Preliminary Comments Development Team (PCDT) Presentation:

Payment Issues Related to Population-Based Total Cost of Care Models

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September 19, 2022

Objectives of This Theme-Based Meeting

Examine key issues related to the development and implementation of population-based total cost of care (PB-TCOC) models

- March public meeting focused on key definitions, issues, and opportunities
- June public meeting focused on assessing best practices in care delivery
- September public meeting focuses on payment issues

Explore options for incentivizing desired care delivery innovations within PB-TCOC models, and encouraging specialty integration

Relevance:

- *PTAC has deliberated on the extent to which 28 proposed physician-focused payment models (PFPMs) met the Secretary's 10 regulatory criteria (including Criterion 2, "Quality and Cost")*
- *Many of these proposals sought to reduce TCOC and raised issues regarding specialty integration*

Nearly all of the 35 proposals that have been 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. Please see the Appendix for additional information.

Definition of Population-Based TCOC Models

- PTAC's working definition of PB-TCOC models:
  - *Alternative Payment Model (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).*
- This definition will likely continue to evolve as the Committee collects additional information from stakeholders.

Please see the *Environmental Scan on Population-Based Total Cost of Care (TCOC) in the Context of Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs)* for additional information.

Desired Features of PB-TCOC Models

Desired Payment Features

1. Provider accountability and risk-bearing features with entity-level actuarial risk
2. Comprehensive participation strategy that encompasses voluntary and mandatory participation
3. Contemporaneous value-based payments
4. Financial accountability for equity and quality outcomes
5. Provider and beneficiary incentives

Enablers

- Flexibility for accountable entities to determine how to structure care delivery and primary care / specialty care alignment
- Multi payer alignment on payment approaches and rules
- Rewarding both improvement and absolute levels of performance

Desired Care Delivery Features

1. Multidisciplinary team-based, patient-centered care
2. Balanced use of, and coordination between, primary care and specialty care
3. Targeted population-based interventions to prevent or mitigate populations' risk of developing adverse health outcomes – particularly for those with complex needs
4. Identification of health-related social needs and connection to appropriate resources

Enablers

- Real-time access to actionable data
- Forums for the sharing of best practices
- Infrastructure investments in staff and information technology to enable value-based care
- Access to information and metrics on best practices
- Multi payer alignment on performance metrics to incentivize improvements in quality, outcomes and patient experience

Desired Vision and Culture

1. A culture of accountability for clinical, quality, equity, and cost outcomes
2. Proactive, preventive care that prevents or mitigates populations' risk of developing adverse health outcomes
3. Optimal outcomes and eradicated racial and socioeconomic health care disparities
4. Care coordination that meets the needs of all populations, including underserved communities
5. Use of evidence-based diagnostic and treatment protocols
6. Dissemination and uptake of best practices
7. PB TCOC model participation among a broad range of providers

Opportunities and Challenges Associated With Selected Payment Methodologies

Capitation

FFS with shared savings + / - losses

Opportunities

Incentives for providers to engage in care delivery transformation

Clarity of provider-population alignment

Flexibility in care delivery innovations

Flexibility in care networks

Balance between access and reduction of avoidable services

Ramp up for providers with less PB-TCOC experience

Challenges

Risk of under-provision of care and lower access

Determining prospective budgets

Risk adjustment

Progressive difficulty performing against benchmark

Time delay in understanding performance and delivering financial incentives

Risk of over-provision of care

Certain opportunities and challenges may be characterized as more conceptual or operational in nature.

Opportunities and Challenges Associated With Selected Population-Based Payment Methodologies

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

Opportunities and Challenges Associated With Selected Episode-Based Payment Methodologies

Methodology	Opportunities	Challenges	Example
Prospective	Increased incentives to engage in care transformation; flexibility in care delivery innovations; clarity about provider-population alignment	Risk of under-provision of care and lower access; determining prospective budgets	Bundled Payments for Care Improvement Initiative Model 4*; Employers Centers of Excellence Network
FFS with retrospective shared savings + / - losses	Balance between access and reduction of avoidable services; ramp up for providers with less episode-based TCOC experience	Risk adjustment; progressive difficulty performing against benchmarks; time delay in understanding performance and delivering financial incentives (from reconciliation); risk of over-provision of care	Bundled Payments for Care Improvement Initiative Models 1-3*; Comprehensive Care for Joint Replacement Model

*The Bundled Payments for Care Improvement (BPCI) Initiative included four models of care that bundled payments for services received during certain episodes of care with the aim of improving quality and care coordination while reducing cost to Medicare. BPCI Models 1-3 focused on retrospective payments; however, Model 4 involved a single, prospectively determined bundled payment for the episode of care.

