Listening Session 3: Financial Incentives and Performance Metrics Related to Primary Care and Specialty Integration

Presenters:

Subject Matter Experts

- **Amol Navathe, MD, PhD**, Co-Director, Healthcare Transformation Institute, Director, Payment Insights Team, and Associate Director, Center for Health Incentives and Behavioral Economics, University of Pennsylvania; Physician and Core Investigator, Philadelphia Veterans Affairs Medical Center; and Commissioner, Medicare Payment Advisory Commission, US Congress
- **Mark Friedberg, MD, MPP**, Senior Vice President, Performance Measurement & Improvement, Blue Cross Blue Shield of Massachusetts
- **Eric C. Schneider, MD, MSc**, Executive Vice President, National Committee for Quality Assurance (NCQA)

Previous Submitter

- **Brian Bourbeau, MBA**, Division Director, Practice Health Initiatives, American Society of Clinical Oncology (ASCO); *Patient-Centered Oncology Payment Model (PCOP)* proposal

payment insights TEAM

Penn Department of Medical Ethics & Health Policy

Coordinating Specialty and Population-Based Payment Models

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Physician-Focused Payment Model Technical Advisory Committee (PTAC)
September 20, 2022

Population-Based Versus Specialty-Based Models

Population-Based:

- Improve quality
- Reduce hospitalizations and other acute care
- Improve efficiency in post-acute care
- Lower the total cost of care as well as Medicare spending

Specialty-Based:

- Reduce cost and variability
- More focused and practical for hospital/ organization alignment
- More options for policymakers to incentivize participation

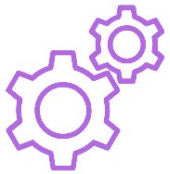
Key Policy Questions on Value-Based Payment Models

IMPACT ON COST AND QUALITY

WHERE SAVINGS ARE LOCATED

VOLUME EFFECT

CASE MIX EFFECT



STANDARDIZATION OF CARE

SPILLOVERS

VOLUME vs MANDATORY

OVERLAP WITH OTHER APMs

Why Does APM Overlap Matter?

CMS Goal: Near-universal participation in value-based payment models by 2030.

- Comprehensive strategy likely requires both population-based and episode-based models
- Need to harmonize models across the continuum of care (i.e., population-based) with those that target specific diseases/events/sites (i.e., episode or bundled payment).
- There could be synergies or redundancies
- Medicare policy has potentially discouraged rather than encouraged model overlap

Key Questions with Evidence

JAMA Health Forum™

Original Investigation

Association of Patient Outcomes With Bundled Payments Among Hospitalized Patients Attributed to Accountable Care Organizations

Amol S. Navathe, MD, PhD; Joshua M. Liao, MD, MSc; Erkuan Wang, MS; Ulysses Isidro, MPH; Jingsan Zhu, MS, MBA; Deborah S. Cousins, MSPH; Rachel M. Werner, MD, PhD

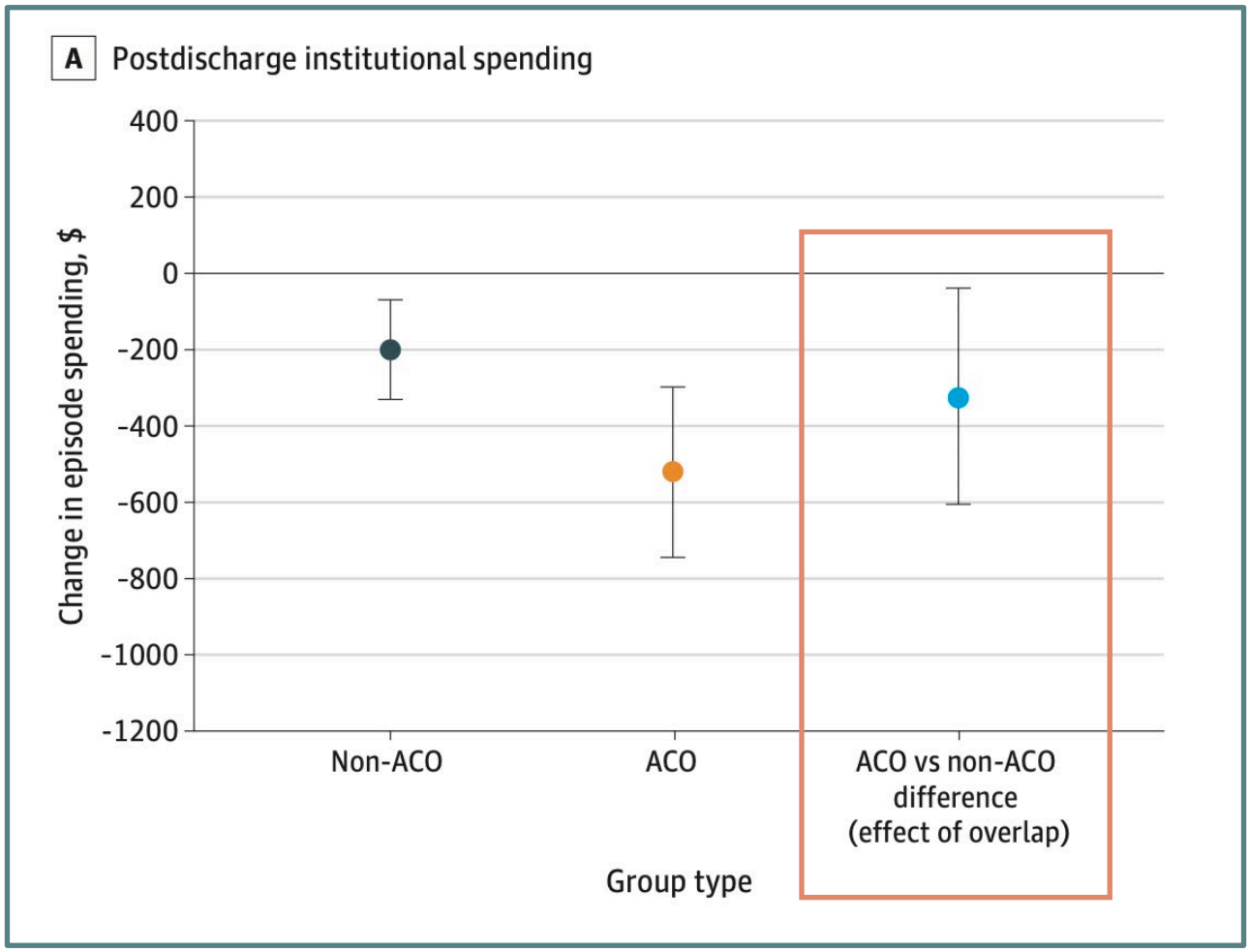
1) What is the impact of overlap between ACOs and bundled payments on patient outcomes?

2) How does this vary for medical conditions vs. surgical episodes?

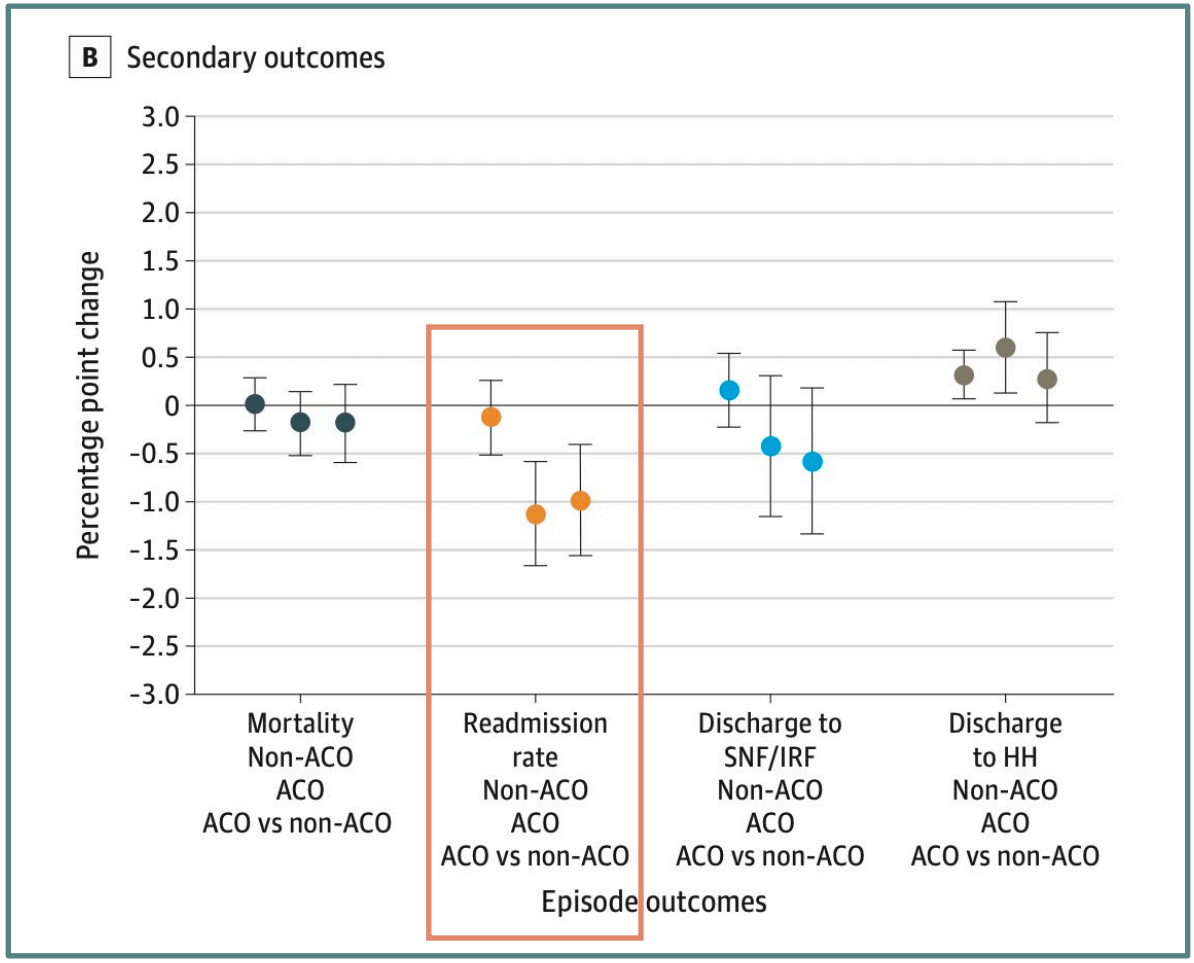
Study Details

- ACOs - MSSP ACOs from 2012 – 2018
- Bundled Payments - BPCI Episode Initiators from 2013-2018
- Design – Examine how ACO status modifies the bundled payment “effect”
- Robust design that mitigates confounding:
  - “within-ACO” (for BPCI vs. non-BPCI)
  - “within-hospital” (for ACO vs. non-ACO)

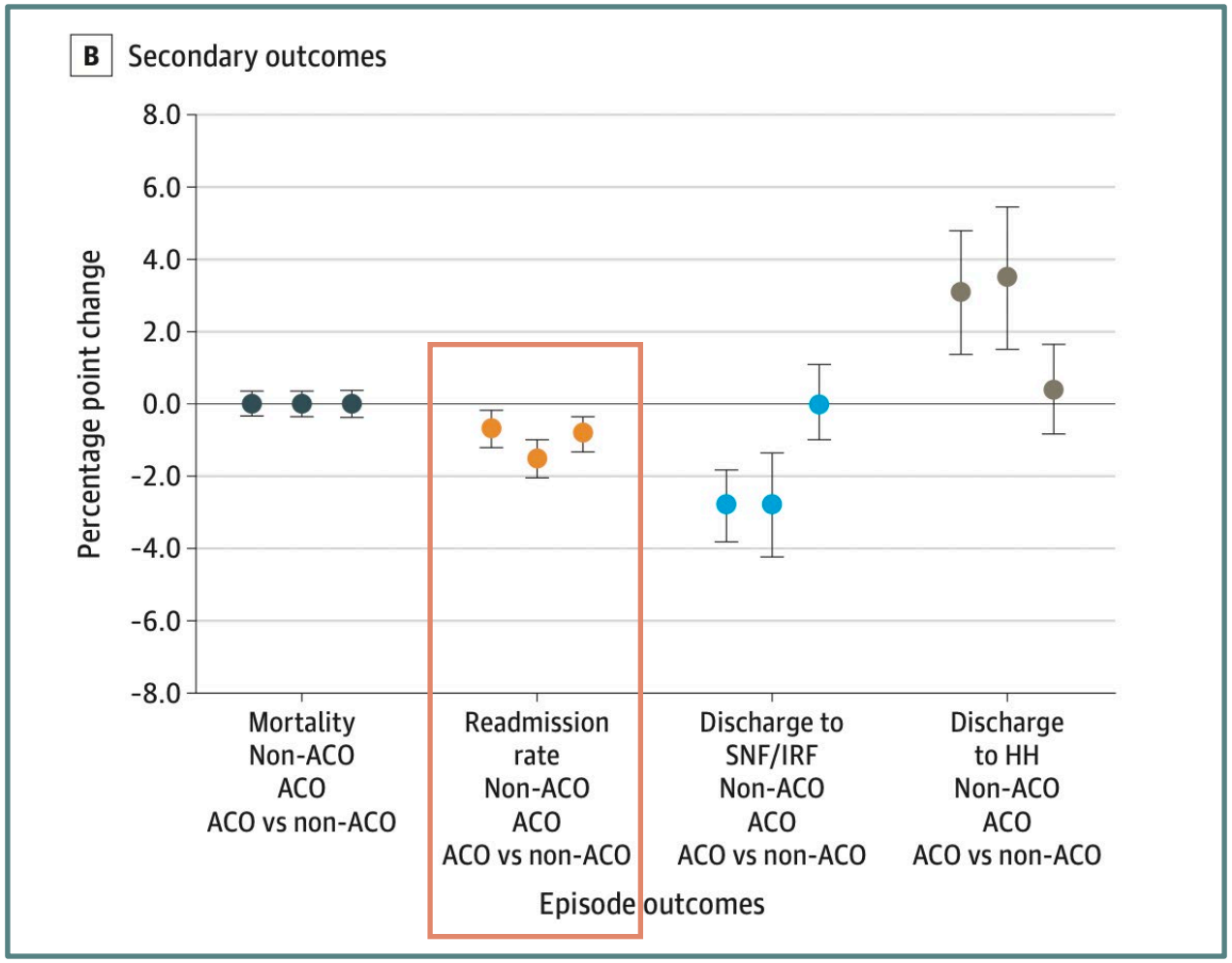
Overlap in ACOs and Bundles Lowers Spending for Medical Conditions



Overlap in ACOs and Bundles Reduces Readmission Rates for Medical Conditions



Overlap in ACOs and Bundles Reduces Readmission Rates for Surgical Procedures



Bundled Payments Seem To Work Well Together With Other Value-Based Payment Models Like ACOs

Overlap between ACOs and bundle payments was associated with:

- Medical: Lower spending and fewer readmissions
- Surgical: Fewer readmissions

First evidence to date of overlap synergies

- Benefits of model overlap are larger when clinical complexity is greater (CHF > knee replacement)

Important for policymakers to consider deliberate policy design to

- Fairly distribute savings
- Encourage overlap (?)

A Potential Approach to Harmonize Model Types

VIEWPOINT

Hierarchical Payment Models—A Path for Coordinating Population- and Episode-Based Payment Models

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Humana Inc, Louisville, Kentucky.

Michael E. Chernew, PhD
Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts.

Amol S. Navathe, MD, PhD
Department of Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania, Philadelphia; and Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania.

