

Physician-Focused Payment Model Technical Advisory Committee

Preliminary Comments Development Team (PCDT) Presentation:

An Overview of Proposals Submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) That Included Components Related to Population-Based Total Cost of Care (TCOC) and Other Highlights from Background Information

Lawrence Kosinski, MD, MBA (Lead)
Josh Liao, MD, MSc
Chinni Pulluru, MD

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Introduction

- From 2016 to 2020, PTAC received 35 stakeholder-submitted proposed physician-focused payment models (PFPMs).
- During this period, PTAC voted and deliberated on the extent to which 28 of these proposed models meet the Secretary’s 10 regulatory criteria (including Criterion 2, “Quality and Cost”).
 - Nearly all the proposals submitted to PTAC addressed the potential impact on costs, to some degree – including at least 10 proposals that discussed the use of total cost of care (TCOC) measures in their payment methodology and performance reporting.
 - PTAC has assessed these previous submitters’ use of TCOC measures in various PFPM proposals that targeted specific patient populations and episodes of care.
- This presentation provides a summary of the characteristics of 10 selected PTAC proposals that included components related to TCOC.
- This presentation also includes additional background information on definitions and issues related to population-based TCOC models.

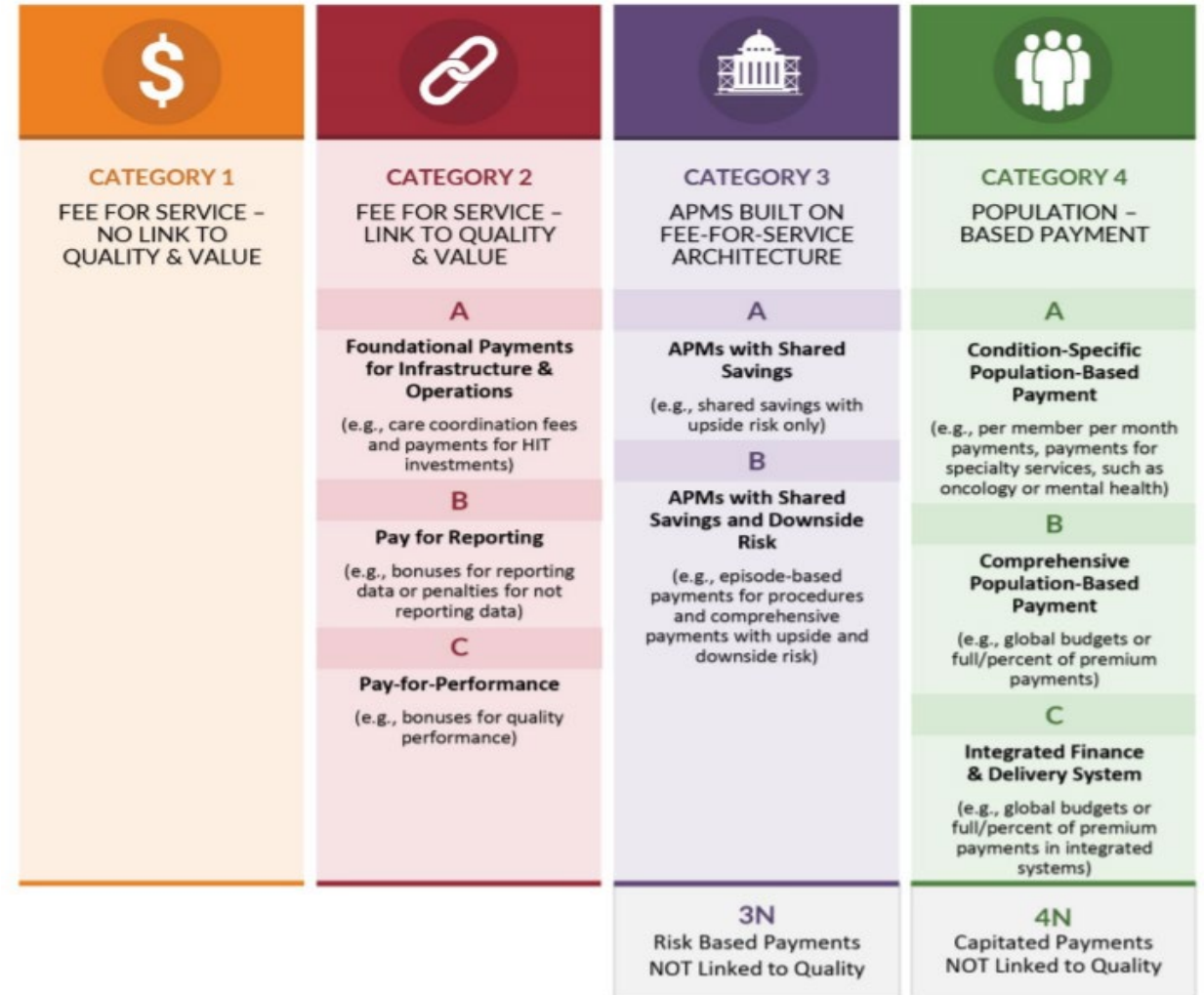
Background: Increased Emphasis on Population-Based Payment

