APM Assessment Framework for Anesthesiologists

Executive Summary

Physician participation in an Alternative Payment Model (APM) forms the core of the U.S. government's efforts to tie quality and value with provider payment. The Patient Protection and Affordable Care Act (PPACA) and Medicare Access and CHIP Reauthorization Act (MACRA) accelerated the transition in provider payments from fee for service volume-based payments to payments increasingly tied to quality or value-based metrics. Beginning in 2019, providers participating in Medicare's Quality Payment Program will have enrolled in the Merit Based Incentive Payment System (MIPS), Advanced Alternative Payment Model (AAPM), or in a partially qualified Alternative Payment Model to receive payment under Medicare Part B. In 2021, eligible clinicians who are participating in a Medicare Advanced APM may combine their participation in a qualified Other-Payer Advanced APM comprised of patients from commercial and private payers to meet requirements to become a Qualifying Alternative Payment Model participant. Providers in an Advanced APM (AAPM) will receive 0.5% more on their Medicare Fee Schedules than MIPS participants by 2026.

Anesthesia groups are increasingly considering participation in an APM as part of an optimal payor contracting strategy. As anesthesia groups are being asked to participate in APMs, it is vitally important the assessment of an APM consider unique practice strengths and weaknesses, current business relationships, and the current healthcare ecosystem. The goal of the APM Assessment Framework for Anesthesiologists is to provide a starting point from which a group can assess the value of participation in an APM. We provide questions to consider when beginning an assessment. Broadly, they are designed to assess understanding of the APM's scope, administration, risk/payment methodologies, as well as quantification of the quality and value of services provided. For example, does the group provide services that are relevant to participation in the APM, how is the APM is to be administered, what are the risks of participation in the APM, how will the group be paid for contributions to the APM, and how will the value and quality of care rendered be quantified? We also include a spreadsheet with an example that may serve as a starting point in calculating financial gain or loss while participating in a proposed bundled payment model.



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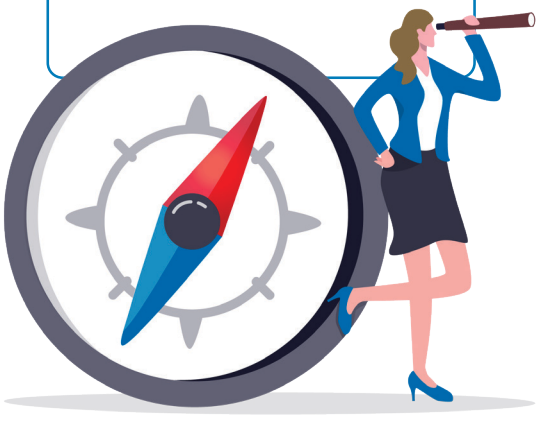
APM Assessment Framework for Anesthesiologists

Commensurate with a national expansion into value-based care initiatives, anesthesia groups are increasingly being requested to participate in Alternate Payment Models (APMs). Assessment of a potential APM depends on your unique practice characteristics, the breadth of current business relationships, and the landscape in which you practice. Below are a series of critical questions to guide you through assessing a proposed APM.

Administration

Scope
(relevance to your practice)

- Is there a role for anesthesia care in this model?
- Is the APM's site of service where you primarily provide care?
- What proportion of your current patient population will be covered by the APM?
- Is there market share growth potential available through participation in the APM?
- Is it worth the effort (the effort to meet the provider thresholds) for you to participate in the APM?



Governance

- Which organization is primarily responsible for the creation of the model?
- Will your group be a participating member of the APM Entity, or simply contracted for services?
- If your group will be a participating member, how is the APM Entity governed?
- Does your anesthesia group have a legal advocate to flag any high-level concerns?
- How does the APM Entity determine the qualifying participants?

- Are decisions made locally (i.e., hospital or physician group) or nationally (i.e., prescribed by APM Entity or regional health network)?
- Who are the primary decision makers?
- Will you have a physician or other advocate in the APM Entity who can listen and support you and your colleagues?

  If not, will you have the ability to appoint someone?

- Will your participation in the APM be determined by your individual patient/revenue thresholds (i.e., by your NPI number) or by thresholds met by the entire provider team (i.e., by the group TIN number)?
- Will your participation in the APM be determined by contract?
- Can the APM Entity help you determine if you are likely to be eligible or successful under the model?

- Does the participation agreement bind individual physicians (NPI) or a group (TIN) in unforeseen ways (e.g., non-competes, binding arbitration, termination without appeals, etc.)?
- Is there an appeals process for any decision made by the APM entity that directly impacts you?
- What are your participation options depending on your institutions' arrangement (e.g., Accountable Care Organization (ACO))?
- If you are a group, does your contract with your institutions allow participation?

