Physician-Focused Payment Model Technical Advisory Committee

PTAC
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Payment Model Challenges and Opportunities Related to Integrating Primary and Specialty Care in Population-Based Total Cost of Care (PB-TCOC) Models

HIGHLIGHTS

- Nesting specialty condition models and acute episode-based payments within larger population-based total cost of care (PB-TCOC) models can address all aspects of specialty care spending; allow specialists to provide longitudinal, comprehensive specialty care management; and promote the sustainability of care coordination.
- Designing models to incentivize specialists to adopt a whole-person, value-based care approach can encourage specialists to participate in PB-TCOC models.
- Different approaches to patient attribution, including proactive attribution and multi-attribution methods, can be used to attribute patients to providers held accountable for their care.
- Creating performance metrics relevant to specialty care in PB-TCOC models and identifying metrics that can be linked to payment can help address challenges related to the lack of standard metrics on the needs of and care for patients managed by specialists.
- One approach to setting meaningful benchmarks that promote high-value care involves creating empirically derived benchmarks based on a provider's own historical spending for the applicable patient population, adjusting the target to account for national or regional cost growth trends, and risk-adjusting the target to account for the provider's unique patient population.
- Developing models to include entity-level risk for quality and total cost of care (TCOC) while allowing flexibility for organizations to determine how to structure provider-level risk can improve specialty integration in PB-TCOC models.

INTRODUCTION

Population-based total cost of care (PB-TCOC) models manage overall patient health to minimize costs over time for a patient population. Integrating specialty care in PB-TCOC models can encourage specialists to adopt an approach that is focused on delivering whole-person, high-value care.[1] Specialty care is provided by physicians who treat certain health problems and can include specialties such as cardiology, oncology, and psychiatry. This type of care can be ongoing or limited to a specific duration.

[1] PTAC uses the following working definition of the characteristics of specialty integration in the context of value-based care: "*Specialty integration is a desired characteristic of population-based models where: primary and specialty care provider roles and responsibilities are clearly delineated throughout the care journey for a given condition or episode of care; specialist care includes a continuum of responsibilities for a patient or condition, including, but not limited to, single consultation, co-management, and primary management; primary and specialty care providers coordinate to provide patient-centered care using bidirectional, synchronous, and asynchronous communication; specialists provide consultations and/or ongoing care via multiple modes in a timely manner; and primary and specialty care providers have access to use shared real-time data to inform care decisions.*"

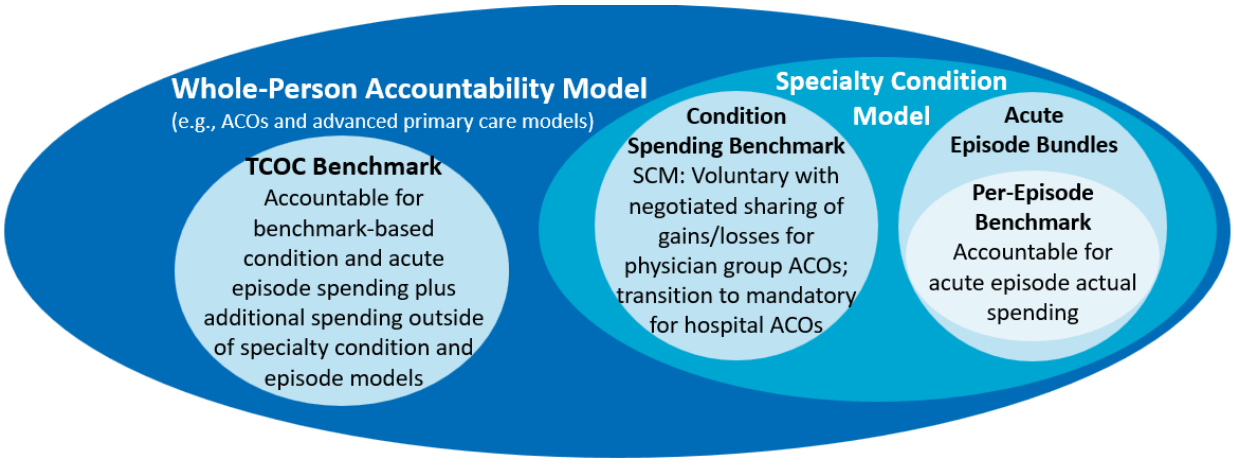
There are payment-related challenges and opportunities to integrating primary and specialty care in PB-TCOC models. Challenges include nesting specialties and conditions within population-based models, incentivizing specialists to participate in PB-TCOC models, identifying appropriate patient attribution methods, determining performance measurement methods, identifying appropriate benchmark methods, and determining risk. It is important to note that some payment-related challenges described in this Issue Brief may be addressed only by certain organizations with the ability to influence payment policy, such as the Centers for Medicare & Medicaid Services (CMS).