- The Center for Medicare and Medicaid Innovation (CMMI) has set the goal of having every Medicare fee-for-service (FFS) beneficiary with Parts A and B in a care relationship with accountability for quality and TCOC by 2030.¹

¹ Center for Medicare and Medicaid Innovation. *Innovation Center Strategy Refresh*; 2021:32. <https://innovation.cms.gov/strategic-direction-whitepaper>

Background: Supporting the Transition to Population-Based Payment

- The HCP-LAN APM Framework² is aligned with the goal of moving payments away from FFS and into population-based payment (Category 4).
- To help support the transition to population-based payments, CMMI is seeking to test incentives to:
 - Increase the number of health care providers that can participate in accountable and TCOC models (including downside risk); and
 - Increase coordination between providers that are responsible for accountable care relationships and specialty providers that are accountable for delivering high-cost episodic and/or complex care.³



² Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Model (APM) Framework: <https://hcp-lan.org/apm-refresh-white-paper/>

³ Center for Medicare and Medicaid Innovation. *Innovation Center Strategy Refresh*

Background: Definition of TCOC

- There are differences in how TCOC is currently defined in various APMs.
- PTAC is using the following working definition for defining TCOC in the context of population-based models:
 - TCOC is a composite measure of the cost of (e.g., the amount of reimbursement for) all covered medical services delivered to an individual or group.
 - In the context of Medicare APMs, TCOC typically includes Medicare Part A and Part B expenditures, and is calculated on a per-beneficiary basis for a specified time period.
- This definition will likely evolve as the Committee collects additional information from stakeholders.

Background: Examples of TCOC Definitions from Selected CMMI Models

- In the Maryland TCOC Model, which holds the state fully at risk for the TCOC for Medicare beneficiaries, “Total cost of care means the **aggregate Medicare FFS costs for all items and services, or a specific subset thereof, delivered to Medicare FFS beneficiaries.**” The aggregate Medicare FFS costs include Medicare Part A and Part B expenditures only. When determining the annual Medicare savings, any Outcomes-Based Credits are also included in the per beneficiary TCOC calculation.^{4,5}
- In the Global and Professional Direct Contracting (GPDC) Model,ⁱ “The Performance Year Benchmark [a target Per Beneficiary Per Month (PBPM) dollar amount] represents the average Medicare beneficiary [TCOC] for aligned beneficiaries and refers to the **target expenditure amount [calculated using the Parts A and B expenditures for aligned beneficiaries during a baseline period]** that will be compared to Medicare expenditures for items and services furnished to aligned beneficiaries (Direct Contracting beneficiaries) during a performance year [to determine the DCE’s savings or losses].”⁶

⁴ Maryland Total Cost of Care Model | CMS Innovation Center. Innovation.cms.gov. <https://innovation.cms.gov/innovation-models/md-tccm>. Published 2021.

⁵ Maryland Total Cost of Care Model State Agreement. hsrcr.maryland.gov. <https://hsrcr.maryland.gov/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf>. Published 2018.

⁶ Center for Medicare and Medicaid Innovation. Direct Contracting Model: Global and Professional Options Request for Applications, 11/25/2019. Published online 2019. <https://innovation.cms.gov/files/x/dc-rfa.pdf>.

ⁱ CMMI announced on February 24, 2022, that beginning in 2023, the GPDC Model will be redesigned and renamed the ACO Realizing Equity, Access, and Community Health (REACH) Model. The redesign includes important changes in advancing health equity, promoting provider leadership and governance, and protecting beneficiaries and the model with enhanced participant vetting, monitoring and greater transparency.

Background: Definition of Population-Based TCOC Models

- PTAC is using the following working definition of population-based TCOC models as a guide for focusing the discussion during this theme-based discussion:
 - *A population-based TCOC model refers to a population-based APM in which participating entities assume accountability for quality and TCOC and receive payments for all covered health care costs for a broadly defined population with varying health care needs during the course of a year (365 days).*
 - *Within this context, a population-based TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be “nested” within a population-based TCOC model.*
- This definition will likely evolve as the Committee collects additional information from stakeholders.

