Physician-Focused Payment Model Technical Advisory Committee

PTAC
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Overview of Payment in Population-Based Total Cost of Care (PB-TCOC) Models

HIGHLIGHTS

- The paradigm shift toward value-based care necessitates careful consideration of various payment arrangements, phased transitions, voluntary and mandatory participation, and multi-payer alignment.
- Clear financial accountability at the organization level and strong financial incentives at the provider level are needed. Payment arrangements, such as episode-based payment, capitation, and fee-for-service (FFS) with shared savings models, have demonstrated potential in reducing total cost of care (TCOC).
- Policy considerations for payment in population-based total cost of care (PB-TCOC) models include determining who receives payment from Medicare, how benchmarks for payments are established and updated over time, and the role of episode-based payments in PB-TCOC models.
- Several payment features are desirable for PB-TCOC models, including determining accountability, attribution, and actuarial risk; using glide paths and incentives for increasing financial risk and participation over time; providing up-front investments to support desired care delivery transformation; caring for socially disadvantaged patients through health-related social needs (HRSNs) screening and risk adjustment; and encouraging multi-payer alignment on model design components.

INTRODUCTION

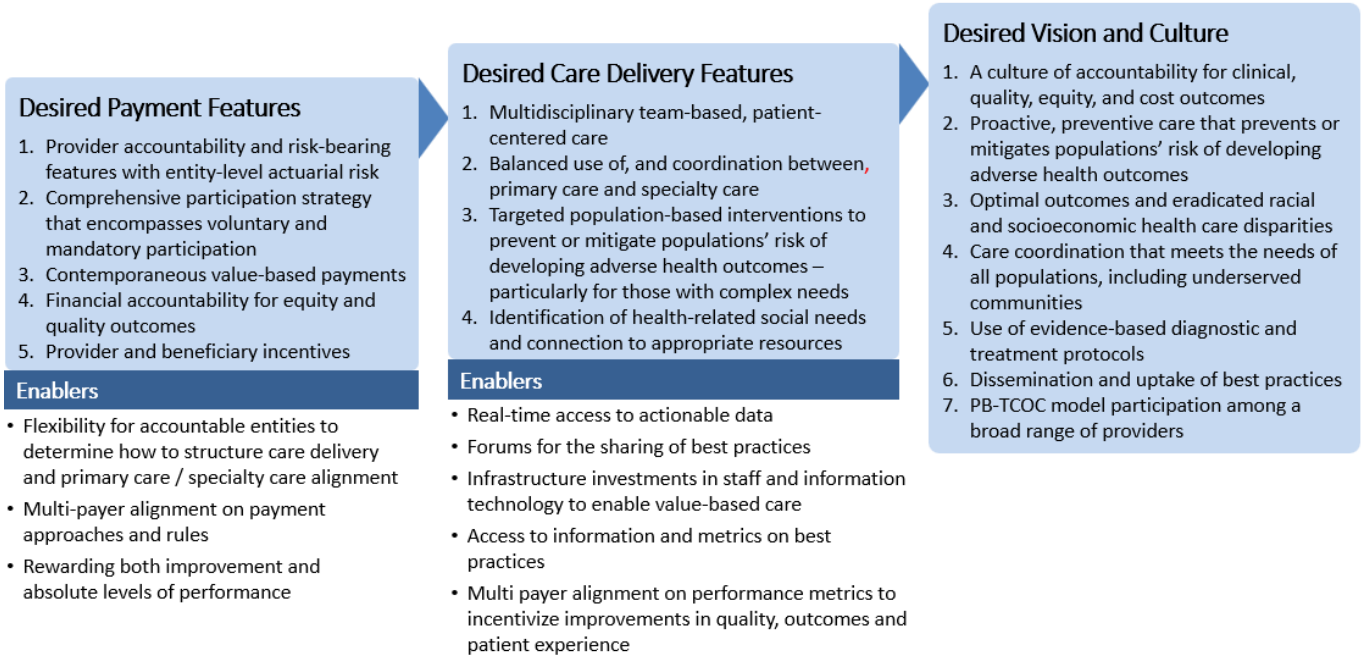
Since March 2022, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) has held a series of theme-based discussions on topics relevant to the transition to value-based care.[1] A key focus for the Committee has been population-based total cost of care (PB-TCOC) models, a specific type of Alternative Payment Model (APM) that involves providers having full accountability for the quality and costs of a specific patient population. A key component of PB-TCOC models is the approach used to determine how payments are made to physicians so that these arrangements encourage and support providers to engage with PB-TCOC.