NESTING SPECIALTIES AND CONDITIONS WITHIN POPULATION-BASED MODELS

Although specialty care accounts for the largest component of spending for whole-person care, specialty integration in value-based care has not been widespread. Specialists commonly treat a range of conditions, which typically require different services, attribution methods, and risk levels. Thus, payment models should not be applied universally across a given specialty.

Policies and payments are needed to support integrated longitudinal condition management, particularly for patients with chronic conditions, and to promote engagement between specialty providers and primary care providers (PCPs). To support effective integration of primary and specialty care, it is important to include specialty care costs in the population-based payment (carve in) instead of excluding specialty care costs from the main payment model and managing them under a separate arrangement (carve out). Specialty condition-based payment models (SCMs)—condition-based payments for specialized care designed to support the delivery of long-term services, condition management, and coordination between PCPs and specialists—can be nested within larger, whole-person PB-TCOC models, such as Accountable Care Organization (ACO) and advanced primary care models (Figure 1). Episode-based payments, which typically include a fixed payment amount to cover all provider services and treatments associated with an acute or chronic episode of care over a fixed period, such as 30 days or one year, can be nested within SCMs. Nesting SCMs and episode-based payments within PB-TCOC models can address all aspects of specialty care spending (e.g., condition management, minor procedures, major procedures, and acute events); support specialists' ability to provide longitudinal, comprehensive specialty care management; and promote the sustainability of care coordination and models focused on maximizing longitudinal patient outcomes.

Figure 1. Nesting Specialty Condition Models and Acute Episode-Based Payments Within PB-TCOC Models

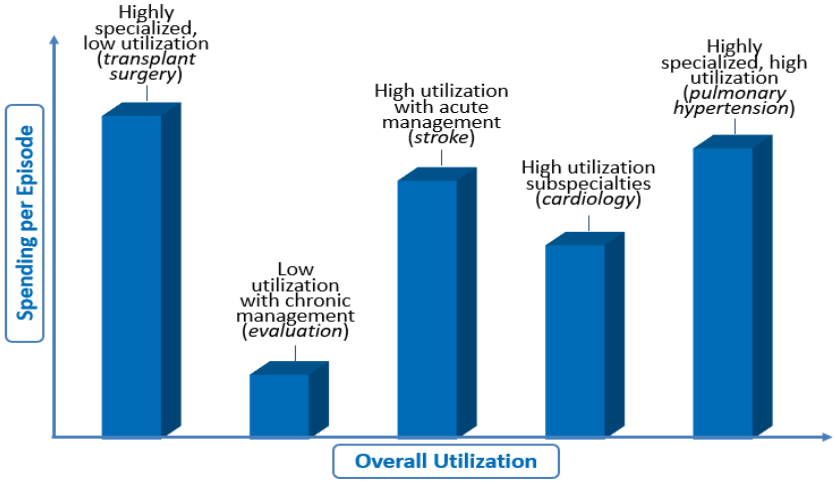


Abbreviations: ACO, accountable care organization; TCOC, total cost of care; SCM, specialty condition-based payment model
Source: Adapted from Mark McClellan, MD, PhD. Opportunities for Integrating Specialty Care Within Population-Based Payment Models. March 2, 2023. https://aspe.hhs.gov/sites/default/files/documents/e30fa1deed9fb49e2e84a57e6df25ef3/PTAC-Mar-2-SME-LS-Slides.pdf