Identifying Key Characteristics of Future Population-Based TCOC Models

Areas Where There Appear to Be General Consensus for Inclusion in Population-Based TCOC Models

- Facilitate accountable relationships for quality and TCOC
- Encourage care coordination and integration of specialty care with primary care, particularly for beneficiaries with complex needs
- Improve patient experience and outcomes
- Facilitate identification of and sharing of best practices
- Use performance metrics, including patient-centered metrics, to incentivize quality improvements
- Improve equity
- Align provider and beneficiary incentives

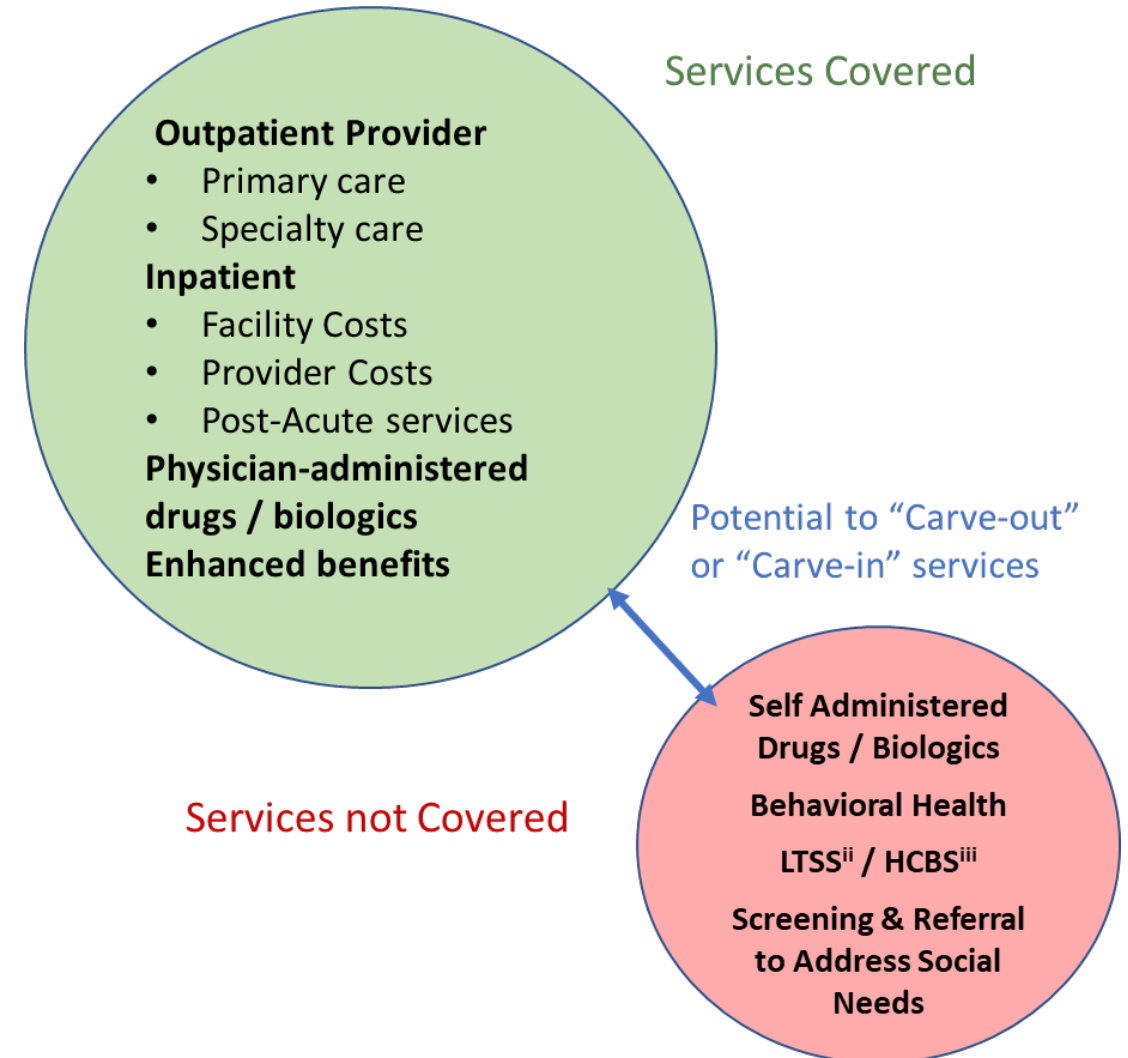
Identifying Key Characteristics of Future Population-Based TCOC Models, continued