DELIVERY SYSTEM TRANSFORMATION, VALUE-BASED CARE, AND APMs

Testing APMs provides evidence for transforming the delivery system toward value-based care. Figure 1 summarizes the desired care model and payment features, with policy considerations to attain that vision. The desired payment mechanisms are those that support and incentivize the desired vision for care. The desired care model and the associated payment mechanisms would encompass the total cost of providing Medicare covered services.

[1] More information on past and upcoming PTAC meetings can be found on the ASPE PTAC website.

Figure 1. The Desired Care Model and Payment Features



Source: Adapted from the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Preliminary Comments Development Team (PCDT), Payment Issues Related to Population-Based Total Cost of Care Models. September 19, 2022. *https://aspe.hhs.gov/sites/default/files/documents/05167b8d3f204f30989f9765fb5069bc/PTAC-Sep-2022-PCDT-Findings.pdf*

EVALUATING PAYMENT ARRANGEMENTS TO SUPPORT PB-TCOC MODELS

While the traditional FFS model reimburses providers for each service they provide, PB-TCOC models incentivize higher value care by paying entities based on accountability for measures of TCOC and quality.[2] Opportunities and challenges associated with population-based payment methodologies are described below.[3]

Comparing Full Capitation, Partial Capitation, and Traditional Fee-for-Service Models

Figure 2 summarizes three payment approaches associated with the PB-TCOC concept: full capitation, partial capitation, and FFS with shared savings and/or losses (i.e., upside and/or downside risk).

[2] This Issue Brief focuses on payment for TCOC models. There are many episode-based models also being tested. Their role is discussed below and will be discussed in other PTAC Issue Briefs.

[3] Additional information on payment methodologies can be found in Section V of the Second Supplement to the Environmental Scan on PB-TCOC Models.

Figure 2. Potential Payment Approaches for PB-TCOC Models

Methodology	Opportunities	Challenges	Example
Full Capitation	• Increased incentives to engage in care transformation • Flexibility in care networks • Clarity about provider-population alignment	• Risk of under-provision of care and lower access • Determining prospective budgets	Medicare Advantage
Partial Capitation	• Flexibility in care delivery innovations • Facilitate transition to increased risk	• Risk adjustment • Progressive difficulty performing against benchmark	Global and Professional Direct Contracting Model (now ACO REACH)
FFS with retrospective shared savings + / - losses	• Balance between access and reduction of avoidable services • Ramp up for providers with less PB-TCOC experience	• Time delay in understanding performance and delivering financial incentives (from reconciliation) • Risk of over-provision of care	Medicare Shared Savings Program

Source: Adapted from the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Preliminary Comments Development Team (PCDT), Payment Issues Related to Population-Based Total Cost of Care Models. September 19, 2022. https://aspe.hhs.gov/sites/default/files/documents/05167b8d3f204f30989f9765fb5069bc/PTAC-Sep-2022-PCDT-Findings.pdf

Full capitation models reimburse providers with a fixed payment for all services delivered to a patient. These payments are usually made on a per-member-per-month basis.[4] These up-front payments have advantages relative to FFS with retrospective shared savings arrangements, including financial planning, provider engagement, infrastructure investment, and payments for social services outside of the traditional scope of health care services. Using process measures and electronic medical record data, rather than claims data, could expedite payment processes. A potential issue with capitation is the risk of underprovision of services, which could be addressed through effective performance measurement.

An alternative payment method involves partial capitation, in which a portion of the cost of care (e.g., primary care services) is paid through capitation with the remaining cost paid through FFS (including risk sharing). Evidence comparing the impacts of partial and full capitation models is limited.[5]

FFS with retrospective shared savings and losses also has advantages and disadvantages. As discussed in the following section, continuing FFS payment allows for a variety of organizations to participate in value-based care, as less integrated entities (e.g., primary care practices) can accept TCOC risk without having to make payment arrangements with other providers of services to their aligned population. Continued FFS payment also assures that providers can access data regarding their performance, as well as data for health services research, evaluation, and actuarial estimates.