In November 2021, the Centers for Medicare & Medicaid Services (CMS) announced a strategy to achieve near-universal participation in value-based payment models by 2030.[1] Core to this strategy is the goal that every beneficiary should be in a clinical care relationship that has accountability for quality and total cost of care. Achieving this goal will require harmonizing the CMS foundational value-based payment models that focus on accountability across the continuum of care (ie, population-based models) with those that target specific diseases, acute events, or sites of care (ie, episode or bundled payment models).

With more than 20 ongoing value-based payment programs, models often overlap. This creates a complex environment for health care organizations to make decisions about participation, care redesign, and investments.[1] This environment also limits the rigor of model testing. Isolating the effect of a model may be nearly impossible,[2] leading to a situation in which singular models are not deemed successful despite contributing to system-level improvements in quality and cost.[3]

Amidst this complexity, articulating how to coordinate population- and episode-based payments could serve to catalyze reform and focus payment and delivery system innovation, much in the way that then-Secretary Sylvia Mathews Burwell of the US Department of Health and Human Services did for value-based payments in 2015. payment models, such as market-level mandatory participation for lower-extremity joint replacement bundles.

Episode-based models are not appropriate for all care, add complexity when episodes are co-occurring (eg, a patient frequently admitted for pneumonia and chronic obstructive pulmonary disease exacerbations), and do not disincentivize episode-triggering use such as hospitalization or surgery in the first place (although research does not suggest this is a problem to date). Population-based and episode-based approaches must be coordinated to create synergies between them, address their shortcomings, and support health care organizations across the spectrum of types, settings, size, and experience with risk.

Population- and Episode-Based Payments

Policy design should ensure episode-based payments, and any other payment approach tested, complement a foundational, population-based model. To maximize participation and accomplish the goal of aligning every beneficiary with an accountable entity, it will be important for the population-based approach to use multiple pathways for different types of participants (eg, those with experience in population management and those who do not have any experience) based on varied design attributes like the amount of downside risk and the incentives to participate. As a result, the role of episode-based payment may vary by pathway.

Hierarchical Payment Model

Global budget of population-based model as the “umbrella of accountability” under which episode-based payments are applied

- **ACO → coordinating entity**
- **Create episode-based payment systems for specific conditions and procedures for which:**
  1) episode-based payment can create efficiencies that population-based models would not likely generate alone
  2) there is evidence that episode payment improves cost, outcome quality, or both.

Benefits of Coordinated Payment Models

Create **closer collaboration** among primary care clinicians, specialists, and facilities.

Create a **blueprint and flexibility for reimbursing** specialists and facilities within coordinated population-based and episode-based models.

- Organizations in population-based models would earn savings when episode-related care is delivered by efficient clinicians.
- Clinicians providing care would earn savings within the episode.

Preserve **successful episode-based models** and support continued innovation.

Do NOT Forget Value ≠ Equity

- **Greater financial accountability** on physicians and hospitals has not historically led to more equitable outcomes.
- **Risk-adjustment tends to be incomplete** for marginalized groups.
- **Clinicians may avoid** patients from marginalized groups and/or participation in value-based payment models.

Make **equity an explicit goal** of any new value-based model (build equity into metrics and financial incentives).

Measure **disparate impact** on access and quality for disadvantaged populations via expedited reporting and data collection.

Thank You!

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FUTURE DIRECTIONS FOR QUALITY MEASUREMENT IN POPULATION-BASED TOTAL COST OF CARE CONTRACTS

PTAC

Sept 20, 2022

Mark Friedberg, SVP, Performance Measurement & Improvement, Blue Cross Blue Shield of Massachusetts

BCBSMA'S ALTERNATIVE QUALITY CONTRACT (AQC) LINKS TCOC RISK & QUALITY MEASUREMENT

MASSACHUSETTS

- Longstanding principles won't change. For high-stakes uses (including payment), quality measures must be:
  - Valid
  - Important
  - Reliable

- Evolution of quality measurement in AQC will stem from improving measure validity and extending high-stakes measurement into areas of increased importance

- Reliability is an ever-present concern, operationalized as a filter on candidate measures (already valid and important) for a given provider group
  - In other words, validity and importance come first. Then reliability.

IMPROVING MEASUREMENT VALIDITY

MASSACHUSETTS

- Measures of shared decision making (SDM)
  - Assess the degree to which decisions are consistent with medical science and individual patient values & preferences
  - Ethically superior construct, compared to guideline adherence without regard to individual patient values & preferences
  - SDM measures could replace most legacy measures for primary care (e.g., cancer screening, chronic condition management)
  - Best measured via patient surveys using uniform fielding methods

- Patient-reported outcomes

- Patient-reported access to mental health services

EXTENDING HIGH-STAKES MEASUREMENT TO NEW, IMPORTANT AREAS

MASSACHUSETTS

- Measures of equity
  - Differences between groups of patients for which no systematic differences are ethically tolerable (e.g., racial inequities)
  - BCBSMA incorporating pay-for-equity (P4E) into AQC now

- Measures of clinical decision making
  - Structured implicit review of clinicians' decisions, including their rationale
  - Examples limited to research, so far

CHRONIC CONDITIONS

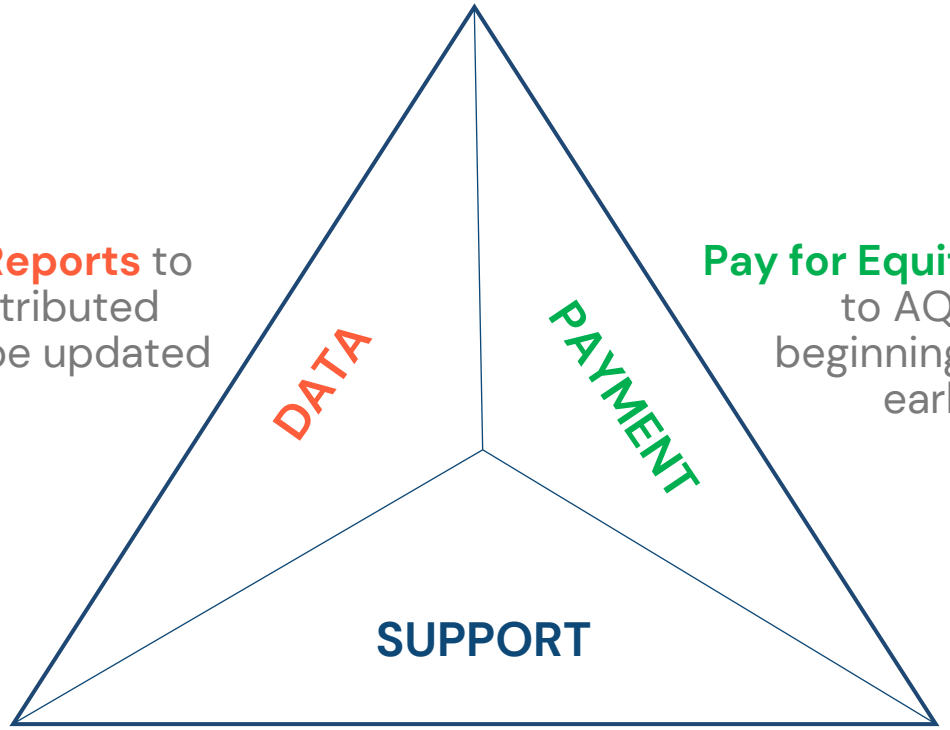
	Asian	Black	Hispanic	White
Asthma Medication Ratio % of members with persistent asthma who received appropriate medication to prevent asthma attacks (ages 5 - 64)	76.20%	69.70%	68.60%	74.70%
Comprehensive Diabetes Care - BP control % of adult diabetic members with blood pressure controlled (ages 18-75)	84.30%	71.40%	76.60%	82.40%
Comprehensive Diabetes Care - HbA1c Poor Control % of adult diabetic members with uncontrolled HbA1c (diabetes) (ages 18-75) (lower rates indicate higher quality care)	17.00%	25.10%	26.30%	19.40%
Comprehensive Diabetes Care - HbA1c Testing % of adult diabetic members who had HbA1c (diabetes) testing (ages 18-75)	94.00%	92.00%	92.20%	92.60%
Comprehensive Diabetes Care - Medical Attention for Nephropathy % of adult diabetic members who were screened for kidney disease (ages 18-75)	91.00%	89.40%	88.40%	90.10%

See
1. Health Equity Report
2. Press Release on P4E plans

INCENTIVES ALONE ARE NOT ENOUGH, ESPECIALLY FOR NEW MEASURES

Adding equity to the Alternative Quality Contract (AQC) triad, for example

Confidential **Equity Reports** to all AQC providers distributed September 2021, to be updated at least annually



Pay for Equity Incentives added to AQC payment program beginning January 1, 2023, for earliest provider groups

Equity Action Community with Institute for Healthcare Improvement launched November 2021

Health **Equity Grants** to contracted provider organizations in 2022-2023 that participate in the Equity Action Community

MASSACHUSETTS

THANK YOU

Health Care Quality and Total Cost of Care Payment Models

Eric C. Schneider, MD, FACP
Executive Vice President

Questions

- What quality accountability infrastructure is needed to support payment models based on total cost of care?

- How will quality accountability systems address key drivers of both health and spending (unmet social needs, community inequities, lack of access)?

To Improve Health Outcomes Address Unmet Social Needs

The Argument for Health Care Intervention

40 to 55% of health outcomes attributable to social determinants of health outside the traditional health care system

Black and Native American infant mortality rates 2x higher than White infants (Artiga, 2019)

Hispanic individuals 60% more likely to die from viral hepatitis than White individuals, despite lower rates of Hepatitis C (OMH, 2020).

Black, Native American and Native Hawaiian individuals receive worse care than White individuals on 4 out of 10 health care access measures (AHRQ, 2019).

From 2003 -2006, total cost of health inequities and premature death estimated at $1.24 trillion (APHA, 2019)

In one Medicaid program, 43% of diabetes cost ($225M) avoidable if racial & economic disparities addressed (Buescher, 2010)

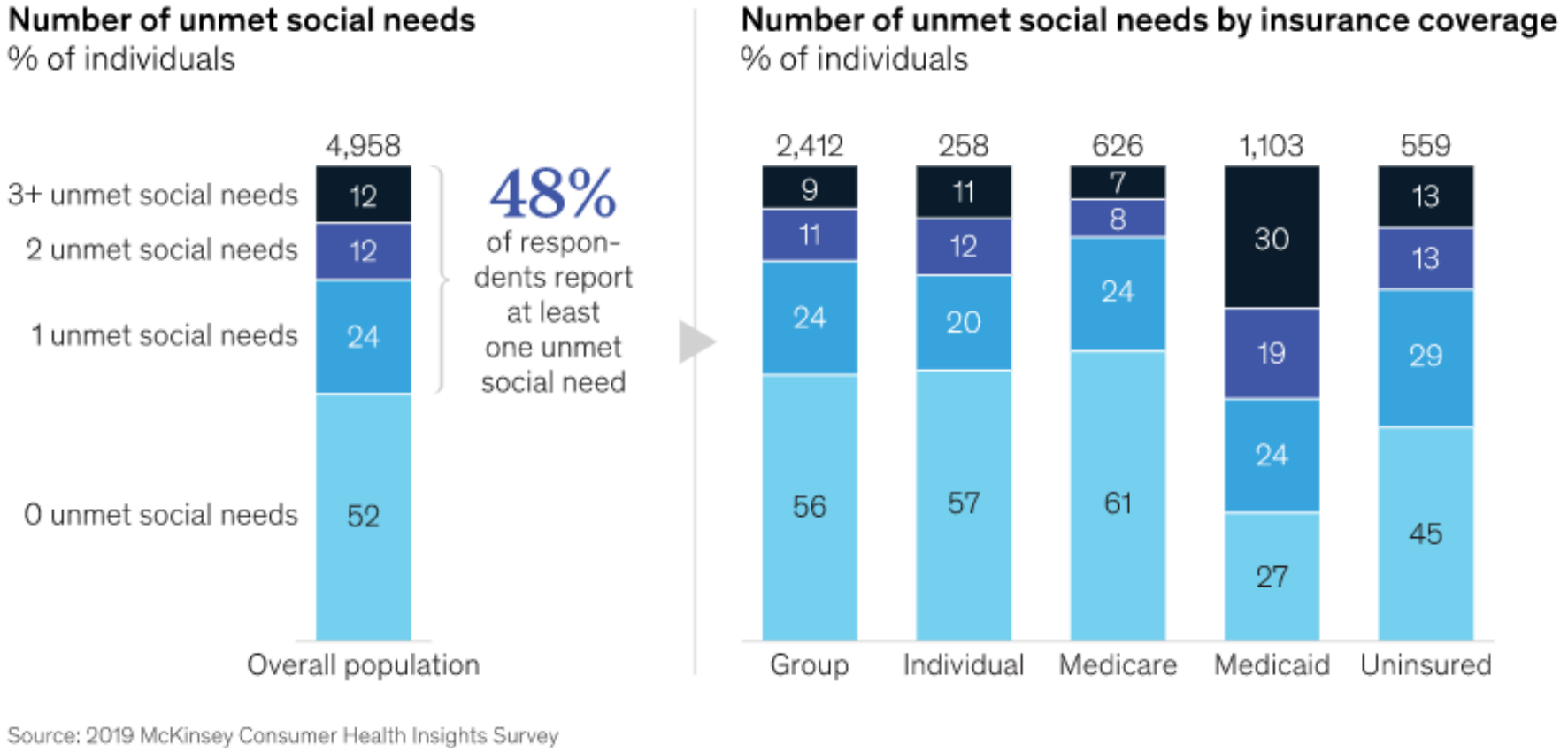
Wide-Ranging Impact

Unmet social needs broadly felt, regardless of payer type

Don’t assume needs are limited to specific populations.

48% of overall population report unmet social needs

44% of members under group commercial insurance



Source: 2019 McKinsey Consumer Health Insights Survey

McKinsey & Company, 2020. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-impact-of-unmet-social-needs-on-consumer-health-and-healthcare

NCQA Quality Accountability Programs

Measurement, Transparency, and Accountability

HEDIS

More than **203 million people—60% of the US population**—are enrolled in health plans that report quality results using our Healthcare Effectiveness Data and Information Set. Americans receive **better care** and can lead **healthier lives** thanks to the accountability and benchmarking that HEDIS makes possible.

Health Plan Accreditation

Our industry-leading accreditation is a rigorous assessment of health plans' structure and process, clinical quality and patient satisfaction. More than 173 million people are enrolled in NCQA-Accredited health plans.

Patient-Centered Medical Home (PCMH) Recognition

A medical home is not a place, but a way to organize primary care so it's "the way patients want it to be." Since 2008 we have built the most widely used medical home model. More than 10,000 practice sites and 50,000 clinicians have earned the NCQA PCMH Recognition seal.