Areas Where Additional Discussion is Needed

- Definition of TCOC and which services are included (which definition is best for the patient?)
- Identification of types of accountable entities and types of clinicians and groups
- Duration of accountability period (e.g., 30 vs. 60 vs. 90 vs. 365 days)
- Minimum threshold of the number of patients that could be included
- Options for desired care delivery model
- Variations in structure of payment models
- How to do patient attribution, benchmarking, and risk adjustment
- How to incentivize participation and facilitate transition (not all providers are prepared to have 365-day accountability for TCOC with two-sided risk)
- Encouragement of multi-payer alignment on model design components
- How to address overlap between models (e.g., nesting, carve-outs)

Potential Services to be Included in Population-Based TCOC Models

- Current population-based Medicare APMs typically include accountability for Medicare Part A and Part B expenditures.
- There may be an interest in including additional services in future population-based TCOC models to support:
 - Patient-centered care,
 - Addressing social determinants of health, and
 - Incentivizing additional efficiencies.



ⁱⁱ Long Term Services and Supports (LTSS) . ⁱⁱⁱ Home and Community Based Services (HCBS)

Incorporation of TCOC Components in Proposals Submitted to PTAC

Characteristics of 10 Selected PTAC Proposals That Included TCOC Components

- At least 10 proposals that were submitted to PTAC were identified as having components related to TCOC in their payment methodology and performance reporting. ⁱⁱⁱ
 - 1 of these proposals had an advanced primary care focus.
 - 3 of these proposals had a population-specific focus.
 - 6 of these proposals had an episode-based focus.
- The 10 PTAC proposals with TCOC components varied by clinical focus and setting of care.

Clinical Focus ^{iv}	Clinical Setting
Primary Care (n=6)	Primary/Specialty Care Practices (n=8)
Specialty Care (n=7)	Hospital-Based Outpatient Clinics (n=6)
Oncology-Related Care (n=4)	Patient Home (n=3)
Chronic or Advanced Illness (n=3)	Skilled Nursing Facilities (SNFs) (n=1)

^{iv} These proposals were identified using TCOC-based keyword searches of key documents related to the Committee's proposal review process.

^v The numbers in parentheses do not add up to 10 because some proposals were linked to more than one area of clinical focus and/or setting.

Cost Reduction Objectives and Approaches in PTAC Proposals That Included TCOC-Related Components

- All 10 of the PTAC proposed models that included TCOC-related components sought to reduce health care costs.
- Common cost reduction objectives in these proposals included:
 - Decreasing hospitalizations and ED visits
 - Limiting costs associated with a particular episode of care (defined by diagnosis, prognosis, or procedures)
 - Avoiding unnecessary services and medications

Note: More information about the strategies, performance measures, and payment methodologies used in these PTAC proposals can be found in the Appendix of these slides, and the *Environmental Scan on Issues Related to the Development of Population-Based Total Cost of Care (TCOC) Models in the Broader Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs)*.

Cost Reduction Objectives and Approaches in PTAC Proposals That Included TCOC-Related Components, continued

- Common cost reduction approaches in PTAC proposals that included TCOC-related components included:
 - Improving care management
 - Financial accountability for TCOC through:
 - PBPM payments with two-sided shared risk (with some including a stop-loss provision)
 - Performance-based incentive payments contingent on quality, cost, and/or utilization of care