PB-TCOC Model Design Considerations

- Participation incentives and organizational requirements (size and capabilities of accountable entities) *
- Upfront resources and infrastructure to support desired care delivery transformation *
- Level of financial accountability for clinical, quality, equity and cost outcomes (clinician, entity, other level) *
- Attribution, benchmarking, and risk adjustment *
- Selection and use of performance metrics *
- Duration of accountability period (e.g., 365 days vs. another duration)
- Incentives to encourage clinical coordination and integration between primary and specialty care
- Overlap between PB-TCOC and other models (e.g., nesting, carve-outs)
- Incentivizes for screening and referral for health-related social needs
- Encouragement of multi-payer alignment on model design components

Model Design Considerations Associated With *Participation Incentives* and *Upfront Resources and Infrastructure*

A major factor that can influence providers' decisions to participate in PB-TCOC models is whether upfront resources and infrastructure are sufficient to promote care delivery changes

Other factors that may influence providers' participation decisions:

- Appropriateness of rules related to performance and accountability
- Consistency between model requirements and organizational capabilities
- Whether payment appears reasonable and sufficient to cover the cost of services
- Whether participants are financially rewarded for improving patient outcomes and experience

Model Design Considerations Associated With *Level of Financial Accountability*

Financial accountability relates to the amount of potential financial upside (increased payments) and downside (decreased payments) that providers assume as PB-TCOC participants

Challenges include assigning accountability at different levels within a PB-TCOC participant, including:

- At the level of the PB-TCOC participant entity
- At the level of entities (practices, hospitals, etc.) within a PB-TCOC participant
- At the level of individual clinicians or smaller groups of clinicians

Model Design Considerations Associated With *Attribution*

Attribution seeks to identify the beneficiaries whose care a PB-TCOC participant is accountable for managing

Challenges include ensuring clarity and consistency of the relationship between beneficiaries and an accountable PB-TCOC participant, particularly when beneficiaries are being seen regularly by multiple providers

Model Design Considerations Associated With *Benchmarks* and *Risk Adjustment*

Benchmarks

- Benchmarks (e.g., historical averages) can establish incentives for participation in APMs and attempt to constrain spending growth
- Challenges include setting and updating benchmarks using geographic, organizational type, and other factors

Risk Adjustment

- Risk adjustment seeks to enable fair comparisons across entities and minimize risk selection (where entities may select healthier, lower-cost patients)
- Challenges include capturing risk without inappropriate coding changes

Model Design Considerations Associated With *Selection and Use of Performance Metrics*

While PB-TCOC models are typically focused on rewarding absolute *achievement* in performance, rewarding *improvement* in performance can encourage provider engagement and care delivery innovation

Even if not used as formal performance metrics for determining payment, metrics that capture certain processes (e.g., number of primary care and overall encounters) may be useful to monitor within PB-TCOC models for the purposes of understanding processes that are associated with strong achievement or improvement

Areas of Focus for Discussion During the September Meeting

- Long-term vision for PB-TCOC payment methodologies
- Payment model design considerations and financial incentives that are most important for encouraging provider accountability and successful care transformation in PB-TCOC models
- Strategies for improving clinical integration of primary care and specialty care
- Care delivery innovations for higher cost / higher risk populations
- Selection of performance metrics for PB-TCOC models
- Most important steps for maximizing the impact of PB-TCOC models on outcomes

Appendix on Innovative Payment Methodology Approaches in Proposals Submitted to PTAC

Selected PTAC Proposals that Included TCOC-Related Components*

Nearly all of the proposals that have been 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.

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)

* 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 Selected 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

Payment Characteristics of 10 PTAC Proposals with TCOC-Related Components

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