Bringing Transparency to Inequities: Early in the Journey

Comparing organizations on quality and equity requires large samples

Stratification by socioeconomic status

(Medicare only)

- Diabetes A1C
- Breast Cancer Screen
- Colorectal Cancer Screen
- All-Cause Readmission
- Hypoglycemia ED Visits*

Stratification by race & ethnicity

- HEDIS MY 2022: 5 Measures
- HEDIS MY 2023: 8 Measures

Evaluating race, ethnicity and language data

- Diversity of Race/Ethnicity
- Diversity of Language

* Approved by CPM 5/6/2022

Organizational Capabilities that Support Change: Lessons from PCMH

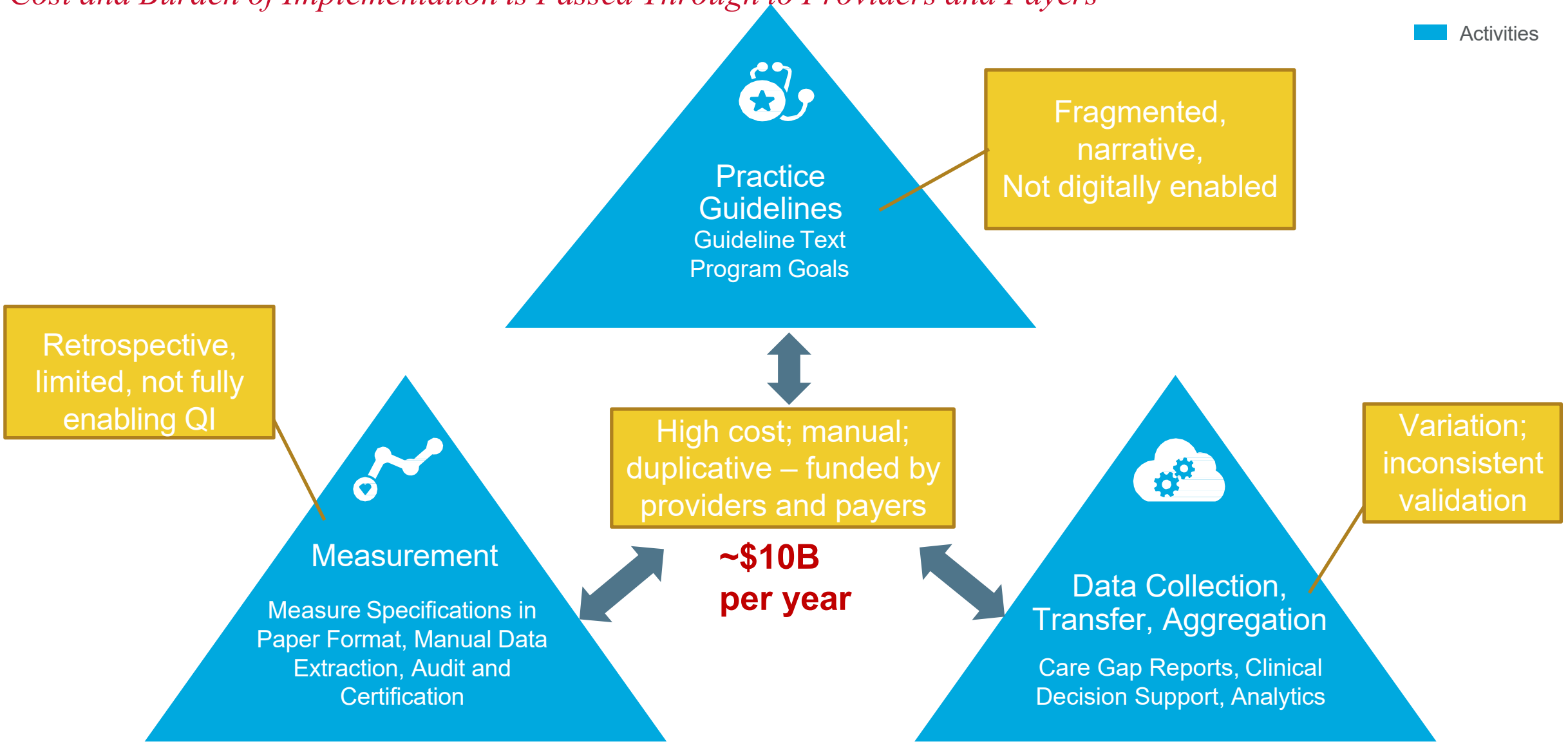
Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The Changes Involved in Patient-Centered Medical Home Transformation. Primary Care: Clinics in Office Practice. 2012; 39:241-259.

High-performing PCMH Practices Use Digital Capabilities

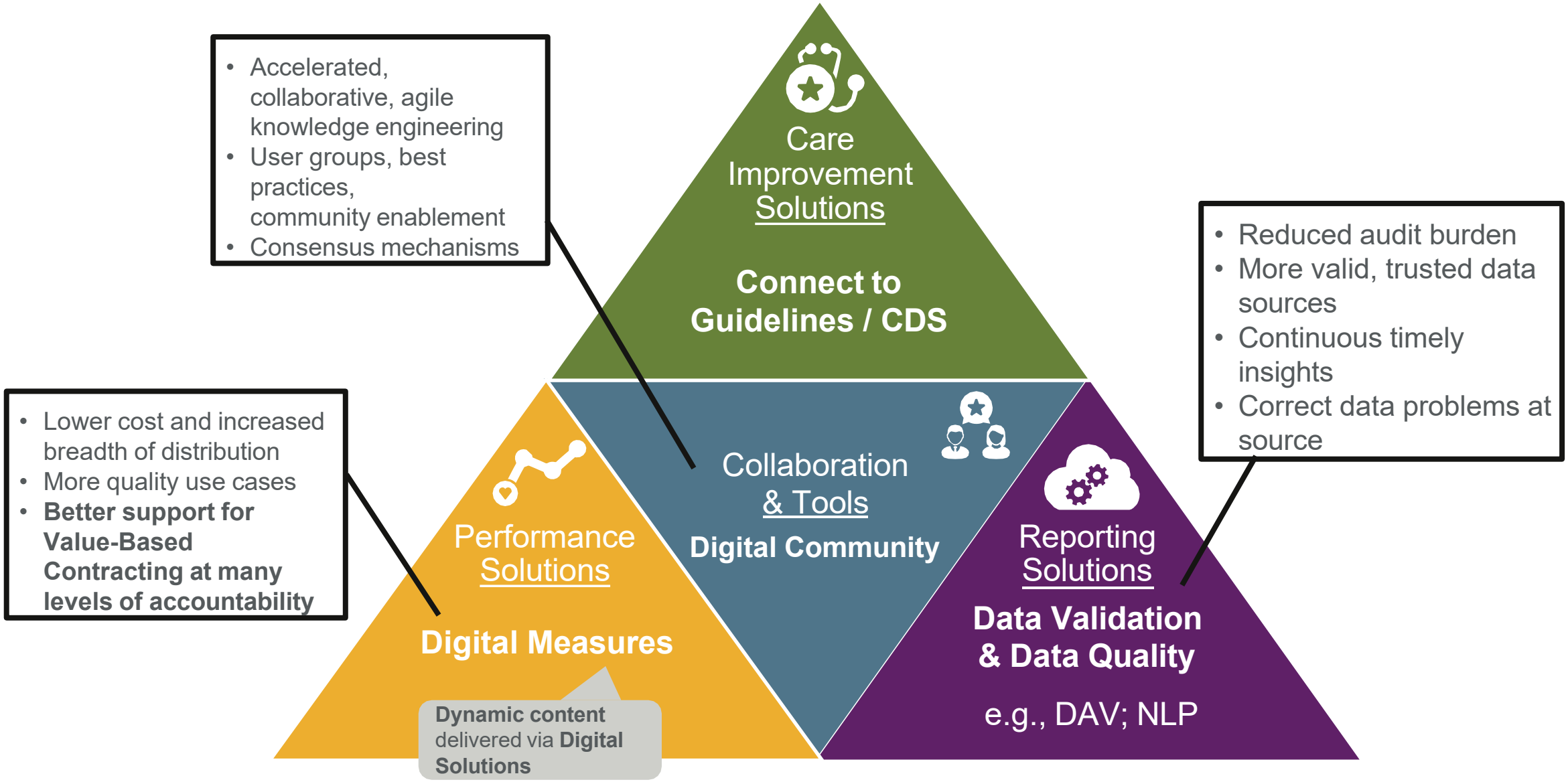
Practices grouped by approach to PCMH implementation

Quality Today – Separate and Disconnected

Cost and Burden of Implementation is Passed Through to Providers and Payers



Quality Accountability and Improvement Tomorrow – NCQA's Roadmap



A Journey Towards Interoperability

Beginning

- **1997 Institute of Medicine Report** urges EHR use to improve patient records
- **2004**: **National Coordinator for Health IT** appointed
- **2009 HITECH Act**: $540 million in incentives and technical assistance

Progress

- **Meaningful Use** contributes to 80% EHR adoption
- Creation of **standards**
- **2016 21st Century Cures Act**: focus on transparency and access to electronic health information

Regulation

- **May 2020:** ONC and CMS **Final Rules** intended to move the health care ecosystem towards **interoperability**

Transformation

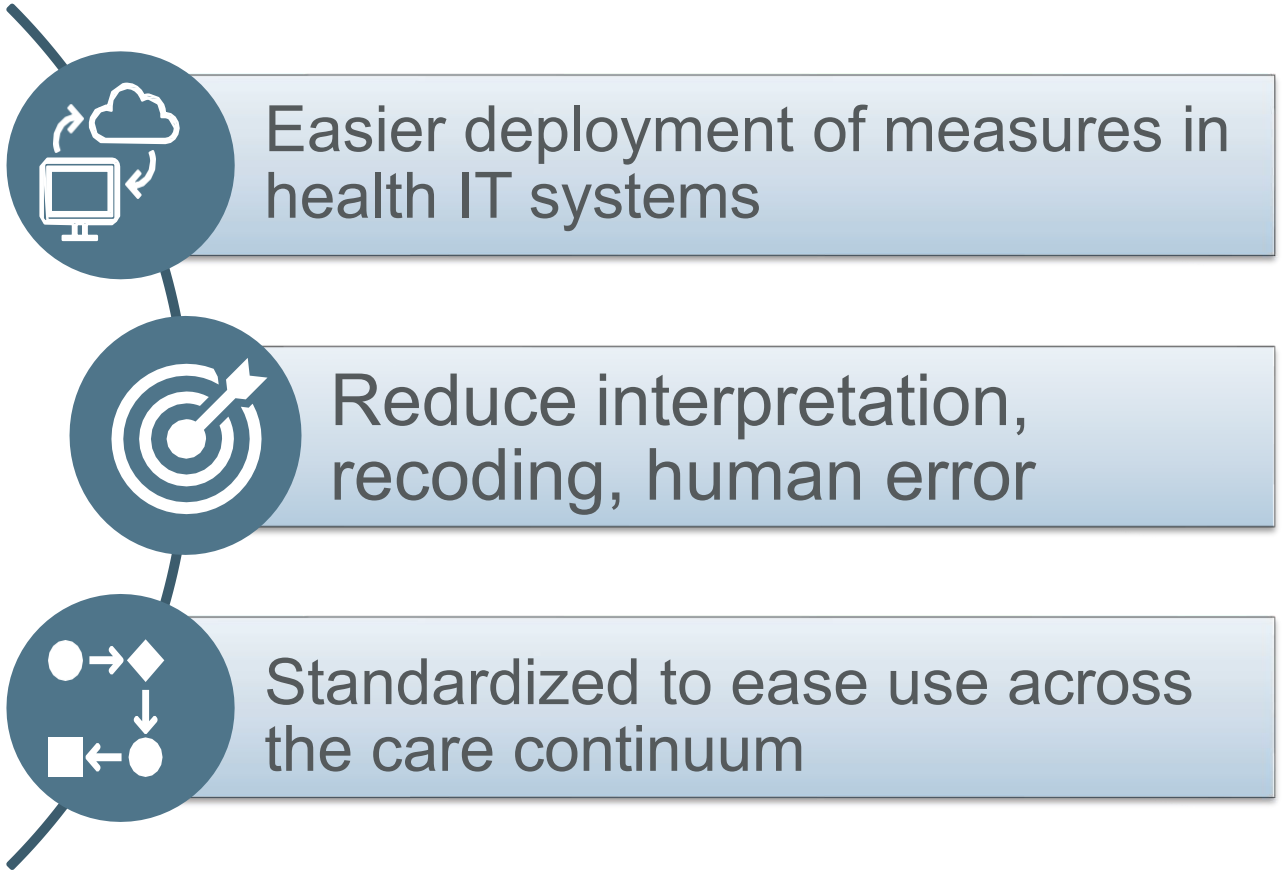
Implementation of rules:

- **Information blocking**/patient access to data
- **EHR certification** updates
- Data **exchange** for providers, patients, payers

What are Digital Quality Measures (dQMs)?

Digital quality measures:

- Use a standards-based **interoperability** format
- Use **machine-interpretable** measure logic (e.g., Clinical Quality Language or CQL)
- Include a **data dictionary/model** (e.g., Fast Healthcare Interoperability Resources or FHIR)
- Incorporate **data concepts/terms** (e.g., value sets) required to **execute** the measure



Quality Infrastructure to Support Total Cost of Care Models

- Trusted, consensus-based evaluation standards and methods for evaluating the capabilities and care processes that teams and organizations use to achieve high quality care

- Measurement approaches to evaluate unmet social needs and barriers to access

- Standardized health data exchange to support novel digital quality and equity measures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Considerations for Nested vs. Carveout Specialty Care Episodes

Brian Bourbeau
Division Director, Practice Health
American Society of Clinical Oncology

September 22, 2022

Oncologists Participation in Medicare ACO and Specialist Models

Model / Track	2017	2018	2019	2020	2021	2022
MSSP Participants (AAPM)	1,243	3,052	3,877	4,093	4,184	5,989
MSSP Participants (Not AAPM)	6,856	7,047	7,247	7,082	7,019	5,727
OCM Participants (AAPM)			1	2,146	1,940	1,886
OCM Participants (Not AAPM)	4,009	4,053	4,079	1,294	1,374	1,349

Gynecologic Oncology, Hematology / Oncology, Radiation Oncology, Surgical Oncology
Accessed 8/8/22 from qpp.cms.gov. 2022 includes July snapshot.
Manuscript in writing.