OVERARCHING CONSIDERATIONS FOR PAYMENT IN PB-TCOC MODELS

Regardless of which payment mechanism is chosen for TCOC models, there are several overarching policy issues, including the flow of funds (who receives the payment from Medicare), the stability of payment benchmarks, and the role of episode-based payments in PB-TCOC models.

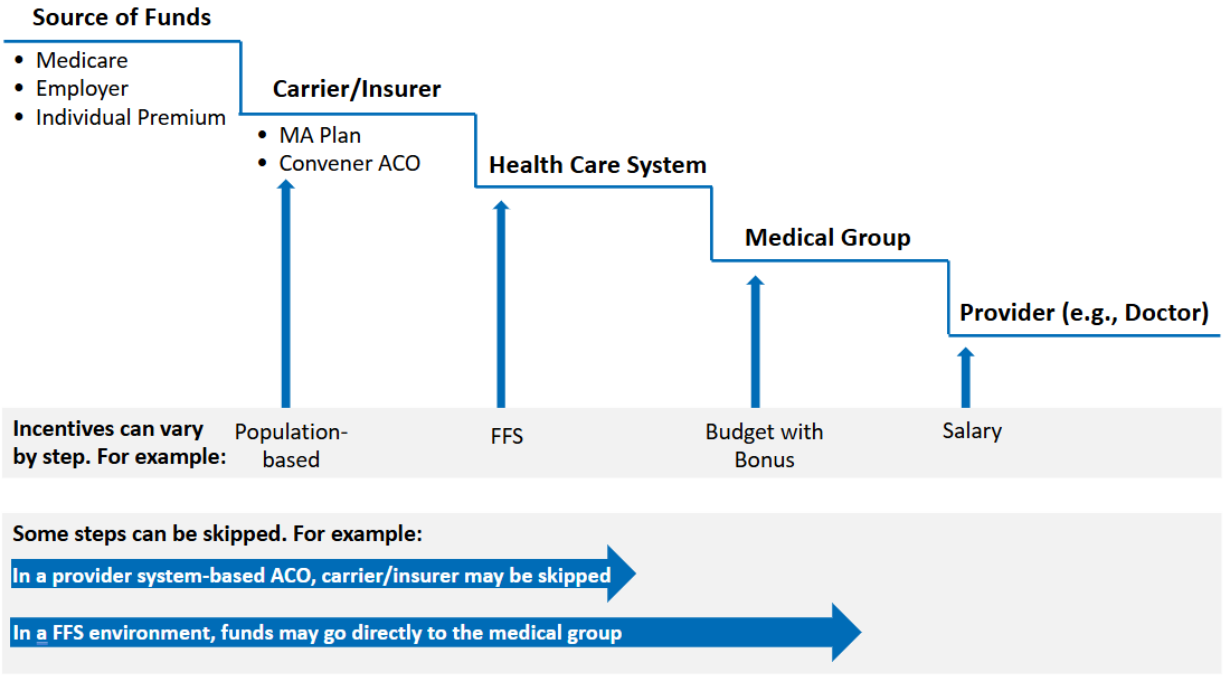
[4] Payment based on a global budget is a related method. In contrast to capitation, up-front payments might be made on a quarterly or annual basis and not necessarily based on a fixed number of participants.

[5] Additional information on the evidence of the impacts of partial capitation models can be found in the Second Supplement to the Environmental Scan on PB-TCOC Models.

Flow of Funds

One critical issue for PB-TCOC models is the level at which payments are made and how the funds flow down to the providers of the services. Figure 3 illustrates the health system levels, potential flow of the funds, and possible payment methods at each step.

Figure 3. Health System Levels Relevant for TCOC Payment



Abbreviations: ACO, accountable care organization; FFS, fee-for-service; MA, Medicare Advantage; TCOC, total cost of care
Source: Adapted from Michael Chernew. Incentives vs Cash Flow in Population Based Payment Models. September 19, 2022.
https://aspe.hhs.gov/sites/default/files/documents/24caec1577ea356fe58dc12819f4c203/PTAC-Sep-19-SME-LS-Slides.pdf

Funds that flow from Medicare or other purchasers might first go to insurers or Accountable Care Organization (ACO) conveners, next to a health care system, and then to medical groups and individual providers. A provider organization, such as an integrated delivery system, might agree to become the risk-taking entity, skipping the carrier/insurers step. In addition, as is generally the case with current Medicare ACOs, FFS payments might be made directly to providers for their services, bypassing health care systems and medical groups.

