

# ALTERNATIVE PAYMENT MODEL CONTRACTING GUIDE

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## INTRODUCTION

Alternative, collaborative health care delivery systems are the wave of the future. The Centers for Medicare and Medicaid Services (CMS), as well as commercial payers, are committed to moving to outcomes-based payment and tying business to new financial incentives. These changes will impact all providers—if not now, then in the future, except possibly those operating cash-based practices. This guide, divided into 3 parts, walks you through information you should know and steps to take as you consider participating in an alternative payment model (APM).

**Part 1: What you need to know about the model and the environment before considering participation as an APM collaborator**

**Part 2: What you need to know about your practice before considering participation as an APM collaborator**

**Part 3: Specific APM contracting considerations—final questions to ask yourself**

## PART 1

**What you need to know about the model and the environment before considering participation as an APM collaborator**

*Terms to know:*

- Collaborator: an active participant contracting with the convener as a provider in an APM model.
- Convener: the party ultimately accountable for the APMs performance (ex. The hospital in the comprehensive joint replacement model).
- Star rating: rating provided by Medicare shows how well each hospital performed, on average, compared to other hospitals in the US.
- Total cost of care: accounts for all professional payments and are risk-adjusted to capture differences in patient population characteristics.

### **Know the APM Collaborators**

When deciding whether or not to pursue an APM agreement, remember that you are not only establishing a relationship with the convener but with all the other collaborative partners. Learn as

much as you can about all potential partners before you consider signing an agreement. Research the players in your local health care marketplace, including inquiring from others who may have current or prior professional or business dealings with them. Review your potential partners' data—and be prepared for their requests for yours. You can find hospital data for patient satisfaction and rate of complications on the [Medicare Hospital Compare website](#).

In addition, find out what other physical therapy practices near you that might be competing for referrals from the APM.

*Questions to consider:*

- Do you have the staff capacity and expertise to conduct the needed research on potential collaborators?
- How far is your practice from the closest referral source participating in the model?
- What are the reputations of other providers in the local business community?
- What are their corporate cultures?
- What are their patient care philosophies?
- Have you worked with them before?
- Can you inquire from others who may have prior professional and or business dealings with these providers?
- What are the star ratings of the hospital and its partners?
- How many PT practices (private or hospital run) are near the hospital and in what areas do they specialize?

***Know if the Model Is Mandated and if You Are in a Selected Metropolitan Area***

Some APMs are mandated, such as the comprehensive joint replacement (CJR) model. If this is the case, and your geographic region is part of the model, local hospitals and their satellites are required to participate in the model. Many of these hospitals likely lack the capacity to meet the therapy needs of the patient population, and they are struggling to assemble the resources and operational teams to implement the model. This is an excellent opportunity for you to assist in developing the rehabilitation component.

***Adopt a Collaborative Mindset***

APMs require a different way of thinking and working. You must be an active rather than passive participant. It is not solely about what is good for your practice but what is good for all of the partners participating in the model. It is imperative, then, that you do your due diligence on the potential partners before signing any agreement; you can be sure they will do the same. You must adequately differentiate yourself from others in terms of quality and value. Understanding the convener's vantage point and needs can help you obtain a valuable contract.

Providing the payer with data on your practice's cost and quality will help in your negotiations. Be as specific as possible; for example, an 86% rate of return-to-work within 1 month for carpal tunnel patients, or an episode duration of 3 visits or less for 92% of sprain/strain patients. You also can use

additional research articles to support the value of physical therapy in general. For example, research shows that PTs with board certification, such as in orthopedics or sports, are more knowledgeable than their noncertified peers.

### ***Know the Concept of Total Cost of Care***

You and your staff need to have a good understanding of the concept of total cost of care; that is, looking at physical therapy as part of the care continuum instead of in isolation. Numerous studies demonstrate that early access to physical therapy for musculoskeletal conditions reduces the overall cost of care by decreasing what are known as “upstream and downstream costs.” These costs include physician visits, reducing the need for surgery, imaging, pharmacy, and readmissions. This is where a true value of physical therapy lies—not in the service alone but in the overall impact on health status and recovery. The ability to converse and share data with potential partners on the value of physical therapy is essential, particularly in a collaborative model such as an APM.

### ***Know the Concept of Value***

The value equation is defined as:

$$\text{Value} = \text{Outcomes}/\text{Cost}$$

To derive the value of physical therapist services, you need tools to assess both the outcome and cost portions of the equation. The cost of providing services includes all expenses attributed to running a business and must be recalculated annually. Outcomes data for your patients is critical to the model and includes functional measures and patient satisfaction. The physical therapy quality metrics need to be clearly defined in any contract with model partners. All APMs will have quality metrics; however, some may not have measures that demonstrate the full value of physical therapist services. You will need to understand and be able to discuss and demonstrate how your services impact the model measures, as well as any additional measures that you think would bring value to the model.