Cancer Care Journey – A Collection of Episodes

Screening	Diagnosis	Treatment			Survivorship
		Surgical	Radiation	Medical*	
PCP Driven	PCP/Specialist Driven	Specialist Driven			PCP/Specialist Driven
Low Intensity	High Intensity	High Intensity			Moderate Intensity
Routine Health	Acute	Acute	Acute	Acute/Chronic	Chronic
Indefinite	Weeks to Months	30-90 days	60-90 days	180+ days	Indefinite
Primary Care Medical Home		*Oncology Medical Home			Primary Care Medical Home

Nesting vs. Carveout

Nested Episode

- Defined Duration
- Predictable Financial Impact
- Care Management Remains with Primary Care
- Opportunity to Reduce Data Collection, Measurement, and Reporting
- E.g., Joint Replacement, Radiation Oncology Model

Carveout Episode

- Indefinite Duration
- Financial Impact Varies Within and Over Time
- Specialty Care Management
- Need for Distinct Data Collection, Measurement, and Reporting
- E.g., Enhancing Oncology Model, End-Stage Renal

Coordinated Care

- Indefinite Duration
- Costs Trends with Overall Patient Risk
- Ongoing Care Coordination between PCP and SCP
- Diabetes, Cancer Survivor

Considerations for Nested Episodes

- Simplify payment methodology
  - Bundled payments
  - Remove duplicate discounts & performance payments/recoupments
- Reduce duplicate and conflicting quality measures
  - E.g., if an ACO beneficiary receives radiation therapy, does CMS need both CAHPS for MIPS and CAHPS for RO?
- Reduce duplicate data reporting and other administrative burden
  - E.g., Collection and reporting of sociodemographic data

Considerations for Carveout Episodes

- Select disease episodes that justify:
  - Shift in responsible provider
    - Patient engagement, care management / navigation, data collection, health related social needs, cost of care
  - Need for differing quality measures and performance scoring
  - Need for additional demographic or disease data
- Build in care delivery requirements and measures focusing on “hand-offs” between PCP and SCP

Continuity of Comprehensive Care in the Patient-Centered Oncology Payment Model

- 24/7 access to provider; expanded in-person/virtual visit access
- Financial counseling services
- Missed visits / referrals follow-up
- Care team coordination
- Addressing psychosocial related health needs
- Symptom management
- Advance care planning
- Use of certified EHR technology

Hand-offs in the Patient-Centered Oncology Payment Model

- Primary Care to Specialty Care:
  - Patient education on Oncology Medical Home
    - What services to expect
    - How to contact the care team
    - Responsibilities of the patient and provider
  - Individualized treatment plan
    - Final diagnosis, goals, treatment, potential adverse effects, follow-up plan, home care management
- Ongoing Care Collaboration:
  - Communication from SC to PC on patient status, treatment and referrals
- Specialty Care to Primary Care:
  - Survivorship care plan
    - Treatment summary
    - Follow-up care: PC & SC

Phases of Care in the Patient-Centered Oncology Payment Model

- New patient
- Cancer treatment
- Active monitoring (survivorship)

Carve-out

Coordinated

Considerations for Coordinated Care

- Fee-for-service creates competitive / uncoordinated care management (e.g., one provider may bill transitional care management; first one to bill gets paid)
- Fee-for-service includes time thresholds for a provider or practice (e.g., 30 minutes for chronic care management)
- Population health models with care management fees should vary fees based on **individual** patient needs, rather than aggregate
- Population health models should encourage sharing of fees between PC and SC

Economics of an Accountable Care Model

Model Components

- Care management fees
- Shared savings/risk
- Quality incentives

Other Effects

- Market share gains
- Reduced leakage
- Foregone service utilization

Specialty Care Incentives:

- Shared care management fees for patients with chronic conditions
- Shared savings / risk with specified thresholds
- Shared quality incentives

- Preferred provider / center of excellence
- How does a health system led ACO and a specialty care provider treat the question of leakage?
- Beneficiary incentives to comply with referrals for consultation

Listening Session 4: Payment Considerations and Financial Incentives Related to Population-Based Total Cost of Care Models

Presenters:

Subject Matter Experts

- **Mark McClellan, MD, PhD**, Robert J. Margolis Professor of Business, Medicine, and Policy, and Founding Director, Duke-Margolis Center for Health Policy, Duke University
- **Joseph Francis, MD, MPH**, Executive Director, Analytics and Performance Integration, Office of Quality and Patient Safety, Veterans Health Administration
- **Kate Freeman, MPH**, Manager, Market Transformation, American Academy of Family Physicians
- **Nancy L. Keating, MD, MPH**, Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Professor of Medicine and Practicing General Internist, Brigham and Women's Hospital
- **Robert E. Mechanic, MBA**, Executive Director, Institute for Accountable Care; and Senior Fellow, Heller School of Social Policy and Management, Brandeis University

Specialty Care Engagement and the Future of Comprehensive Care and Payment Reforms

Mark McClellan, MD, PhD

Robert J. Margolis Professor of Business, Medicine, & Policy

Founding Director of the Duke-Margolis Center for Health Policy

September 20, 2022

CMS Strategic Commitment to Advance Comprehensive Care and Equity

CMS Strategic Aims

- All Medicare Part A/B beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.
- CMS will support system-wide health care reform for whole-person, accountable care

Some Key Challenges and Opportunities in Realizing 2030 Comprehensive Care Vision

- **Multipayer alignment**: increasing directional alignment to reduce burden and increase critical mass of support for comprehensive care models
  - Quality measures, equity data and measures, payment reform components, reliable and timely sharing of key data, technical support and learning collaboratives
  - Health Care Payment Learning and Action Network
  - Predictable pathway for Medicare participation in aligned multipayer initiatives
- Steps to address **structural barriers for underserved populations**
  - Social risk adjustment and complementary payment policies for comprehensive safety net care
  - Integration of equity-related measures and steps to address disparities
- Complementary reforms nested in population accountable care models to **engage specialists, increase coordination and alignment** between primary and specialist care providers, and **support and sustain reforms in specialty care pathways**

Sources: https://healthpolicy.duke.edu/publications/future-risk-adjustment-supporting-equitable-comprehensive-health-care
https://www.healthaffairs.org/do/10.1377/forefront.20220513.630666/
https://www.healthaffairs.org/do/10.1377/forefront.20220517.755520

Specialist participation in APMs to date has been limited

While ~50% of all specialists (+266K) participated in Medicare Shared Savings Program in 2020, most specialists do not feel directly engaged or supported for achieving ACO goals

Key Factors

1. **Limited operational impact so far** resulting in many specialists appear to be unaware that they are part of an ACO

    - **Hospital-based ACOs**: Limited change in practice operations including physician compensation and reimbursement model
    - **Primary care-based ACOs:** Attempted savings and care improvements driven by selective referrals not from changing specialist compensation and supporting longitudinal coordinated-care models

2. **Misperception** that "ACOs are for primary care providers" from limited engagement and alignment with specialty care providers

https://www.ahajournals.org/doi/full/10.1161/CIRCOUTCOMES.118.005438

Specialty Care Is the Largest Component of Whole-Person Health Care

Specialist care is a key driver of cost and service utilization across the health care system

Components of Total National Medical Expenditures

Key Takeaways

- **More than 60% of all office visits** are attributable to specialist care
- Services account for **more than 90% of professional expenses**
- **Services result in $2T or 63% of all medical expenditures** in the United States

Source: Authors' Analysis, CMS National Medical Expenditures Data, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData

Duke | MARGOLIS CENTER *for* Health Policy

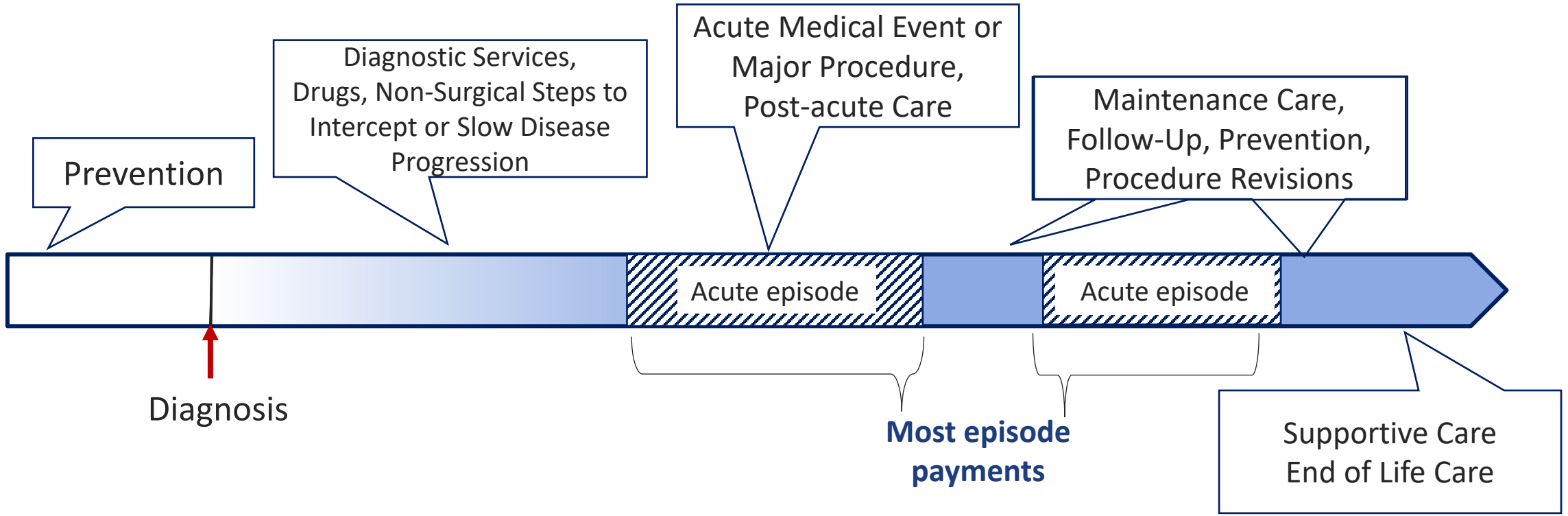
CMS Innovation Center has released its initial specialty care integration strategy

- Specialist engagement will help **enhance care coordination** with primary care, **expand accountability** for the quality and cost of care, and **advance health equity** by increasing access to high-value specialty care
- CMMI's strategy to increase specialist participation involves:
  - Leveraging episode-based models nested within ACO models
  - Enhanced data sharing between primary and specialty care
  - Attribute accountability to specialists that assume primary responsibility of care
  - Integrating specialty care into primary care pathways

Source: https://www.cms.gov/blog/pathways-specialty-care-coordination-and-integration-population-based-models

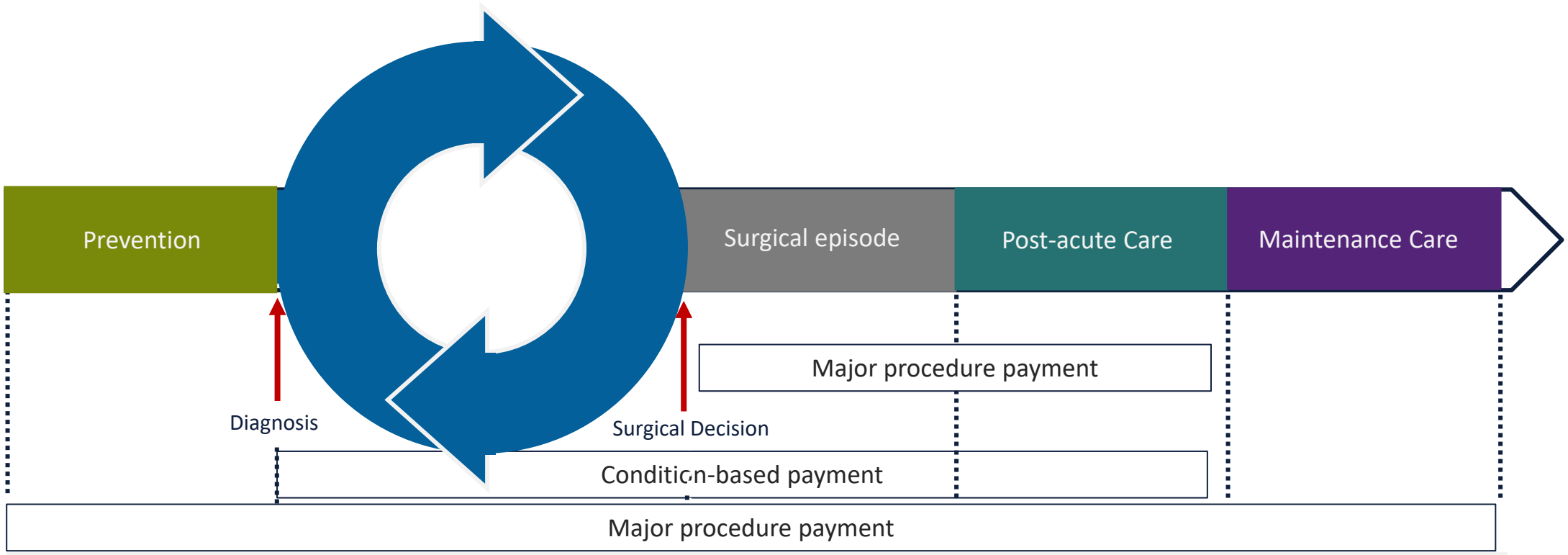
Health care from *person* perspective

Care Pathway or Care Journey with Primary, Specialty, and Primary-Specialty Care

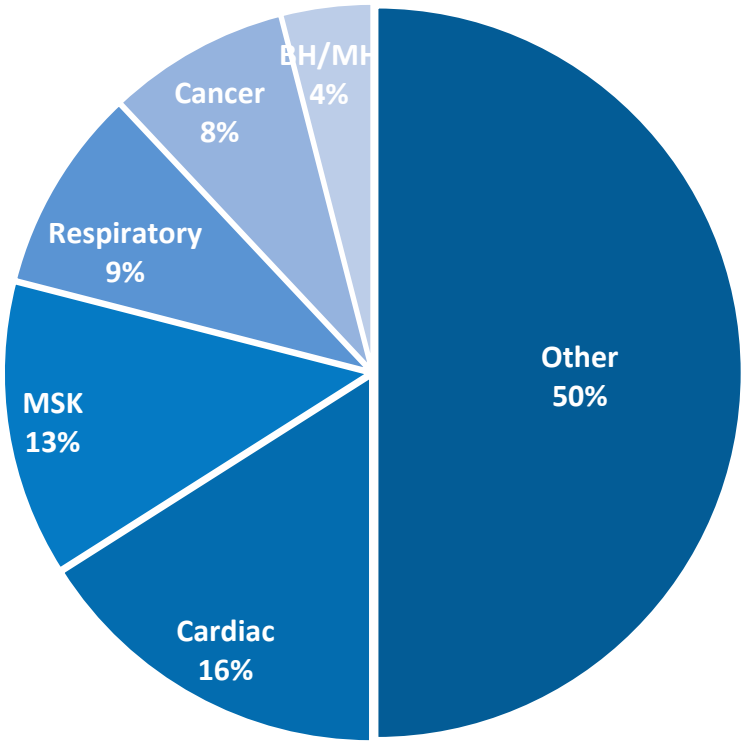


Components of care pathway generally influenced by specialty care

Opportunities for Care Integration Supporting Comprehensive Musculoskeletal Care



Small number of specialty conditions drive significant share of Medicare beneficiary disease burden and spending



Important Considerations

Cardiology and Musculoskeletal	Many procedures of low/no value – better longitudinal patient management and accountability can encourage appropriateness
Respiratory	Many acute hospitalizations that could be avoided with better patient management
Cancer	Chemotherapy could be prescribed and administered more efficiently
Dementia and other mental health conditions	Worsens with age, often poorly managed today

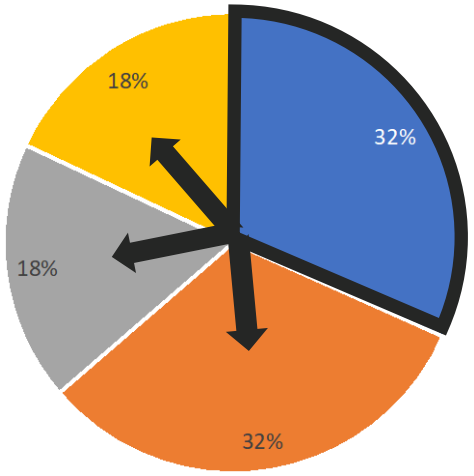
Source: Analysis by Signify Health

Significant Portion of Spending Occurs Outside of Episodes

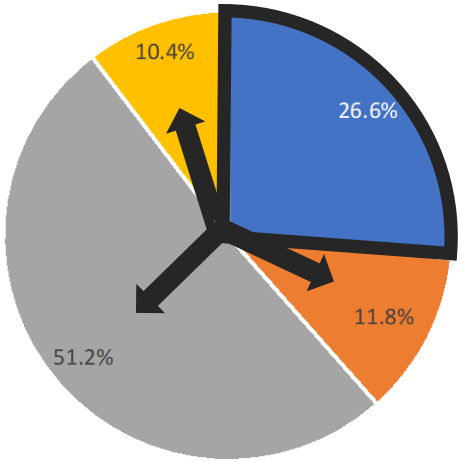
Condition management is a substantial component of specialty spending, and potential driver of acute events and major procedures – but is mostly left out of current payment reforms for specialty care

Optimizing base condition management enables opportunity to limit major procedures