Organizational structure can affect an ACO's ability and willingness to adopt SCMs, suggesting different pathways to implementation. For physician-led (low-revenue) ACOs, there is little financial integration of specialists, but the ACO is strongly motivated to collaborate with specialists on longitudinal patient care, suggesting a voluntary path to transitioning to SCMs. Technical barriers such as administrative costs and low patient volume make it difficult for physician-led ACOs to engage specialists. PCPs need better information and support for data sharing with specialists and for comparing specialists for patient referrals, along with templates and models to support value-based contracting with specialists. In contrast, for hospital-led (high-revenue) ACOs, there is high financial integration of specialists (e.g., through direct employment), but the ACO is not strongly motivated to engage specialists in longitudinal care, suggesting a mandatory path to transitioning to SCMs. Successful transformation would lead to reductions in a hospital's specialist services, such as inpatient procedures, which would reduce volume-driven hospital revenue. Hospitals need alignment of financial rewards with longitudinal care management from specialists to shift focus away from patient volume. Finally, shadow bundles—that is, cost and quality data along with simulated payment information for episodes of care—can allow both physician- and hospital-led ACOs to analyze specialist information and financial impacts to support the transition to SCMs.[2]

It can be challenging to identify the most appropriate specialties, conditions, and episodes to nest within PB-TCOC models and determine whether certain specialties should not be nested within PB-TCOC models. Conditions or procedures that have predictable care trajectories and low variability in spending may be the most appropriate for nesting in PB-TCOC models, as costs for these types of conditions or procedures can be relatively predictable for the accountable entity and specialist. Evaluating cost and utilization associated with different conditions can help to identify avoidable costs. Figure 2 shows considerations for nesting specialty-focused models within PB-TCOC models.

Figure 2. Considerations for Developing Specialty-Focused Models for Nesting in PB-TCOC Models by Specialty Characteristics



Abbreviation: PB-TCOC, population-based total cost of care
Source: Adapted from the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Preliminary Comments Development Team (PCDT), Improving Care Delivery and Integrating Specialty Care in Population-Based Models. March 2, 2023.
https://aspe.hhs.gov/sites/default/files/documents/2ffb75f3de3c194f8a43743e18e5a9c9/PTAC-Mar-2-PCDT-Findings.pdf

[2] Japinga M, Jayakumar P, de Brantes F, Bozic K, Saunders R, McClellan M. Strengthening Specialist Participation in Comprehensive Care through Condition-Based Payment Reforms. Duke Margolis Center for Health Policy. November 9, 2022. https://healthpolicy.duke.edu/sites/default/files/2022-11/Strengthening%20Specialist%20Participation%20in%20Comprehensive%20Care%20through%20Condition-Based%20Payment%20Reforms.pdf

It should be noted that in addition to episode-based and condition-based payments, gainsharing (i.e., sharing in the net savings or losses associated with cost improvements from value-based care) can promote specialist integration in PB-TCOC models.

Additional work is needed to nest payment models for specialists within larger PB-TCOC models. Future research should consider assessing the longitudinal impact of nesting specialty episodes on cost and patient outcomes.

INCENTIVIZING SPECIALISTS TO PARTICIPATE IN PB-TCOC MODELS

Incentives can encourage providers to transition from Medicare fee-for-service (FFS) to value-based care. However, there are currently insufficient incentives to encourage specialists to transition into value-based relationships. Specialists tend to rely on volume-based FFS reimbursement within and outside of value-based care models. It can be difficult for specialists to have time to engage in certain activities such as care coordination that are generally not reimbursed within the current relative value unit-based systems. Financial incentives for specialists to participate in PB-TCOC models are often offset by the risk of financial loss, particularly for practices with small patient panels in value-based care arrangements.[3] As a result, there is less participation among specialists in value-based care and a smaller proportion of overall patient panels in value-based care arrangements.

To date, many nested models have not sufficiently accounted for patients with multiple chronic conditions and multiple condition episodes, creating potential overlap between nested episode-based and condition-specific models.[4] It can be challenging to determine the amount of flexibility that accountable entities in PB-TCOC models should have in deciding how to structure financial incentives for participating providers. One strategy is to design Alternative Payment Models (APMs) to incentivize specialists to adopt a more holistic, total cost of care (TCOC) approach. For example, specialists and PCPs could be engaged to monitor a patient electronic health record (EHR) dashboard to track a patient's condition and progress and to proactively review the EHR to increase opportunities for early detection and prevention. Another approach is to reward physicians for preventing disease progression using condition-specific payment approaches nested within APMs. Condition-specific models nested within population-based models may include sub-capitated payments to providers who cover costs associated with longitudinal, chronic care management. Additional work is needed to empirically evaluate the link between capitated payment arrangements and improved care management and coordination.