#### *Questions to consider:*

- What, if any, outcomes measures will be used?
- How will baseline and functional change be assessed?
- Will outcomes be risk adjusted?
- How will your performance be assessed?

### ***Know the Inherent Risks in the APM***

As with any payment model, there are inherent risks. APMs under Medicare are required to take on varying levels of financial risk, depending on the model (see Risk Corridor below). Payment typically is done on a prospective basis under the standard fee schedule for each setting, with a post-payment reconciliation annually for all episodes within the model. To determine bonuses or penalties, Medicare will compare actual costs with target costs, along with use of the quality measures required by the model. The convener controls the APM and is permitted by CMS to share the risk with collaborating providers, but guidance on the allocation of bonuses or penalties among the rehabilitation partners is somewhat unclear. How this affects you depends on your contractual agreement with the convener. If

the APM partners meet specified criteria, you may be eligible for profit-sharing or a bonus payment if your contract calls for it. However, if APM participants underperform, you may have to repay monies—again, if that is how your contract is negotiated. If so, be prepared and maintain reserves. It is critical to discuss your risk tolerance with your attorney and accountant prior to considering any alternative delivery arrangement.

#### *Risk Corridor*

APMs are required to have financial risk. The risk corridor may be static or it may change over time as the model matures. An example of a changing risk corridor is the CJR model. CJR is a 5-year initiative with risk-sharing provisions that include limits to the hospital's obligation to repay funds to Medicare. In the first year (2016), CSM waived the requirement for repayment but allowed for gainsharing if the hospital met or exceeded the specified cost and quality targets. Repayment is limited to 5% in the second year, 10% in the third year, and 20% in years 4 and 5 for participating hospitals (other than rural hospitals). That means if the CJR hospital does not meet specified benchmarks, it will have to repay funds to Medicare, potentially sharing that risk with its APM partners.

#### *Risk of Not Participating*

Beginning in 2020, payment updates (either increases or decreases) for Medicare part B will be determined solely by providers' participation in the Medicare Quality Payment Program either through the Merit-Based Incentive Payment System (MIPS) or an APM. This means you can expect APM participation to increase significantly. If you are treating a high percentage of patients targeted by an APM and you do not participate, you may experience a significant reduction in referrals over time. Estimating the actual financial loss will require data analysis. While Medicare beneficiaries retain the right to choose a provider and select services, the convener will now have a financial incentive to influence those decisions. Therefore, it is advisable, particularly for those anticipating a measurable change in revenue, to reassess their business plan and focus on diversification. In the process, it is important to keep in mind that alternative delivery models are the way of the future.

#### *Patient Choice*

Medicare patients retain the freedom to choose their providers and services. While the convener cannot require the patient to pursue follow-up care in any specific facility, it can and will likely encourage patients to secure ongoing services (skilled nursing, home care, outpatient rehab) with the model partners. This means facilities not participating in the model still are able to treat these patients and provide medically necessary covered services.

#### ***Potential for "Cherry Picking"***

Depending on the contract terms, the convener or collaborating partners may be incentivized to limit services, delay care, or refer patients who are more complex or have multiple comorbidities to a collaborating partner in another setting. This may mean on one hand sending the patient to receive more physical therapy and possibly negatively impacting the perceived value of the physical therapist service. On the other hand, it may mean fewer patients receive skilled nursing or home care services

prior to referral to outpatient. There is also incentive for the convener to redesign care to reduce costs, which may mean providing uncomplicated patients with home programs instead of skilled rehabilitation.

CMS is aware of this potential and will monitor provider activities and consumer concerns. Consequently, as you review and consider an APM, carefully examine the referral/transition-in-care process to ensure you are not penalized for making a determination that, based on sound clinical judgment and objective findings, patients need services other than physical therapy.

*Questions to consider:*

- Can you refuse a patient if you are operating at capacity?
- Does the contract permit alternative arrangements?
- Does the contract specify scheduling or follow-up appointment requirements such as turnaround times?
- If so, are these realistic for your practice?
- If the targets are not met are you penalized?
- If so, in what form?
- What happens with patients who require treatment for additional diagnoses or conditions concurrent with the model?
- How does that impact the performance measures and data collection within the APM?
- What happens if a patient leaves the participating practice and seeks services with a different provider?

***Participating Now vs Waiting***

As mentioned, beginning in 2020 payment updates for Medicare part B will be determined by provider's participation in either MIPS or APMs. Additionally, participation in an advanced APM could yield a 5% incentive payment for every year of successful participation. There are many unanswered questions regarding APMs. For this reason, it is expected there will be ongoing revisions of the early models. You will need to consider the pros and cons of "sitting it out" to see what transpires and to learn from others' experience. Keep in mind, though, that early participation may provide an opportunity to shape the rehabilitation component of health care payment and to positively influence the role of physical therapy in these new and emerging models.