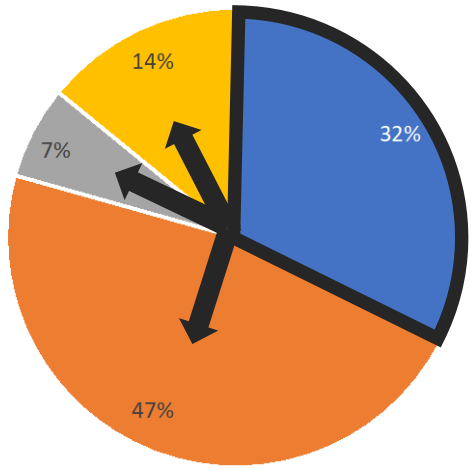
Cardiology



Orthopaedics

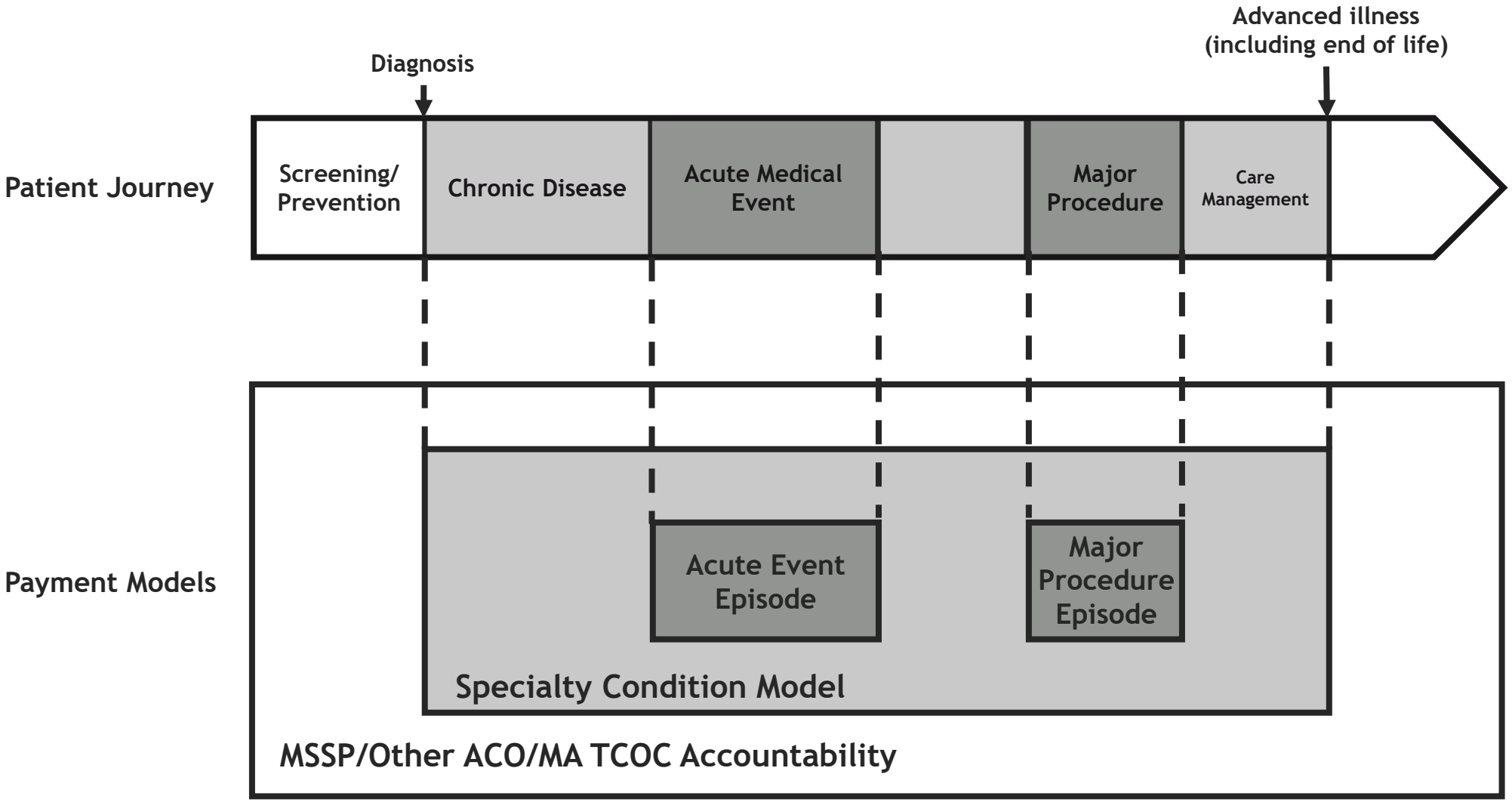


Respiratory medicine



- Base Condition Management
- Acute Events/Stays
- Major Procedures
- Minor Procedures

Specialty-Focused Condition-Based Payment Models *Nested in Population-Based Payment Models* Can Support Patient Journey



Next Steps for Comprehensive Specialty Payment Reform

Transformation Strategy	Key Characteristics
Increased data and feedback	• Producing condition-level measures of quality and spending, which can be provided back to specialists and referring primary care clinicians • Implementing longitudinal quality measures into MIPS
Condition-based payment models for specialty care	• Nest longitudinal, condition-based models between DRG-based bundles and TCOC payment reforms, starting with top 3-5 conditions (MSK, CV, oncology, neurodegenerative disease, respiratory…) • Provide guidance for voluntary participation by physician group led ACOs, with mandatory participation by hospital led ACOs
Mandatory bundles for major procedures	• Transition all beneficiaries to mandatory 30-day bundled episode payments for major procedures and acute medical admissions
Modify ACO models to better engage specialists	• Increase non-financial incentives for specialist engagement, such as reduced reporting requirements or data/feedback on quality measures • Shift to quality measures that can better capture specialist contribution to important outcomes for common conditions, such as PROs

VETERANS HEALTH ADMINISTRATION

Population-Based Total Cost of Care Models
Insights from VHA

Presentation for: **Physician-focused Payment Model Technical Advisory Committee**

Presented by: **Joseph Francis MD, MPH Analytics & Performance Integration**

Date of Briefing: **September 20, 2022**

VHA Overview

***VHA** operates the **nation's largest** integrated health care system and is one of the largest health care employers in the world.*

371,000+ Total VHA Employees

100,000+
Veteran Employees

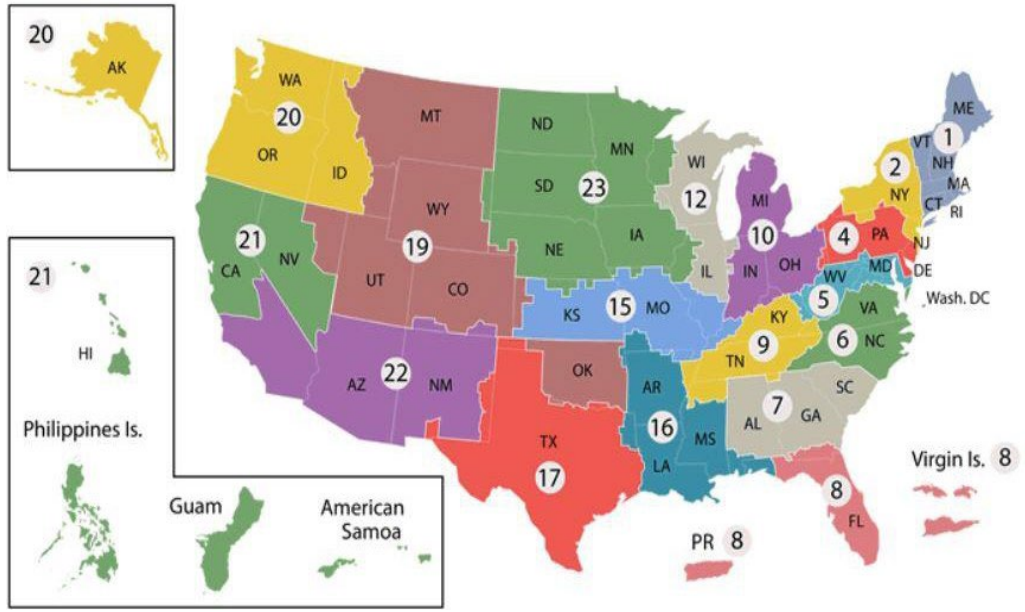
232,000+
Clinical Employees

Four Statutory Missions:

- **Care Delivery**
- **Education**
- **Research**
- **Emergency Response**

Our Healthcare System

- **Organized by geographic region - 18 Veteran Integrated Service Networks (VISNs)**
- **1,303 VA Healthcare Facilities including:**
  - **171 VA Medical Centers (VAMCs)**
  - **1,125 VA Outpatient Sites**
- **318 Vet Centers (Readjustment Counseling)**
- **136 Community Living Centers (Nursing Homes)**
- **116 Residential Rehabilitation Treatment Programs**
- **51 Mobile Clinics – each connected to a medical centers**



Source: VHA Quarterly Executive Summary Q4

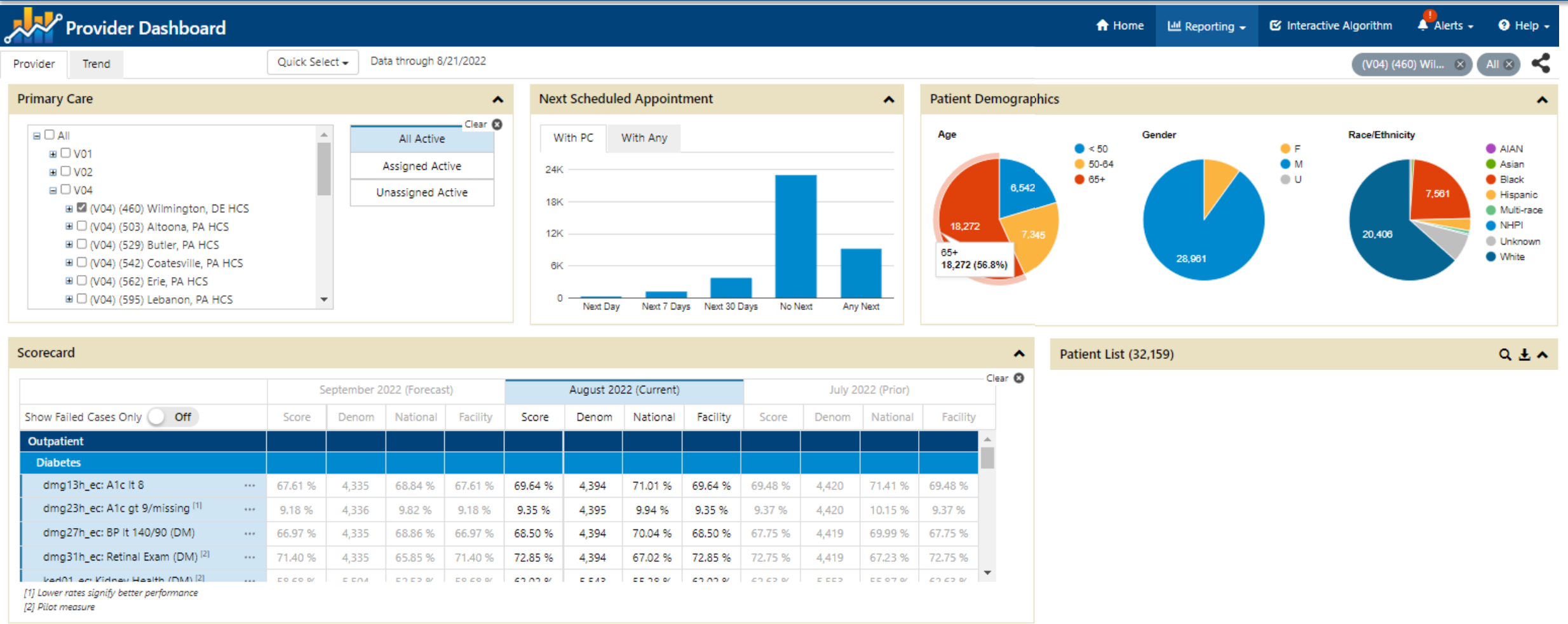
VHA Mission – Characteristics supporting Value-driven Care

- **Global Budget**
- **Salaried Providers (Base + Market Pay + Performance Pay)**
- **Foundation of Strong Team-Based Primary Care (Team Attribution)**
- **National Prescription Drug Formulary**
- **Expanded Access to Community Care with Care Coordination**

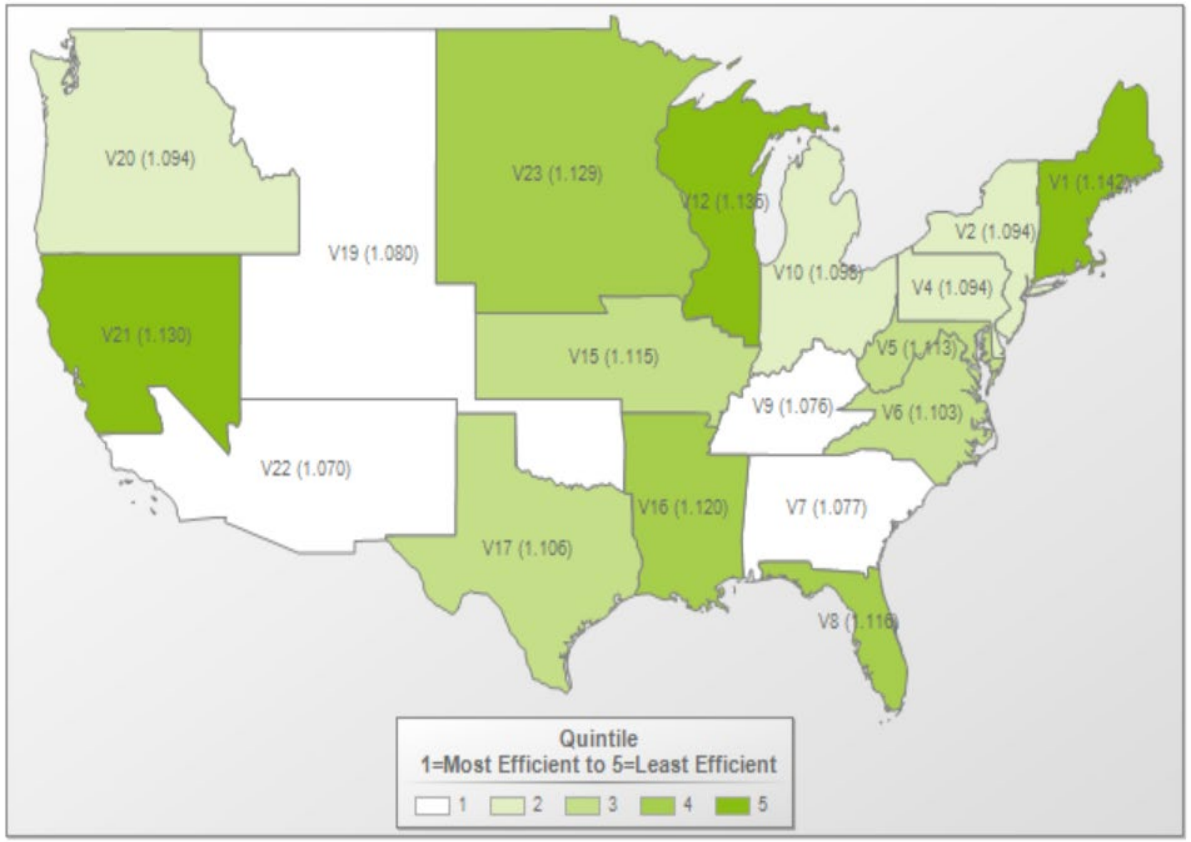
Veterans Equitable Resource Allocation (VERA)