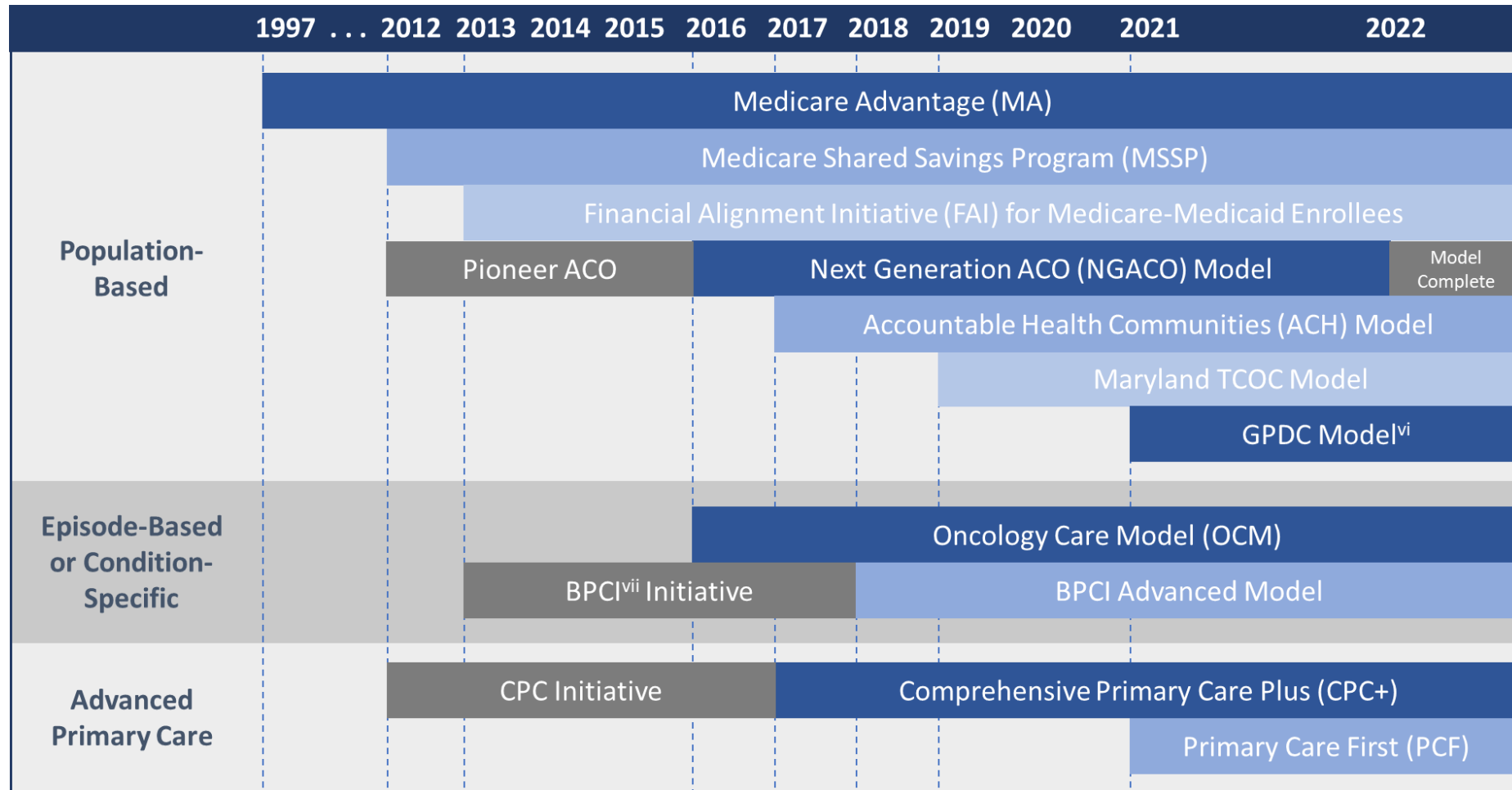
Performance Measures in Selected PTAC Proposals Related to Measuring Reductions in TCOC

- Performance measures in the 10 PTAC proposed models that included TCOC-related components varied across three domains:
 - Cost Measures:
 - Many of the PTAC proposals included TCOC for a specified group, episode, time period, or care (e.g., average inpatient cost per patient) as a cost-specific performance measure.
 - Additional cost measures included net savings/losses to Medicare (Part A or B), and supportive and maintenance drug costs.
 - Utilization Measures: All 10 of the PTAC proposals included utilization measures related to TCOC, including number of ED visits, ICU days, and hospital admissions; unplanned hospital readmission within 30 days; and medication-related complications.
 - Quality Measures: All 10 of the PTAC proposals included quality measures related to TCOC, including patient satisfaction, medication review, timeliness of care, comprehensive assessments and screening, and advanced care planning.

Additional Background Information from the Environmental Scan

Various CMMI Models and Other CMS Programs Include Relevant Approaches for Development of Future Population-Based TCOC Models

The evolution of various CMMI models and other CMS programs includes a range of approaches that can provide relevant information for developing future population-based TCOC models.



^{vi} Global and Professional Direct Contracting (GPDC) .