## **PART 2**

**What you need to know about your practice before considering participation as an alternative payment model (APM) collaborator**

***Know if the APM Is a Good "Fit" for You***

No single payment methodology is inherently good or bad, and each has potential to pay you fairly or poorly for the services you deliver. When evaluating payer contracts, select those that make the most sense for your particular practice setting and goals. There are advantages and disadvantages to all of the common payment methodologies. It is important to know the differences and how they might affect

your practice as you review and negotiate your contract. More important than the methodology is the adequacy of payment. Fair payment rates are possible with each of the methodologies; unfortunately, inadequate payment rates exist in each as well. Weighing the benefits of a payment method can help you determine which will work best in your practice setting.

If you wish to delve into the utilization trends and risk analyses that are inherent in APMs, participation in one may be an appropriate and successful choice. However, for the typical physical therapist who is more interested in clinical outcomes than accounting and spreadsheets, this may be a challenging choice that requires gaining additional skills or securing external expertise.

*Questions to consider:*

- Do you have a business plan and goals? (If not, this would be a good time to develop one!)
- If you do, does the APM fit into it?
- Will joining an APM further your objectives?

***Know Your Cost of Doing Business***

The crucial first step is to define your cost of providing services. [APTA's Know Your Costs webpage](#) can help you with this. Knowing your costs will help determine whether a contract is financially feasible for your practice. For a simple analysis, add up your costs, divide the total by either 12 or 52 to get your monthly or weekly overall costs. Determining whether a contract offered by a payer is fiscally acceptable depends on a detailed understanding of these costs. Some costs can increase depending on patient volume. All costs need to be reevaluated at least annually. Labor costs are a key area for a service business such as physical therapy and can make or break your practice. It is recommended that labor costs for PTs should equal 28%–40% of gross collections.

Specifically, examine all the varied costs that contribute to the overall cost per diagnosis for the patient population included in the model. If your facility treats more patients in a specific segment of the population, determine if this will increase or decrease your overall costs of care.

***Know Your Risk Tolerance***

As discussed in Part 1, there is risk involved in participating an APM. It is critical to discuss your risk tolerance with your partners, attorney, and accountant prior to considering any alternative delivery arrangement.

***Know Your Target Patient Populations***

Is this your target population? Is this an area where you can demonstrate clinical excellence? Does your practice focus on a unique area or provide care in an underserved location? Remember, it's not *your* perception of value that counts, but that of the payer and patients. What puts your practice in a position where the payer wants to contract with you? What makes your practice stand out? Board-certified specialty credentials or other certifications? Extended hours or workweek? Cost and outcomes data demonstrating your value proposition? Proven track record with these patients? Decreased wait times? Easy and quick access for new patients?

If this population represents a new patient demographic, a new diagnosis, or both for you, there may be additional expenses for such things as staff training, an initial drop in productivity because of learning curves, and costs of purchasing specialized equipment.

Assess your claims and medical record data to determine the current percentage of this same patient population that is treated in your practice. Calculate the number of patients as a percentage of the total case load. Then calculate the average visits per diagnosis, length of stay per diagnosis, cost per case per diagnosis, outcome per diagnosis, and patient satisfaction per diagnosis.

*Questions to consider:*

- How many patients are treated with these diagnoses on a weekly, monthly, and yearly basis?
- What percentage do these patients represent of your overall patient population?
- What is the typical number of treatment sessions for these diagnostic codes or conditions?
- What happens if you increase this population within your patient mix?
- What are the staff needs for these diagnoses (eg, supplies, space, support staff, equipment)?
- What are your new and existing patient appointment wait times?
- If you add X number of new patients on an ongoing basis, what happens to those wait times?
- What is the impact on your existing patient base?
- What is your scheduling capability?
- Will adding these patients change your staff's ability to deliver high-quality services to their remaining case load?

***Know Your Marketing Skills***

Do you have the skills, staff, and time to market your services to the model convener? Will you need to hire additional staff or consultants to perform this service? If so, what are the costs in dollars and time lost in patient care? Can you articulate your value proposition and measurably demonstrate why you are the best potential partner? For help with these and similar issues, see the APTA's [Marketing to Health Care Professionals webpage](#) and APTA's [Business Skills in Physical Therapy: Strategic Marketing home-study course](#), which includes a comprehensive marketing readiness assessment tool.

