highlighted how Colorado PTN discovered pockets of innovation for specialty care practices and found ways for them to join APMs. They created an electronic survey tool called Inventory, which helps track their practices' movement into APMs. In addition to using Inventory, Colorado also trains quality improvement advisors (QIAs) on the APM categories and asks probing questions which help them think about how they can benefit from APMs.

Timeline and Reminders

Ms. Gallegos reviewed the schedule for the remaining APM Faculty Office Hours. The event on July 11th will feature Dr. Carol Greenlee and Dr. Lisa Lewis and focus on the business care for specialists and common APM scenarios available for specialists.

Ms. Gallegos also encouraged PTNs to look at their APM performance on the Healthcare Communities Portal to ensure the DSFR reports accurately reflect their network participation.

Ms. Gallegos lastly highlighted the [APM Virtual Toolkit](#) on the Healthcare Communities portal and requested the Community of Practice (CoP) share additional relevant materials with the group.

Closing Comments from CMS

Dr. Robert Flemming provided final thoughts from CMS leadership. He noted that the event highlighted how TCPI has succeeded in helping practices be competitive in producing outcomes and move to APMs. Dr. Flemming congratulated the CoP on creating a path for future practices to join APMs and encouraged them to continue the work.