The flow of funds framework raises two important issues for model testing and the future of APMs. The first issue, from the perspective of Medicare and other purchasers, is what health care system level should be made accountable for TCOC and performance. There should be organizational-level accountability from the perspective of Medicare. Payment might be made directly to the accountable entity, which would then be responsible for distributing payment and incentives to providers. Even if payment to the accountable entity is determined by a form of population-based payment, such as capitated rates, the entity's payments to participating providers might take the form of capitation, FFS, or salary/bonus arrangements. This arrangement would be comparable to how funds flow in the Medicare Advantage (MA) program. If FFS payment is made directly to providers by Medicare, then shared savings/penalties can retrospectively be settled at the accountable entity level.

The second issue is whether a capitated arrangement or FFS with shared risk provides stronger entity-level incentives for improving health care value. Although strong evidence to compare the impacts of two methods is not available, FFS with appropriate two-sided risk could provide similar incentives to capitation.

Stability of Payment Benchmarks

Another critical issue for PB-TCOC models is how the benchmarks for payment are established and updated over time. One concern with current methods is the disincentive for participation related to "ratchet effects" that occur when benchmarks are recalculated periodically based on newer spending data. Under this approach, ACOs are penalized for strong performance by having their cost target benchmarks lowered even further, resulting in lessened opportunities for future shared savings. Thus, a critical issue for the future of PB-TCOC models is determining how to calculate benchmarks that balance two important objectives: 1) benchmarks should be consistent with a trajectory of Medicare spending that results in future savings—that is, slower growth over time than currently projected for the program; and 2) benchmarks should follow a stable and predictable path over time and allow accountable care entities to realize shared savings that reflect adequate returns on their investments in value-based care.

Role of Episode-based Payments in PB-TCOC Models

Another important issue is the potential functions of episode-based payment in a TCOC environment. Episode-based payment can play an important role for specialty integration within PB-TCOC models. Payment based on defined episodes can provide valuable performance data for primary care practices to use in determining specialty referral for their patients. The payment and associated performance measurement may also incentivize specialists to transition to value-based care. For integrated organizations, episode-based payment might be nested within the TCOC payment arrangements. Finally, episode-based models can provide evidence on best practices to inform care delivery among model participants.

PAYMENT-RELATED FEATURES OF PB-TCOC MODELS

Several features related to payment are desirable for future PB-TCOC models.[6]

Determining Accountability, Attribution, and Actuarial Risk

PB-TCOC models require clear assignment of accountability to identify which entity is responsible for various aspects of care. Accountability for TCOC should be placed at the organization level rather than the provider level because ACOs and hospitals often have more infrastructure and financial capacity for risk assumption, care organization, and decision-making compared with individual providers. Therefore, a key issue is determining whether payment should be made at the organization or provider level. While organization-level incentives could foster provider collaboration, they may not be effective in influencing providers who continue to receive FFS reimbursement. Provider-level incentives are beneficial when care management teams are embedded into primary care, but tailoring incentives to individual providers may be challenging. Incentives, such as patient-specific base payments and population-based payments, can also strengthen clinical coordination and specialty care integration.

The central role of primary care providers (PCPs) in care delivery makes them generally suitable to assume accountability, although specialists may be better equipped to assume accountability for patients with chronic conditions. Cascading accountability structures can help integrate specialty

[6] For additional information on desired payment features, see Section IV of the Second Supplement to the Environmental Scan on PB-TCOC Models.

providers into PB-TCOC models and foster coordination with PCPs. Shifting from retrospective, utilization-based alignment to a prospective approach may also clarify provider and population alignment and attribution. Criteria for assigning accountability include selecting providers based on the amount of care they provide, targeting areas of inefficiency in the health care system, and holding providers accountable only for the services over which they have direct control.

Barriers to establishing accountability include patients receiving care outside of value-based models, infrequent patient interactions, a limited number of specialists willing to take on shared risk, and incentives that encourage ACO providers to reduce spending on care they do not provide. Additionally, providers are often unable to realize the benefits of PB-TCOC models if shared savings at the organization level do not flow to them. Barriers such as limited health information technology interoperability and model overlap hinder attribution. Furthermore, attribution commonly requires a primary care physician visit even though primary care is not always provided by physicians. Prospective or voluntary approaches to attribution may mitigate these issues and improve patient choice.