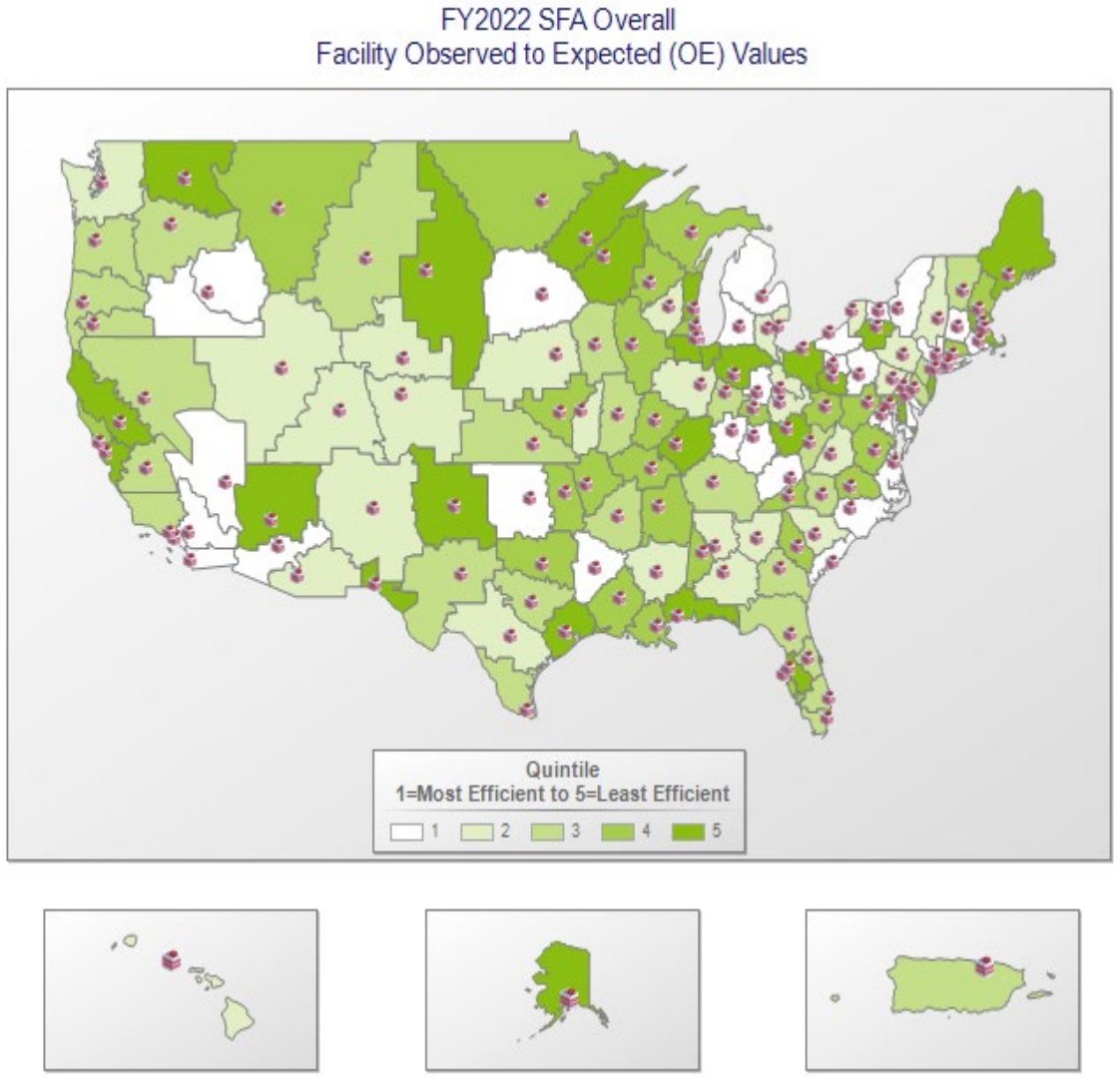
- **Risk-adjusted capitation model designed to equitably distribute VHA's Medical Care budget across 18 VHA Networks**
- **28 distinct VERA price groups based on their medical treatments and service-connection.**
- ***90% of VERA is driven by clinical diagnoses and care practices*.**
  - **VERA allocates an additional 1% to address high cost outlier patients.**
  - **VERA applies a geographic adjustment to the allocations**
  - **Additional adjustments for Research and Education**
- **Annual updates are made to the allocation model in consultation with key stakeholders to ensure equity and responsiveness to evolving trends in medical care.**

Near Real-Time* Electronic Quality Measurement



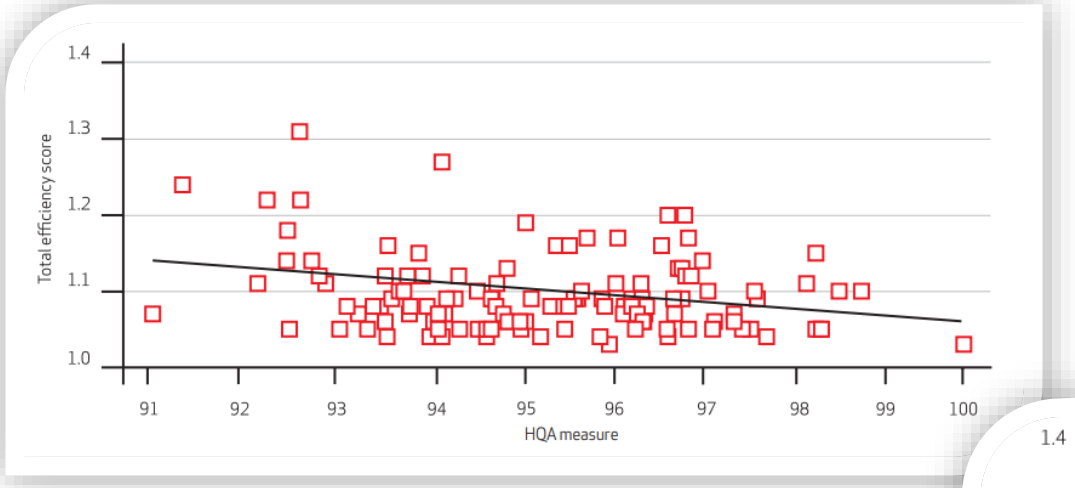
Variation in Efficiency

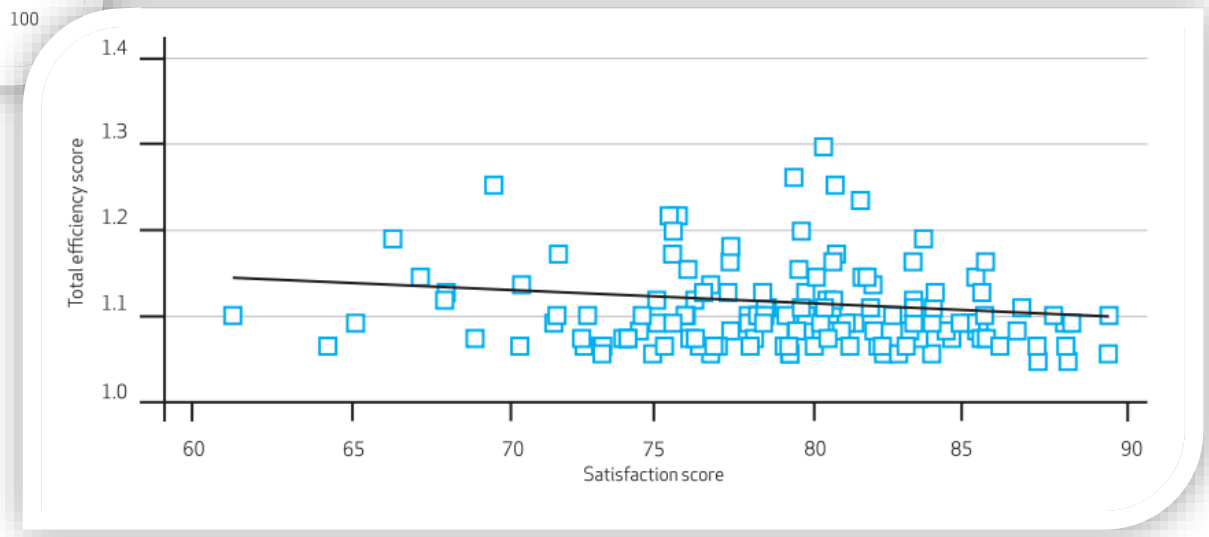




Cost Efficiency and Quality of Patient Care

Cost Efficiency and Quality of Patient Care Go Hand in Hand[1]



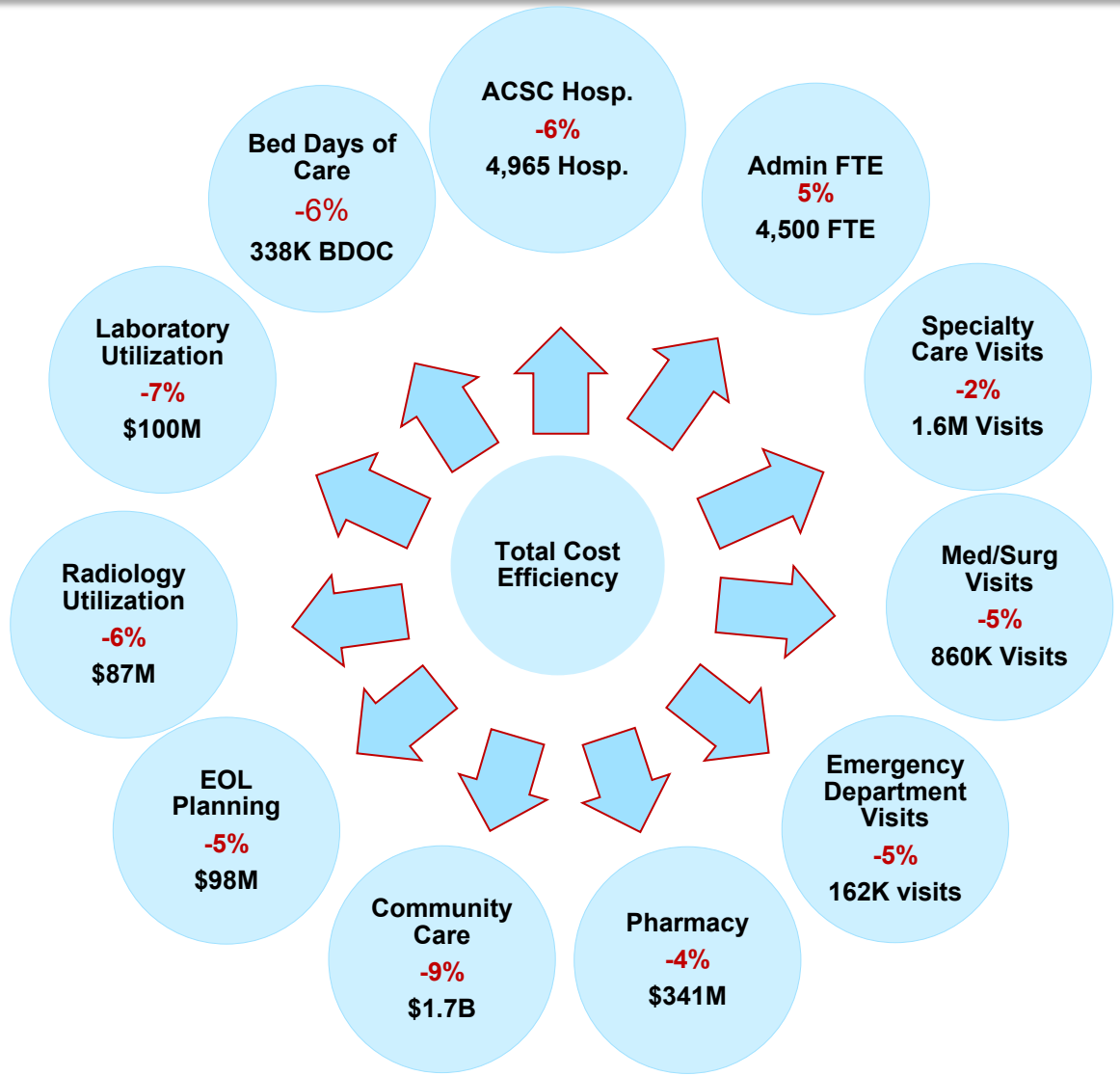


Improving Efficiency – from Modeling to Action

Efficiency Opportunity Grid

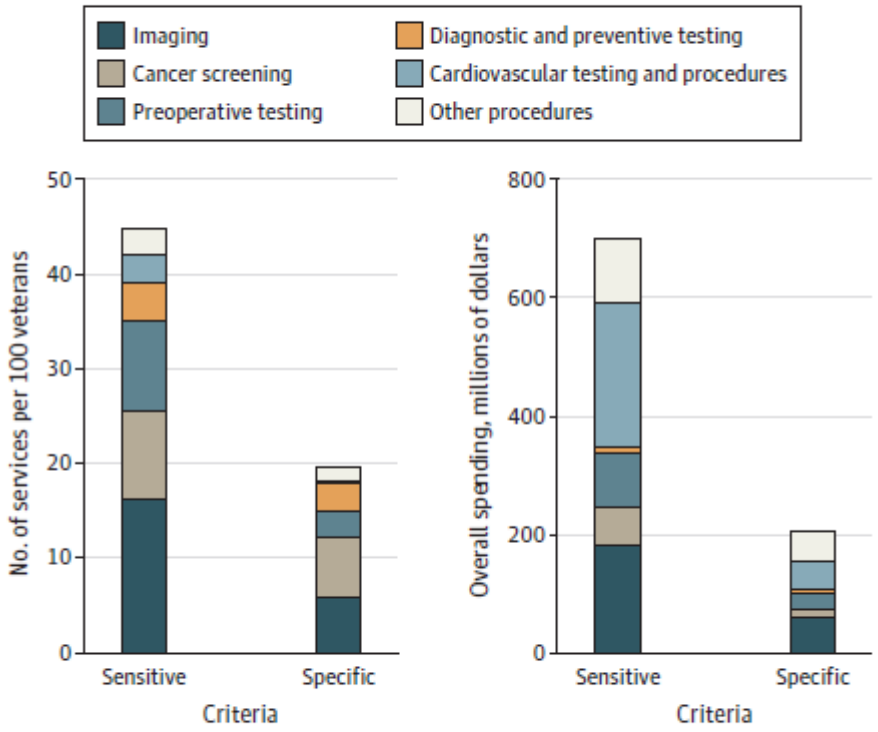
-- Identify Areas of Inefficiency for Improvement

- Multivariate regression is applied to each area of high cost & high volume
- An O/E ratio is derived for each hospital on each outcome modeled by controlling for confounding factors such as patient characteristics (e.g., case-mix) and hospital characteristics (e.g., teaching status)
- Set targets for improvement



The Remaining Challenge of Low-Value Care

Figure. Overall Use and Cost of Low-Value Services Delivered to Veterans Health Administration–Enrolled Veterans in Fiscal Year 2018, Applying Both Sensitive and Specific Criteria



Number of services per domain: imaging, 8; preoperative testing, 4; cardiovascular testing and procedures, 5; cancer screening, 4; diagnostic and preventive testing, 6; and other surgery, 2.