Prospective, capitated payments can support the up-front costs needed to develop infrastructure and technology to support the integration of primary and specialty care and enable more providers and organizations to participate in value-based care models. Offering specialists sufficient incentives can encourage participation in value-based care and potentially create healthy competition among providers vying to manage care among the same group of patients.

PATIENT ATTRIBUTION

Patient attribution methods determine which provider is considered responsible for a patient's care and eligible for financial incentives or gainsharing. To date, many payment models have focused on the PCP as the provider accountable for the patient's care, leaving out the role of specialty care providers. There are several considerations for attributing patients to primary and specialty care providers in PB-TCOC

[3] Wiler JL, Kosinski LR, Mills TL, Walton J. Where are all the specialists? Current challenges of integrating specialty care into population-based total cost of care payment models. *Ann Intern Med*. 2024 Mar;177(3):375-382. doi:10.7326/M23-2991.
[4] Wiler JL, Kosinski LR, Mills TL, Walton J. Where are all the specialists? Current challenges of integrating specialty care into population-based total cost of care payment models. *Ann Intern Med*. 2024 Mar;177(3):375-382. doi:10.7326/M23-2991.

models, including the plurality of services, or where patients receive most of their health care services; the timing of attribution, which can be based on the current year or prior year; the duration of attribution, such as quarterly or on an episode-by-episode basis; and the potential for sharing accountability with a PCP and/or specialist for specific stages in a condition or disease.

It is important for providers to collectively understand which patients the primary care and specialty team is accountable for managing. However, it can be challenging to identify attribution methods that are most appropriate for primary and specialty care providers in PB-TCOC models, including those with nested episode-based or condition-specific models. Determining the appropriate attribution method can be particularly challenging when patients do not have a PCP; patients receive their care from multiple providers and networks with different EHRs; patients see more than one physician for multiple conditions, such as co-occurring chronic health conditions; there is variation in data quality and access; and there is difficulty in assessing outcome measures that are not linked to a single provider or organization. For many patients, determining the most accountable provider is complex because accountability for care may not always rely on a single provider-patient relationship.

There are several opportunities to address challenges with determining appropriate patient attribution methods. A shift in the culture among specialists is needed to recognize collective accountability and promote the adoption of cascading accountability that acknowledges different roles of primary and specialist care. Models should consider identifying the providers who are most capable of influencing a patient's outcomes as the accountable entities.

Specific attribution methods for successfully integrating primary and specialty care in PB-TCOC models include proactive attribution and multi-attribution. Proactive attribution—the assignment of a provider to a patient's care prior to receiving services from that provider—can be facilitated by using information on a patient's preferences, utilization patterns, and needs, as well as the specific role that each provider should play at a given point in the patient's care journey, independent of provider specialty. The use of proactive attribution can enable care coordination in integrated primary and specialty care models. To ensure that patient preferences are considered in alignment, patients should be given the opportunity to affirm the provider relationship.

Multi-attribution methods may also be appropriate to account for nuances in real-world care delivery where multiple providers are involved in a patient's care. Multi-attribution methods allow a single patient to be attributed to more than one provider and are applicable in scenarios where multiple providers should be accountable for a patient's care. One type of multi-attribution method is weighted attribution, which can allow patients to be attributed to the clinicians involved in their care based on pre-determined weights. However, this attribution approach has not been sufficiently explored in the current health care context. Additional testing of the design and implementation of weighted attribution is needed.

It is important that attribution approaches be applied to the individual physician responsible for the patient's care and not just to the Taxpayer Identification Number (TIN), which may be aggregated to the level of the practice or ACO. Using a combination of the TIN and the individual provider's National Provider Identifier (NPI) may be appropriate for attributing patients to providers.

Additional work is needed to understand how to best determine which provider should be accountable for a patient's care. Attribution models should be tested, verified, and reviewed to ensure that they are fair and equitable.