^{vii} Bundled Payments for Care Improvement (BPCI)

Insights from Current Population-Based Models and Programs

Model Type	Care Transformation Strategies	Payment Mechanism	Measuring TCOC and Incentives	Issues and Considerations
Population-Based Models	Practitioners and facilities share accountability for quality and cost outcomes and are incentivized to use data analytics, care coordination, and other strategies to manage population health.	<ul style="list-style-type: none"> • Participants/ accountable entities responsible for cost and quality for target patient population • Various payment arrangements (e.g., FFS-based, capitation) • Bonus payments if cost is below threshold 	<ul style="list-style-type: none"> • Performance bonuses for lower total TCOC • Voluntary participation leads to lower cost of care. 	<ul style="list-style-type: none"> • May offer extra benefits • Model overlap • Challenges include attribution, risk adjustment, and benchmark setting. • Issues related to safety-net provider participation • Provider consolidation • Typically exclude drug coverage

Insights from Current Episode-Based or Condition-Specific Models

Model Type	Care Transformation Strategies	Payment Mechanism	Measuring TCOC and Incentives	Issues and Considerations
Episode-Based or Condition-Specific	Practitioners and facilities share accountability for overall quality and cost outcomes related to a specific treatment or procedure and are incentivized to coordinate transitions in care.	<ul style="list-style-type: none"> • Participants are accountable for cost and quality of care that beneficiaries received during a specific episode of care or period of disease. • Prospective payment leads to two-sided risk for participants. 	<ul style="list-style-type: none"> • Two-sided risk with benchmark based on discounted historical spending creates incentive for lower cost. • Separate payment for care coordination activities 	<ul style="list-style-type: none"> • Model overlap • Could potentially be nested within population-based models, allowing providers to address specific conditions that beneficiaries may develop or procedures they may need

Insights from Current Advanced Primary Care Models

Model Type	Care Transformation Strategies	Payment Mechanism	Measuring TCOC and Incentives	Issues and Considerations
Advanced Primary Care	<p>Primary care practices coordinate care for beneficiaries through a Patient-Centered Medical Home (PCMH). PBPM payments enable practices to offer enhanced services to improve access and quality.</p>	<ul style="list-style-type: none"> • PCMH with combination of population-based payment (prospective) and per-visit payments • Payment is risk-adjusted based on each patient. 	<ul style="list-style-type: none"> • Positive performance-based adjustment is based on a comparison with the benchmark. • Hybrid payment model is intended to increase beneficiary access and improve patient experience. 	<ul style="list-style-type: none"> • Specialists and hospitals operating in a largely FFS system are incentivized to deliver high-volume, high-cost care. • Tier-based risk adjustment based on Hierarchical Condition Category (HCC) scores

Insights from Selected Medicaid Section 1115 Waiver Programs

Model Type	Care Transformation Strategies	Payment Mechanism	Measuring TCOC and Incentives	Issues and Considerations
Selected Medicaid Section 1115 Waiver Programs	Use of accountable entities with a network of providers responsible for delivering all primary care services, coordinating care across the full spectrum of services (medical, dental, behavioral health), partnering with community organizations and social services agencies	<ul style="list-style-type: none"> • Various payment arrangements (episode of care, bundled payment, shared savings, capitation) • Inclusion of non-risk-bearing track for smaller entities and risk-bearing track for larger entities • Potential eligibility to receive population-based payment to support care coordination activities 	<ul style="list-style-type: none"> • Use of quality measures 	<ul style="list-style-type: none"> • Varying eligibility requirements by state • Mixed outcomes regarding cost savings • Opportunities for multi-payer alignment • Transferability of ideas into Medicare

Encouraging Findings on the Effectiveness of Population-Based Approaches in Improving Quality and Reducing TCOC

- Early performance results from the Medicare Shared Savings Program suggest that **ACOs with greater financial accountability are more likely to deliver better coordinated and efficient care** for Medicare patients. These ACOs joined one of the Shared Savings Program's new participation options on July 1, 2019, under the program's Pathways to Success policies, which were intended to improve the accuracy of financial benchmarks and provide incentives to take on downside risk.
- Although **recent research has produced mixed findings**, several evaluations of models that seek to reduce TCOC have demonstrated the role these initiatives have played in reducing health care costs and avoidable care utilization while maintaining or improving quality of care, including for Medicare beneficiaries.
- Models with accountability for TCOC often **target higher-risk, higher-cost beneficiaries with greater potential for reducing expenditures and utilization**. For example, preliminary findings from the Accountable Health Communities (AHC) model show decreases in ED visits.

Note: Additional information about these findings is available in the *Environmental Scan on Issues Related to the Development of Population-Based Total Cost of Care (TCOC) Models in the Broader Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs)*.