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Payment/Risk

Payment methodology

- Who is the primary payor?
- How are the payments for the services that you provide structured in the model?
- If the APM is episodic, how is the episode defined (i.e., are all pre- or post-operative services for a specific period of time included in the per-case cost calculations)?
- How will contributions to savings be calculated for you and other providers'?
- How will your contribution to patient care be calculated?
- Is this an Advanced APM (AAPM)?

- Participation in an AAPM may allow the group to avoid MIPS participation
- 5% incentive payment from CMS if:
  - *25% of your Medicare Part B payments are through the AAPM; or*
  - *20% of your Medicare patients are seen through an AAPM*

- Government payors, specifically the Centers for Medicare and Medicaid (CMS), have historically developed bundled arrangements and APM models. Commercial carriers are now following these examples. Each arrangement represents a unique structure.
- Is the payor also the organizer of the APM, or is there a secondary APM Entity that will manage financial risks and rewards?

- Are initial payments mainly traditional fee-for-service (FFS)?
- Are there per-month or prospective payments made?
- Currently, models are mostly episodic and procedural (total joints, spine, and cardiovascular) but will eventually expand to medical episodes, cancer care, and maternity.
- There are two payment models: (1) prospective with one payment to accountable entity, or (2) FFS with retrospective reconciliation and sharing of savings/losses.
- Pricing is best determined by:
  - *Starting with provider's historical cost and regional average*
  - *Estimating cost savings based on achievable quality improvements*
  - *Revising over time*

- Will you be limited to cost reductions related to anesthesia services?
- Can you benefit from global per-case cost reductions, including reductions in post-acute care services and readmissions?
- Are there other members of the APM whose costs you can help reduce (e.g., hospital LOS, inpatient testing, use of specialist consultations)?
- Does the model allow for local (i.e., hospital, physician group) variation or is it prescribed nationally?

- Is it strictly through fee-for-service payments, or are there other factors?
- Consider factors beyond the OR: length of stay (same-day discharge), PACU care (length of stay, pain score, PONV), patient satisfaction scores, blood utilization, use of blocks.

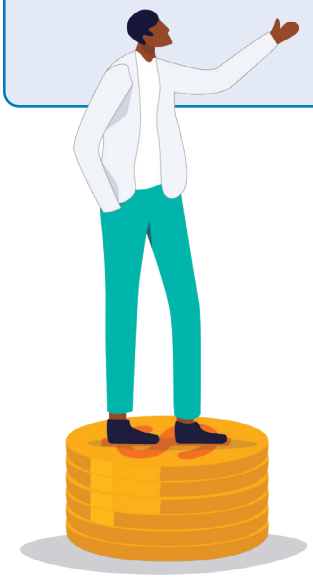


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Payment/Risk, continued...

Risk methodology

- Are there downside financial risks (potential penalties or repayments) attributed to your group under the proposed arrangement?
- Do you have access to the historical data (financial and clinical) required to assess your likely performance under the proposed APM?
- Depending on your practice size, is the amount of risk likely to be prohibitive? Could your practice absorb the maximum projected penalty or repayment and remain financially viable?
- Is there a period of transition where risk is not immediately implemented, or is the full risk applied during the first year of the arrangement?
- Are there new costs/overhead required to participate in the APM arrangement? Are these likely to be substantial, and how do they compare to the projected potential financial benefits?
- Will the APM provide any of the required administrative support or information technology?
- Can risks be mitigated by limiting the patients included in the analysis pool to exclude high-risk individuals?
- Will the APM implement steps to encourage active patient participation in the program and/or increase market share for your group?
- Can risks be distributed by implementing models from more than one APM/payor that serve the same or similar patient populations?
- If applicable, does the APM have a track record of success in predicting risk and obtaining positive returns?
- Risk should be set to accomplish enough upside and downside risk to motivate and engage
- Is there protection for catastrophic downside risk?
- Is there adjustment for case mix and patient populations?



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Quality

Quality metrics

- Are you required to report anesthesia-specific quality measures?
- What type of metrics will be captured? Provider specific metrics and process measures and/or claims data and outcome measures?
- Can you positively affect any required anesthesia-specific measures?
- Will the anesthesia-specific measures required overlap with existing quality reporting already being performed, or will they require additional effort to implement?
- Can you use existing reporting methods such as a QCDR to report required quality performance?
- Who bears the cost of any new quality reporting requirements for the APM entity?
- Are there global performance metrics relevant to the PSH core competencies around surgical care coordination or population health principles? For example:
  - *Hospital length of stay*
  - *Potentially avoidable complications*
  - *Unplanned readmissions*
  - *Patient reported outcomes*
- Can your group participate in accountability for global performance metrics? Will your group be required to participate in accountability for global performance metrics?
- Is there flexibility to add/remove measures if needed?



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