PERFORMANCE MEASUREMENT

There is a lack of standard metrics on the needs of and care for patients managed by specialists in PB-TCOC models. Creating metrics relevant to specialty care in PB-TCOC models and identifying appropriate performance metrics that can be linked to payment can help to address this challenge and identify specific areas in need of improvement. Measuring the value of specialty care may be assessed by:

- The availability of specialists, such as the number of specialists within a specific distance, the ratio of participating specialists to aligned beneficiaries, the waiting time for an initial specialty visit, the number of specialty visits reflected as a percentage of all office visits, and the time from request to appointment;
- Patient health outcomes;
- Patient-reported measures, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey;
- Safety;
- Equity in care delivery;
- Utilization; and
- Total cost of care.[5]

Although specialty care practices may not be structured to focus on population health, population health measures can incentivize team-based care. To encourage team-based care, it is important to organize workflows under a population health "umbrella" where there is joint responsibility assigned between PCPs and specialists involved in the patient's care plan. To leverage population health measures, providers will need access to digital tools beyond EHRs, such as natural language processing and electronic clinical quality measures, to aggregate patient data. The use of process measures focused on proactive engagement and communication between providers may also be integrated into payment model design to encourage team-based care, including communication between PCPs and specialists and communication between specialists.

It is important to identify appropriate performance metrics that can be linked to payments while acknowledging that some providers may not have experience in value-based models, including specialists. Payment models can be designed to connect specialists' performance to payment, incentivizing care delivery improvements through benchmarking and one- or two-sided risk.

BENCHMARKING

Benchmarks are essential to ensuring that providers deliver and are rewarded for value-based care. Benchmarks are the targets that providers are expected to meet in terms of quality and cost. These targets are used to determine financial incentives in value-based care models and are commonly rebased over time to reflect updated information and to encourage providers to continue to make improvements. It can be challenging to create meaningful benchmarks to evaluate high-value care, including accurately benchmarking payment for episode types that have low volume and high variation in condition-specific models. In addition, benchmarks can be a barrier to participation for many providers, particularly when benchmarks are improperly set, are not adequately risk-adjusted to account for different patient populations, or are frequently reset or rebased. It is important to consider provider volume when setting achievement versus improvement thresholds to ensure that comparison across providers is possible.

[5] Wiler JL, Kosinski LR, Mills TL, Walton J. Where are all the specialists? Current challenges of integrating specialty care into population-based total cost of care payment models. *Ann Intern Med*. 2024 Mar;177(3):375-382. doi:10.7326/M23-2991.

To allow providers to successfully manage the fiscal components of their businesses, benchmarks should be stable and predictable. One common approach to setting financial benchmarks is to create empirically-derived benchmarks based on a provider's own historical spending on a patient population, adjusting the target to account for national or regional cost growth trends, and risk-adjusting the target to account for the provider's unique patient population. Benchmarking methods should also consider who the risk-bearing entity is.

RISK

There are challenges to determining the arrangement for structuring entity-level and provider-level risk when integrating primary and specialty care in PB-TCOC models. Determining risk arrangements in this context is important because the implementation of specialty integration strategies may vary with the level of risk assumed by entities and/or providers.

One strategy is to develop PB-TCOC models that include entity-level risk for quality and TCOC to improve specialty integration while offering organizations the flexibility to determine how to structure provider-level risk. Specifically, financial risk should be at the entity level (e.g., ACO, hospital, or group practice) in integrated models while financial incentives should be at the provider level. Large entities are typically capable of spreading risk across a larger patient and provider population than are independent physician practices and individual providers. Large entities should consider extending incentives to providers, as providers can directly influence care delivery. To support shared risk and accountability between primary and specialty care providers, policies could emphasize the importance of PCPs following up with referred specialty providers after visits.

CONCLUSION

To encourage the integration of specialists in PB-TCOC models and promote the delivery of whole-person, high-value care, episodes and conditions should be nested within population-based models; sufficient incentives should be provided to specialists for delivering holistic care and preventing disease progression; and appropriate patient attribution, performance measurement, benchmarking, and risk methods should be identified and implemented.

RESOURCES

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

- Report to the Secretary: Improving Care Delivery and Specialty Integration in PB-TCOC Models
- Environmental Scan: Improving Care Delivery and Integrating Specialty Care in Population-Based Models
- Preliminary Comments Development Team (PCDT), Improving Care Delivery and Integrating Specialty Care in Population-Based Models, March 2, 2023

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.

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