Challenges Related to Designing Effective Population-Based TCOC Models

- To date, there is **limited research exploring the relationship between TCOC and care coordination**, as well as **how models with accountability for TCOC impact health equity**.
- There continue to be **disparities in savings** associated with various approaches for reducing TCOC that vary based on a range of factors, including geographic location, patient population, and provider readiness to participate in an APM.
- Several evaluations of APMs that include approaches for reducing TCOC have **observed negative returns on investment**; however, research also indicates that investments in TCOC reduction approaches **require time to generate savings**.
- There continue to be questions regarding the impact of **voluntary versus mandatory implementation** of APMs under Medicare; research suggests that mandatory models may pose challenges to provider engagement.

Note: Additional information about these findings is available in the *Environmental Scan on Issues Related to the Development of Population-Based Total Cost of Care (TCOC) Models in the Broader Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs)*.

Potential Opportunities for Improving Multi-Payer Alignment

- Potential options for improving multi-payer alignment in population-based TCOC models and assisting payers with shifting financial risk for patient care to non-payer accountable entities include:
 - **Multi-layered accountability structure** or established governance with multiple payer participation and representation - Nesting
 - **Leveraging state-specific models** to build upon existing value-based models and state-level delivery system reform initiatives, and tailor the model design to the state's health care network
 - **Technical assistance** to ensure that commercial, Medicare Advantage (MA), and Medicaid provider payment reforms meet the standard for Medicaid APMs and therefore qualify for bonus payment incentives
- A key goal of multi-payer models is to bring a provider's patient panel under **one set of common initiatives to align incentives**, reduce administrative burden, and increase the business case for provider engagement in meaningful delivery system reform.
 - Some experts believe payer participation in multi-payer models can increase engagement in value-based payment models.
 - Examples of multi-payer TCOC models include: the Maryland All-Payer Model, the Pennsylvania Rural Health Model (PARHM), and the Vermont All-Payer Model.

Areas Where Additional Information Is Needed

- Broader vision regarding the **structural elements of future population-based models**, and how they would compare to current models and programs—such as whether their payment model would be based on an FFS architecture with two-sided risk or capitated payments
- **Services that are appropriate** for inclusion in future population-based TCOC models in order to optimize patient-centered care
- Relationship between broader population-based TCOC models and episode-based or condition-specific models
- How to **enhance provider readiness and incentivize provider participation** in payment models with two-sided risk through innovative physician payment models, particularly for independent physician practices and safety-net providers
- Opportunities for **addressing equity issues and incentivizing screening** and referrals for social determinants of health

Appendix on TCOC Components in Proposals Submitted to PTAC

10 Selected PTAC Proposals that Included TCOC-Related Components ^{viii}

Advanced Primary Care Proposal:

- American Academy of Family Physicians (AAFP)

Population-Specific Proposals:

- American Academy of Hospice and Palliative Medicine (AAHPM)
- Coalition to Transform Advanced Care (C-TAC)
- University of Chicago Medicine (UChicago)

Episode-Based Proposals:

- American College of Surgeons (ACS)
- American Society of Clinical Oncology (ASCO)
- Avera Health (Avera)
- Large Urology Group Practice Association (LUGPA)
- New York City Department of Health and Mental Hygiene (NYC DOHMH)
- Illinois Gastroenterology Group and SonarMD, LLC (IGG/SonarMD)

^{viii} These proposals were identified using TCOC-based keyword searches of key documents related to the Committee's proposal review process, and were selected to include a diversity of provider types, care models and clinical settings, and payment approaches that are relevant for a discussion of the use of TCOC in multiple contexts.

Key Characteristics of 10 PTAC Proposals with TCOC-Related Components

Submitter Name	Proposal Type	Patient Population	Clinical Focus	Setting
1. AAFP	Advanced Primary Care	Medicare beneficiaries	Primary care	Primary care practices
2. AAHPM	Population-specific	Beneficiaries with serious/advanced illness	Palliative care	Inpatient, outpatient
3. ACS	Episode-based	Beneficiaries having at least one of over 100 conditions or procedures	Cross-clinical	Inpatient, outpatient, ambulatory
4. ASCO	Episode-based	Cancer patients	Cancer care	Inpatient, outpatient
5. Avera	Episode-based	Beneficiaries who reside in SNFs	Primary care in SNFs and Nursing Facilities (NFs)	SNFs, NFs
6. C-TAC	Population-specific	Beneficiaries with advanced illness, focusing on last 12 months of life	Palliative care	Patient home
7. NYC DOHMH	Episode-based	Beneficiaries with hepatitis C infection	Hepatitis C virus	Primary care and specialty practices
8. IGG/SonarMD	Episode-based	Beneficiaries with chronic illness (Crohn's Disease)	Chronic disease (Crohn's Disease)	Patient home
9. LUGPA	Episode-based	Beneficiaries who are newly diagnosed with prostate cancer	Urology/oncology	Urology and multispecialty practices
10. UChicago	Population-specific	Frail/complex beneficiaries with hospitalizations	Frequently hospitalized patients	Patient home and rehabilitation sites