- Most prevalent low-value service: PSA screening in men ≥ 75 y
- Most costly low-value service: Imaging for nonspecific back pain
- One-third of these services were delivered in the community by non-VA providers
- Overall count of low-value care was two-thirds that of Medicare beneficiaries, despite the study including 3 additional services than Schwartz et al 2014.
- Work is ongoing to incorporate measures of low-value care into real-time electronic reporting systems

Radomski et al, 2022

Select References

1. Gao J, Moran E, Almenoff PL, Render ML, Campbell J, Jha AK. Variations in efficiency and the relationship to quality of care in the Veterans health system. Health Aff (Millwood). 2011 Apr;30(4):655-63.
2. Gao J, Moran E, Higgins DS Jr, Mecher C. Predicting High-risk and High-cost Patients for Proactive Intervention. Med Care. 2022 Aug 1;60(8):610-615.
3. Gao J, Moran E, Schwartz A, Ruser C. Case-mix for Assessing Primary Care Value (CPCV). Health Serv Manage Res. 2020 Nov;33(4):200-206.
4. Gao J, Moran E, Almenoff P. Case-Mix for Performance Management: A Risk Algorithm Based on ICD-10-CM. Medical Care. 2018 Jun;56(6):537-543.
5. Gao J, Moran E, Li YF, Almenoff P. Predicting Potentially Avoidable Hospitalizations. Medical Care. 2014;52(2):164-171.
6. Radomski TR et al. Use and cost of low-value health services delivered or paid for by the Veterans Health Administration. JAMA Intern Med 2022 doi:10.1001/jamainternmed.2022.2482.
7. Schwartz AL et al. Measuring low-value care in Medicare. JAMA Intern Med 2014:174:1067-76.

ADDITIONAL BACKGROUND

Cost Efficiency -- the Denominator of Value-based Care

Stochastic Frontier Analysis (SFA)

Analytical Tool Assessing Overall Cost Efficiency

- SFA, like traditional multivariate regression models, levels the playing field by controlling for confounding factors (e.g., case-mix, hospital and facility characteristics)
- SFA, unlike traditional multivariate regression models, is designed to separate inefficiency from random factors that are not under the management's control
- SFA, unlike DEA (data envelopment analysis), produces a practical frontier that hospitals can reach
- SFA measures the efficiency of each hospital against the frontier (best practice)
- SFA measures total efficiency with two models – clinical and administrative

Incentives for Primary Care in Moving Across the Risk Continuum

PTAC September Public Meeting

Kate Freeman, MPH
Manager, Market Transformation
American Academy of Family Physicians

AAFP

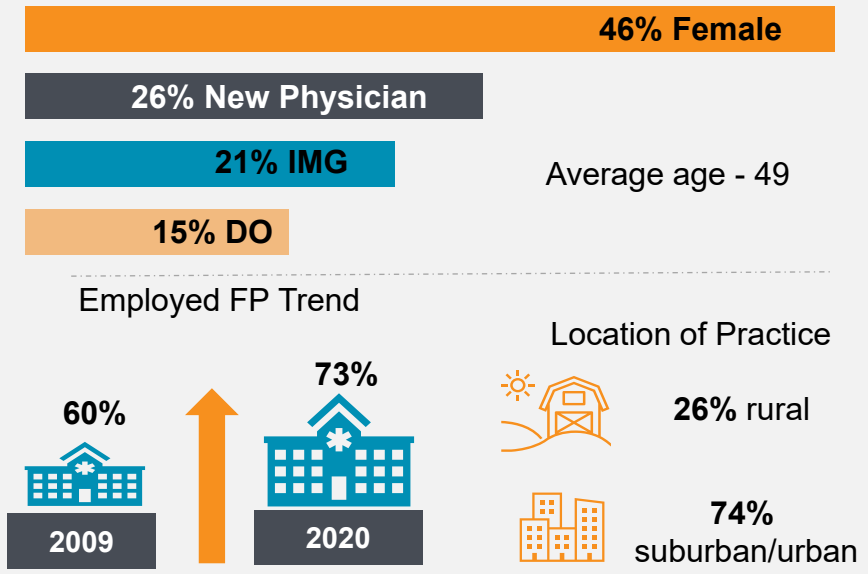
Who is the AAFP?

- National association of family physicians representing 127,600 family physicians, students, and residents
- The largest single specialty medical society in the US
- The only medical society devoted solely to primary care
- Diverse membership: various ages, ethnicities, races, practice types and geographies, inclusive of urban & rural communities
- Non-profit organization (501C-6) with a philanthropic arm, the AAFP Foundation (501C-3)

Total Membership: 127,600

Active Members:	73,400
Student Members:	26,600
Resident Members:	14,600

Who are They?



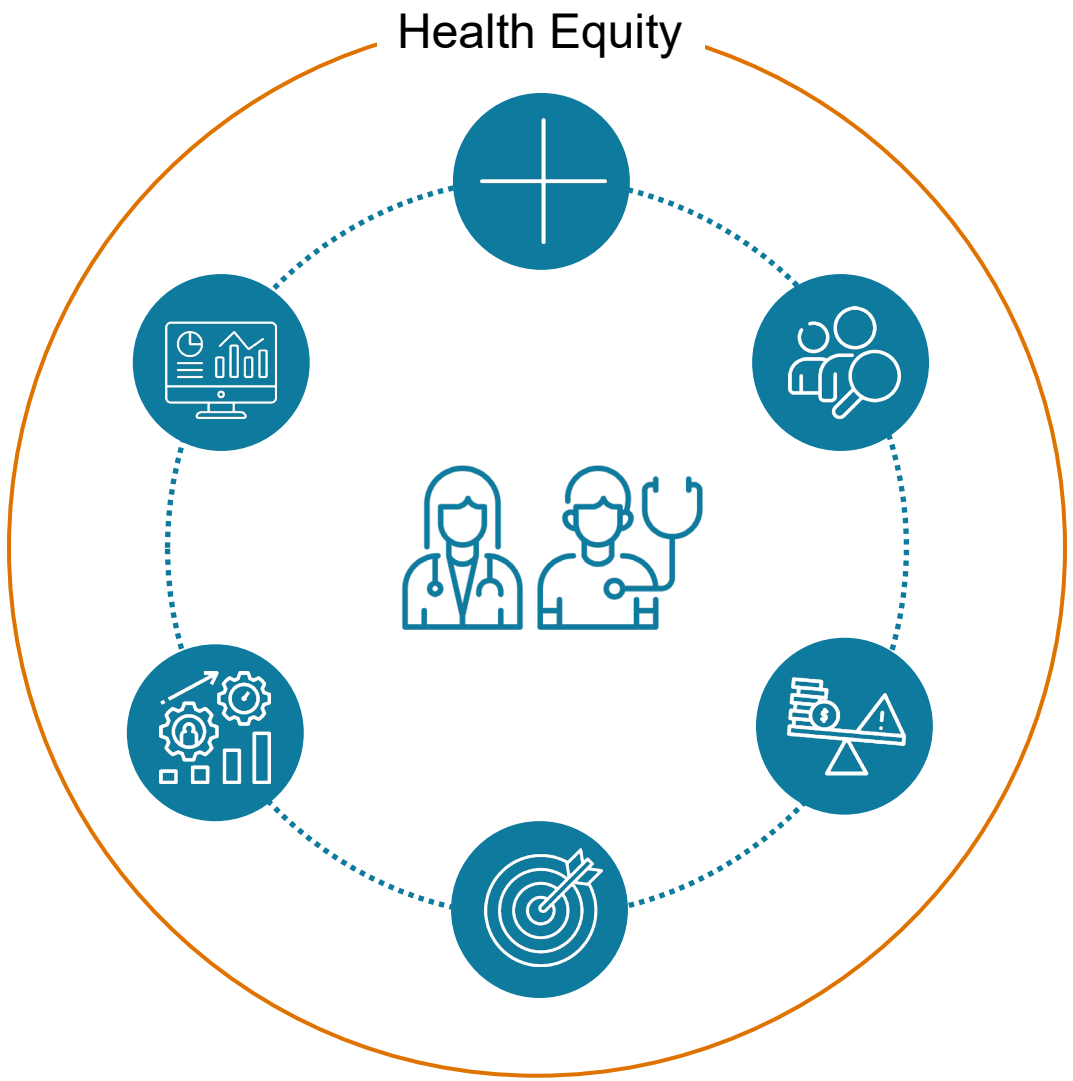
Primary Care as a Common Good

…primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. For this reason, ***primary care is a common good****, making the strength and quality of the country's primary care services a public concern.*

- Implementing High Quality Primary Care Report, May 2021

https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care#sectionWebFriendly

Primary Care Payment Principles

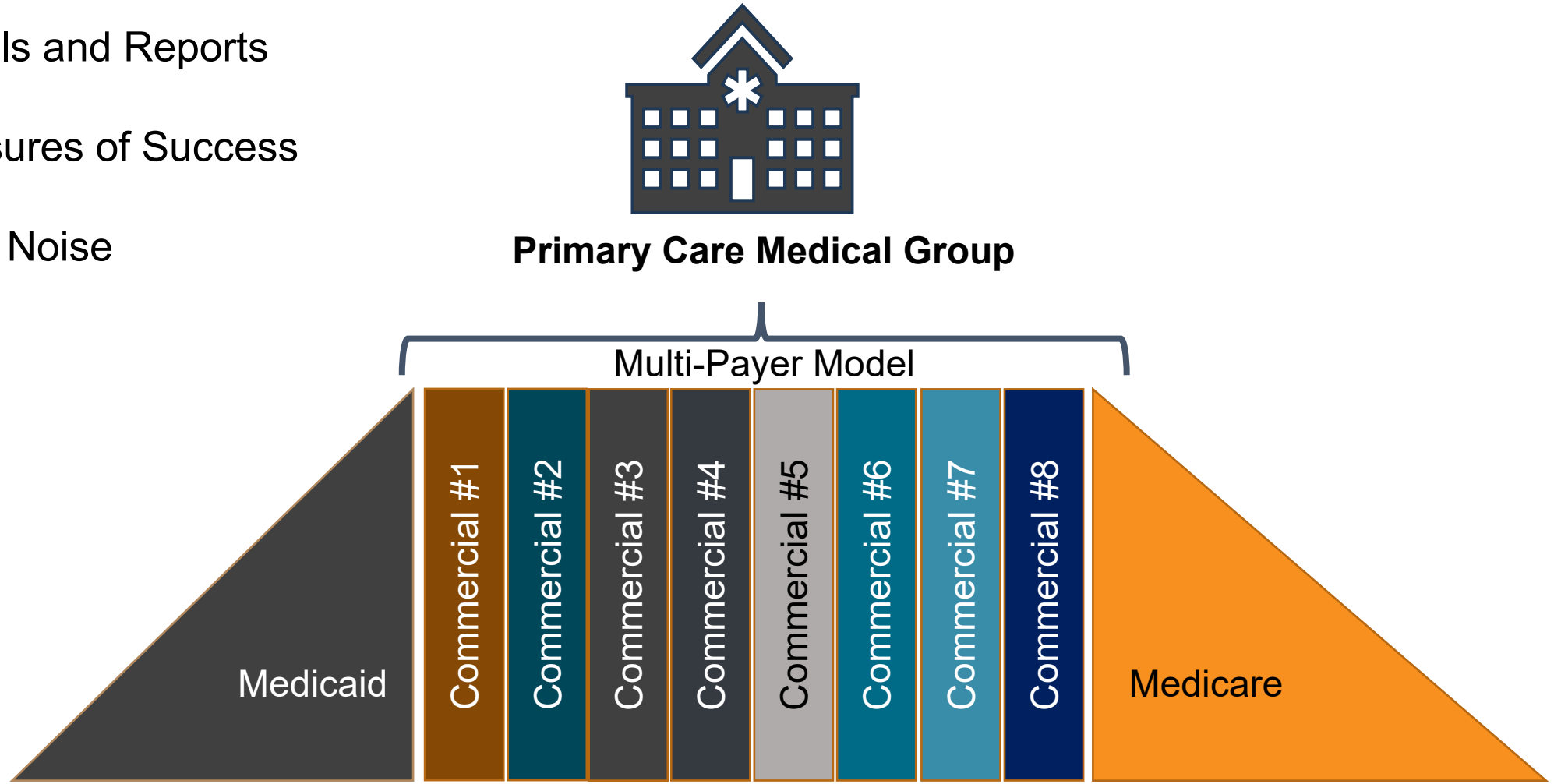


1. Increased investment through predictable, prospective revenue streams aligned across payers
2. Knowing who is accountable for which patient through prioritizing patient-physician relationships
3. Risk adjusted for demographic, clinical, and social determinants of health
4. Financial benchmarks that reward both improvement and sustained performance
5. Performance measures that focus on process and outcomes that matter most to patients and have the greatest impact on health
6. Readily available, clinically relevant, and actionable patient information

Risk, Risk Baby

Where Should Accountability Lie?

- Different Portals and Reports
- Different Measures of Success
- Administrative Noise



Most primary care compensation arrangements still largely based on volume

Rachel O. Reid, MD, MS1,2,3; Ashlyn K. Tom, MPH1; Rachel M. Ross, MPH1; et al. Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems. JAMA Health Forum. 2022;3(1):e214634. doi:10.1001/jamahealthforum.2021.4634

JAMA Health Forum™

Original Investigation

Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems

Rachel O. Reid, MD, MS; Ashlyn K. Tom, MPH; Rachel M. Ross, MPH; Erin L. Duffy, PhD; Cheryl L. Damberg, PhD

Abstract

IMPORTANCE Public and private payers continue to expand use of alternative payment models, aiming to use value-based payment to affect the care delivery of their contracted health system partners. In parallel, health systems and their employment of physicians continue to grow. However, the degree to which health system physician compensation reflects an orientation toward value, rather than volume, is unknown.

OBJECTIVE To characterize primary care physician (PCP) and specialist compensation arrangements among US health system–affiliated physician organizations (POs) and measure the portion of total physician compensation based on quality and cost performance.

DESIGN, SETTING, AND PARTICIPANTS This study was a cross-sectional mixed-methods analysis of in-depth multimodal data (compensation document review, interviews with 40 PO leaders, and surveys conducted between November 2017 and July 2019) from 31 POs affiliated with 22 purposefully selected health systems in 4 states. Data were analyzed from June 2019 to September 2020.

MAIN OUTCOMES AND MEASURES The frequency of PCP and specialist compensation types and the percentage of compensation when included, including base compensation incentives, quality and cost performance incentives, and other financial incentives. The top 3 actions physicians could take to increase their compensation. The association between POs' percentage of revenue from fee-for-service and their physicians' volume-based compensation percentage.

RESULTS Volume-based compensation was the most common base compensation incentive component for PCPs (26 POs [83.9%]; mean, 68.2% of compensation; median, 81.4%; range, 5.0%-100.0% when included) and specialists (29 POs [93.3%]; mean, 73.7% of compensation;

Key Points

Question Do health system physician compensation arrangements primarily incentivize volume or value?

Findings This cross-sectional mixed-methods study of 31 physician organizations affiliated with 22 US health systems found that volume was a component of primary care and specialist compensation for most POs (83.9% and 93.3%, respectively), representing a substantial portion of compensation when included (mean, 68.2% and 73.7%, respectively). While most primary care and specialist compensation arrangements included performance-based incentives, they averaged less than 10% of compensation.

Meaning The study results suggest that despite growth in value-based payment arrangements from payers, health systems currently incentivize physicians to maximize volume, thereby maximizing health system revenues.