Using Glide Paths and Incentives for Increasing Financial Risk and Participation Over Time

There are multiple strategies to increase participation in PB-TCOC models. Incremental implementation of mandatory participation could increase the proportion of providers' revenues in value-based arrangements while mitigating selection effects, particularly among specialists in underserved areas, rural markets, and lower-performing organizations. Organizations that are better positioned to succeed in PB-TCOC models should be heavily incentivized or required to take on more risk, while organizations with fewer resources should be offered lower-risk participation options. Furthermore, establishing minimum participation requirements is critical for investments in patient-centered care. However, accountable entities with smaller patient panels may have greater difficulty in sustaining investments, managing performance, and navigating spending changes compared with larger counterparts. There is a need for a phased approach that incentivizes voluntary participation in PB-TCOC models and offers opportunities to gradually assume more downside risk.

Providing Up-Front Investments to Support Desired Care Delivery Transformation

Up-front investments in resources and infrastructure, including upgrading technology and data systems, hiring additional staff, and implementing process changes, are necessary for care delivery transformation. Risk-free monthly care management payments can help accountable entities in PB-TCOC models tailor investments to their communities' levels of risk, ensuring that providers with complex patient populations receive higher care management payments. Accountable entities in partially or fully capitated PB-TCOC models can spend capitation payments on care delivery transformation investments.

Caring for Socially Disadvantaged Patients Through HRSN Screenings and Risk Adjustment

Different strategies exist for addressing unmet HRSNs and disparate patient outcomes. Supplemental payments could incentivize providers to prioritize screenings and referrals for services that address HRSNs. HRSN screening data could also inform risk-adjustment algorithms, enabling fair comparisons of entities serving patient populations with different levels of risk and utilization, thereby incentivizing providers who care for socially disadvantaged patients to participate in risk-based APMs. Effective risk-adjustment methodologies should consider patient demographics, clinical characteristics, social determinants of health (SDOH), and HRSNs.

Encouraging Multi-Payer Alignment on Model Design Components

Many patients covered by PB-TCOC models receive services covered by other government or commercial payers, underlining the need for multi-payer alignment in PB-TCOC models. Multi-payer

alignment reduces administrative burden, streamlines data collection, and standardizes quality measures across payers. To realize these benefits, future models must aggregate and share data across payers. The Comprehensive Primary Care Plus (CPC+) model is one example of successful multi-payer alignment, as its unique public-private partnership model enabled practices to be supported by 52 aligned payers across 18 regions.[7]

CONCLUSION

Successful development and implementation of PB-TCOC models are intended to incentivize a paradigm shift toward value-based care. This transition necessitates careful consideration of various payment arrangements, phased transitions, voluntary and mandatory participation, and multi-payer alignment. Clear financial accountability at the organization level and strong financial incentives at the provider level are important. Payment arrangements, such as capitation and FFS shared savings models, have demonstrated potential in reducing TCOC.

RESOURCES

The following resources are publicly available on the ASPE PTAC website:

- Report to the Secretary: Optimizing PB-TCOC Models in the Context of APMs and PFPMs
- Environmental Scan: PB-TCOC Models in the Context of APMs and PFPMs
- Supplement to the Environmental Scan on PB-TCOC Models
- Second Supplement to the Environmental Scan on PB-TCOC Models
- Preliminary Comments Development Team (PCDT), Payment Issues Related to Population-Based Total Cost of Care Models, September 19, 2022

ABOUT PTAC

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to make comments and recommendations to the Secretary of Health and Human Services on proposals for physician-focused payment models (PFPMs) submitted to PTAC by individuals and stakeholder entities. Within this context, PTAC also reflects on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in Alternative Payment Models (APMs) and PFPMs. Accordingly, PTAC has held an ongoing series of theme-based discussions on developing and implementing value-based care. The content in this PTAC Issue Brief is based on publicly available information from PTAC's theme-based discussions, including PTAC presentations and recommendations, presentations by stakeholders and experts, environmental scans, original research, and PTAC reports to the Secretary.

[7] Additional information can be found on the Centers for Medicare & Medicaid Services Comprehensive Primary Care Plus model website.

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