TCOC-Related Objectives and Performance Measures of 10 PTAC Proposals with TCOC-Related Components

Submitter Name	TCOC-Related Objectives	TCOC-Related Performance Measures
1. AAFP	Reduce TCOC by increasing percentage of total spending allocated to primary care	Core Quality Measure Collaborative measures; hospital utilization; ED utilization
2. AAHPM	Reduce per capita end-of-life costs by providing coordinated palliative care and support services	Patient-reported outcomes for experience of care, completion of care processes, utilization of health care services
3. ACS	Reduce TCOC for a specific episode	Total savings (number of episodes x [expected cost – actual cost])
4. ASCO	Reduce TCOC by decreasing costs associated with drugs, monitoring activities, and emergency / acute / post-acute care	Unplanned hospital admissions, emergency and observation care visits, supportive and maintenance drug costs
5. Avera	Reduce TCOC through prevention of avoidable escalation of illness for residents living in SNFs	Monitoring 11 scored metrics for determining losses / savings, and 13 additional quality metrics
6. C-TAC	Reduce TCOC for enrollees in their last 12 months of life using palliative care teams (PCTs)	Measures for developing bonus payments and additional quality measures for monitoring program
7. NYC DOHMH	Lower costs by reducing expenses from preventable hospitalizations, ED visits, and complications associated with hepatitis C intervention	Risk-adjusted facility-based sustained virologic response (SVR) score, matched cohort study analyzing the impact of care coordination
8. IGG/SonarMD	Incentivize proactive care to improve patient quality of life and decrease total costs (by reducing avoidable complications, ED visits, and inpatient admissions)	TCOC (including costs related to outpatient visits, ED visits, and infusion / injection biological costs)
9. LUGPA	Defer active intervention (AI) and avoid overutilization of services while reducing morbidity and costs	Proportion of beneficiaries receiving AI after an initial episode, efficiency and cost reduction, care coordination, patient-reported outcomes, cost of care
10. UChicago	Reduce overall spending on high-cost patients (high-risk Medicare beneficiaries) by improving inpatient-outpatient care coordination	Financial and quality measures, patient and provider satisfaction, self-rated patient mental health, rehospitalization rates, TCOC (Medicare) reduction

Payment Characteristics of 10 PTAC Proposals with TCOC-Related Components

Submitter Name	Payment Mechanism	Shared Risk	Risk Adjustment	TCOC-Related Payment Elements
1. <i>AAFP</i>	Per Beneficiary Per Month (PBPM)	*	■	Prospective, risk-adjusted PBPM payment for primary care; prospectively awarded performance-based incentive payments
2. <i>AAHPM</i>	PBPM	■	■	Up-front base PBPM payments with performance-based incentives/penalties or shared shavings/losses linked to TCOC
3. <i>ACS</i>	Episode-Based	■	■	Retrospective incentive payments based on difference between observed and expected spending
4. <i>ASCO</i>	Episode-Based	■	■	Prospective care management payments; bundled payments for value of specified services (Track 2 only)
5. <i>Avera</i>	PBPM	■	■	Prospective payments dependent on quality and financial performance (one-time payment for new admissions and PBPM payments)
6. <i>C-TAC</i>	PBPM	■	■	Wage-adjusted PMPM payments for the last 12 months of life and quality bonus payments or shared losses based on TCOC
7. <i>NYC DOHMH</i>	Bundled Episode-Based/Monthly	■	■	Prospective bundled payment
8. <i>IGG/SonarMD</i>	PBPM	■	■	Prospective PMPM payment with retrospective reconciliation; additional monthly payments for non-“face to face” services
9. <i>LUGPA</i>	PBPM	■	■	Prospective care management payment; retrospective performance-based payment based on difference between target and actual spending
10. <i>UChicago</i>	PBPM	■		PBPM care continuity fee (for physicians who meet benchmarks for providing their patients with both inpatient and outpatient care)

* The AAFP proposal explicitly states that the proposed model does not incorporate provider financial risk; however, the proposed model includes what the proposal refers to as “performance risk” whereby participating entities that meet quality and cost benchmarks retain their incentive payments and maintain their standing in the APM.