***Evidence-Based Practice and Data (Including Outcomes and Patient Satisfaction)***

The ability to measurably demonstrate objective results is critical in the pursuit and development of collaborative health care relationships. This will require you to be up-to-date on clinical practice guidelines and protocols, as well as to be able to document your adherence to evidence-based practices sufficiently, and share your data with the model partners. Also see the "Care Pathways" questions concerning recognition of your professional judgment in developing, implementing, and monitoring the rehab protocols of an APM.

*Questions to consider:*

- Can you demonstrate adherence to best-practice guidelines?
- Does your practice currently collect data?
- If so what data is collected?
- Are you collecting outcome and patient satisfaction data?
- If so, do you use a “home grown” proprietary tool or one recognized by the rehab industry?
- Are the outcomes positive?
- How do the results compare with established national or regional performance standards?
- What are the specific results for your patients?
- Have you used the data to change practice? How?
- Can you explain the implications of the data to a knowledgeable audience?

*Severity mix*

It is important to consider the nature of your current patients and what may happen in your practice if the overall case severity is markedly increased in the target population. This means collecting risk-adjusted data; that is, the ability to adjust data based on severity and comorbidities. You can obtain a reasonable proxy to estimate acuity by collecting data on the average number of days postop that hip and knee referrals arrive at your clinic. Should you decide to participate in an APM, this information can be tracked and compared over time. You can also track the number of patients who are not appropriate for your services and require referral to another health care provider.

*Revenue mix*

It also will be important to know what percentage of your payments come from cash, commercial payers, workers’ comp, and Medicare. You will need to determine if it makes good business sense to increase the percentage of Medicare patients for a Medicare-focused model, given the additional time it may take administratively to manage this patient population, such as functional limitation reporting and medical review.

*Questions to consider:*

- Is your revenue mix stable?
- What is the cost to your business of increasing the volume of this patient population?
- Can you increase this population without impeding other lines of business that may be more profitable or better fit your strategic plan?

**Staff Education**

As a vital part of the team—within both your practice and the APM collaboration as a whole should you decide to pursue participation—your staff will require education on the basics of this payment mechanism. Additionally, you and your staff will need to accept and adhere to the clinical pathways established for the model. The best way to develop staff buy-in and behavior change is hard data. To that end, it is advisable to establish regular staff meetings to share performance data and discuss patient outliers. Furthermore, staff will require education on how to engage patients, and possible other

participating providers, in the APM. You may want to consider appointing an “APM champion” in your practice.

## PART 3

### **Specific alternative payment model (APM) contracting considerations—final questions to ask yourself**

Physical therapists should consider a number of details before contracting with payers, whether private or public. It is imperative to review each contract in its entirety, with professional advice, prior to signing. Terms or provisions in contracts that are often overlooked at the time of signing could significantly impact your practice in the long run. [APTA’s Managed Care Contracting Toolkit](#) offers a comprehensive overview of any contracting arrangement. Additionally, some specific contracting considerations for APMs are outlined below.

#### ***Risk Sharing and Compensation***

- Are the terms of the risk-sharing structure—the potential to share in bonus payments or in repayment of monies due—clearly articulated to your understanding?
- Is the timetable for financial reconciliation clearly articulated?
- Is the timetable for receipt of shared gains articulated?
- Is the timetable for payment of monies due articulated?
- Are the quality metrics clearly defined to your understanding?
- Are the factors contributing to gains or losses clearly articulated?
- Have you assessed the impact on your practice of the potential repayment requirements?
- Are the objective measures to assess physical therapist performance and patient outcomes articulated?

#### ***Care Pathways***

- Do the terms of the model require you to follow a specific protocol?
- Are variances permitted, and if so, how are they defined and quantified?
- What is the process for approval?
- What, if any, are the penalties for nonadherence?
- Are PTs key players in the development of the rehab portion?
- Are PTs key players in the care transition planning process?
- What is your recourse if a patient is inappropriately referred to your facility?
- What is the hospital policy for resolving disputes, including time limitations?
- Are discharge criteria specified?
- What happens if the PT assessment indicates the patient requires additional care?

#### ***Communication Requirements***

- Are there specific requirements for documentation?
- How will you communication with the hospital and other collaborative partners in the APM?

- Are there specific electronic or manual communication requirements?
- Will the hospital require participation in an electronic health record (EHR) system?
- Who will pay for the EHR system costs if required?
- How will staff be trained?
- How will ongoing data management be supported?
- What kind of data are required?
- If you don't collect these data already, how much up-front cost and staff training are required?
- Do you have adequate IT infrastructure, or are there additional IT requirements?
- Are there specific in-person meeting requirements?
- What data are the partners required to share with you?
- How will you monitor the performance of the APM?
- If you don't already have the resources to review these data intelligently, who and at what cost can someone do it for you?
- Will the hospital appoint an APM coordinator to whom you can direct questions?