Health Equity and Risk Considerations

Ensure physicians are not penalized based on the differences in the characteristics of their patients by:

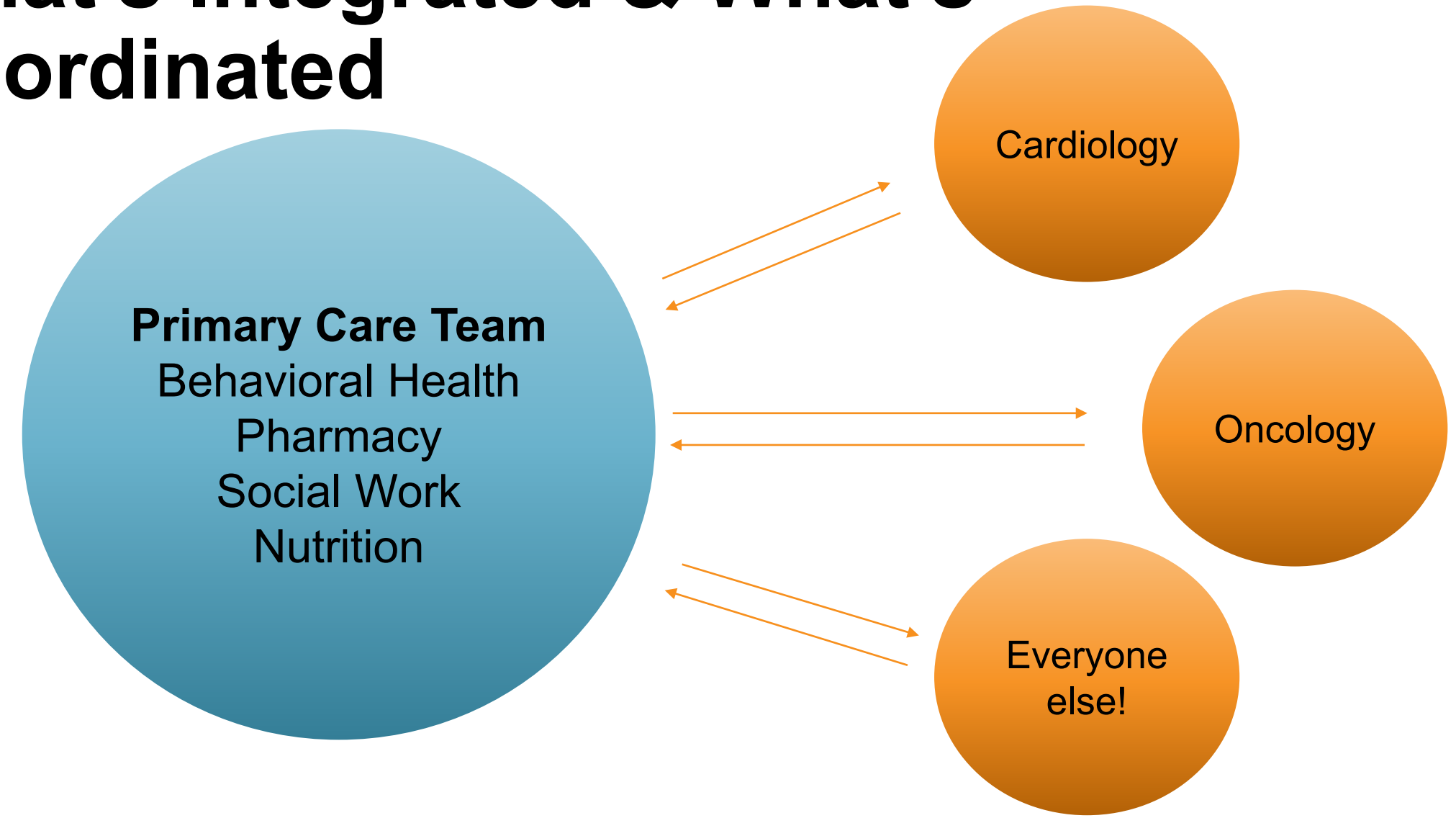
Incorporate equity at the onset of payment design

More emphasis on improving patient outcomes and less on reducing TCOC

Robust risk adjustment, including demographic, clinical, and social determinants of health

Integration, Coordination, & Accountability

What's Integrated & What's Coordinated

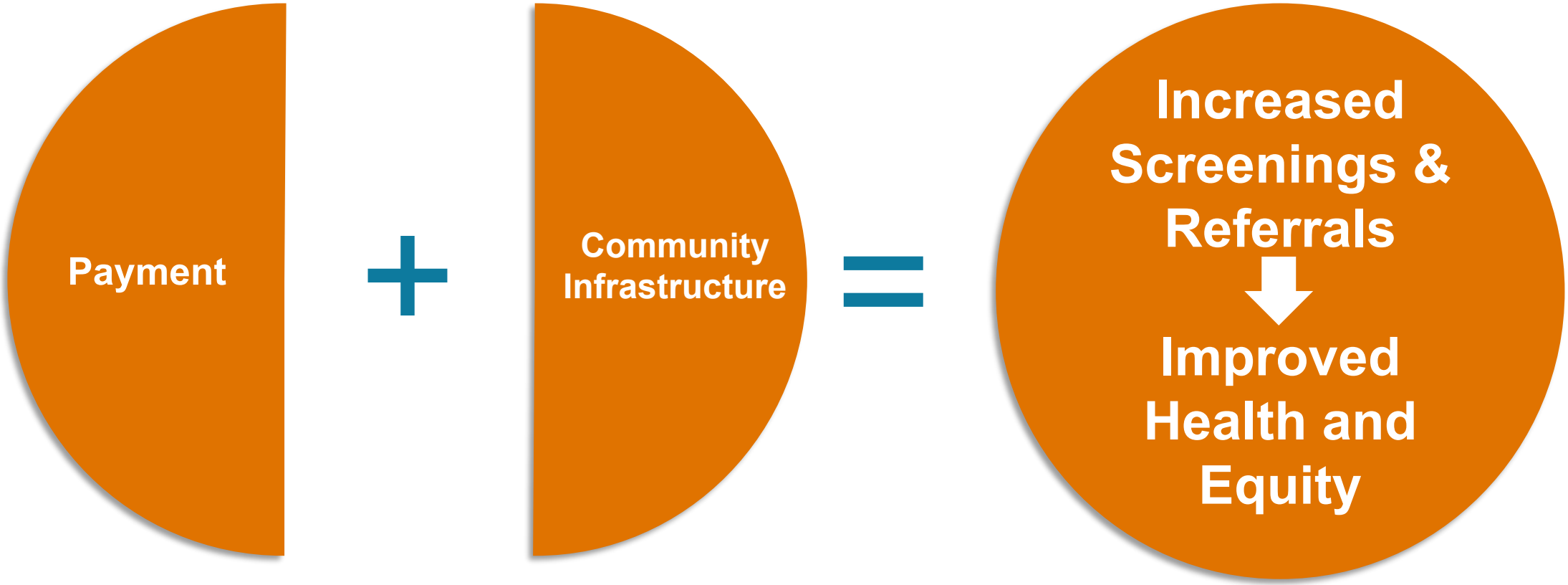


Leaning in to the QB Analogy

Incentivizing SDOH Screening and Referral

Incentivizing SDOH Screening & Referral: A Fractured Reality

A Two-Pronged Approach



How about a big finish to summarize key themes?

- Primary care as a common good is best resourced by increased investment through predictable prospective payments
- Changing the payment structure alone is not enough!
  - Need to re-envision physician employment contracts to reflect the incentives in payment methodologies
  - Payers need to understand that primary care physicians' first priority as "quarterback" is to their patients and coordinating the "playbook" at the regional level can pay off.
  - Accepting accountability for risk is about how they are equipped for success as much as the size of the practice or the number of patients.
  - Health and social care systems must be adequately funded and connected to achieve the vision of health equity for all.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Population-Based TCOC Models and Specialty Care: Lessons from Oncology Care

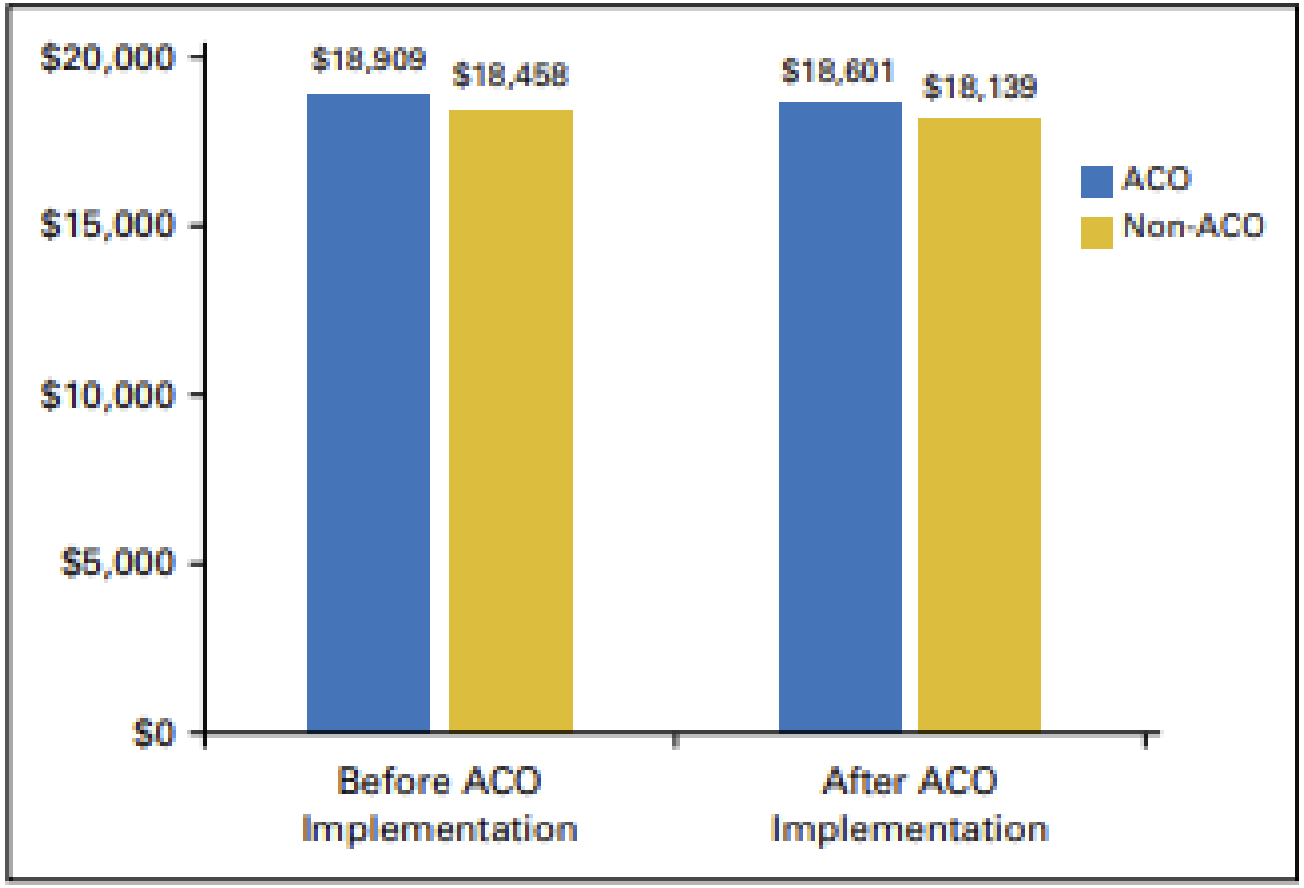
Nancy L. Keating, MD, MPH
Professor of Health Care Policy
Department of Health Care Policy, Harvard Medical School
PTAC Public Meeting
September 20, 2022

Disclosures

- I am Clinical Lead of the CMS Oncology Care Model (OCM) Evaluation Team. Any mention of OCM reflects work that has been published in the OCM Evaluation Team Annual Reports. My comments and opinions are my own and not reflective of those of CMS.

Accountable Care Organizations & Cancer

- Limited/no effect of ACOs on overall spending, care at the end of life, or surgical care quality for patients with cancer



DID impact estimate: $11 (95% CI -$275, $297)

Lam et al, JCO 2018

Oncology Care Disease Spectrum

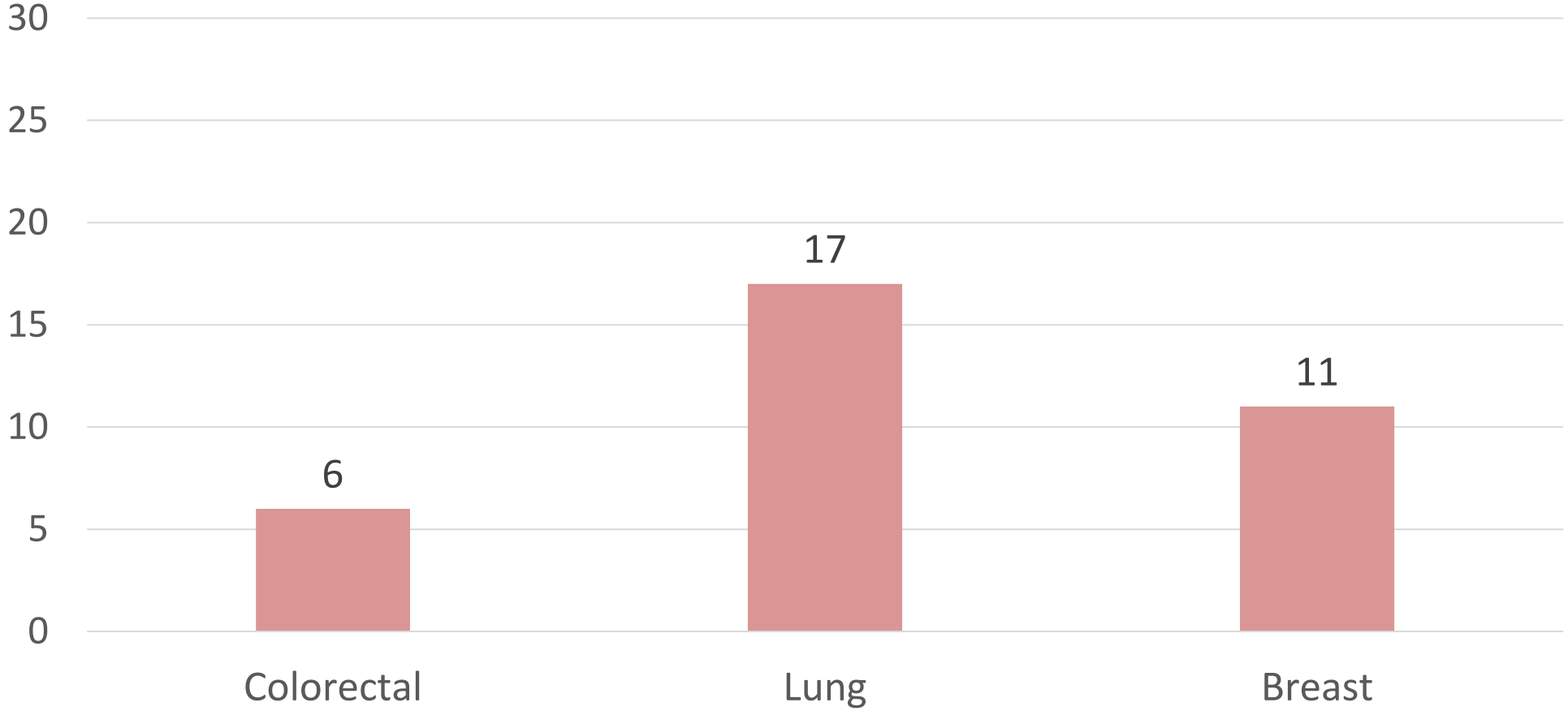
Screening	Diagnosis/ Evaluation	Primary Treatment	Chronic Treatment/ Surveillance	Recurrence/ Resume Treatment	End-of-Life Care

Key Clinicians by Phase of Disease

Primary care	Various specialists	Surgeon Medical oncologist Radiation oncologist Other (e.g., urologist)	Medical oncologist Primary care +/- Surgeon +/- Rad onc	Medical oncologist +/- Surgeon +/- Rad onc	Medical oncologist Primary care +/- others

Receipt of Multimodality Care is Infrequently from the Same Practice

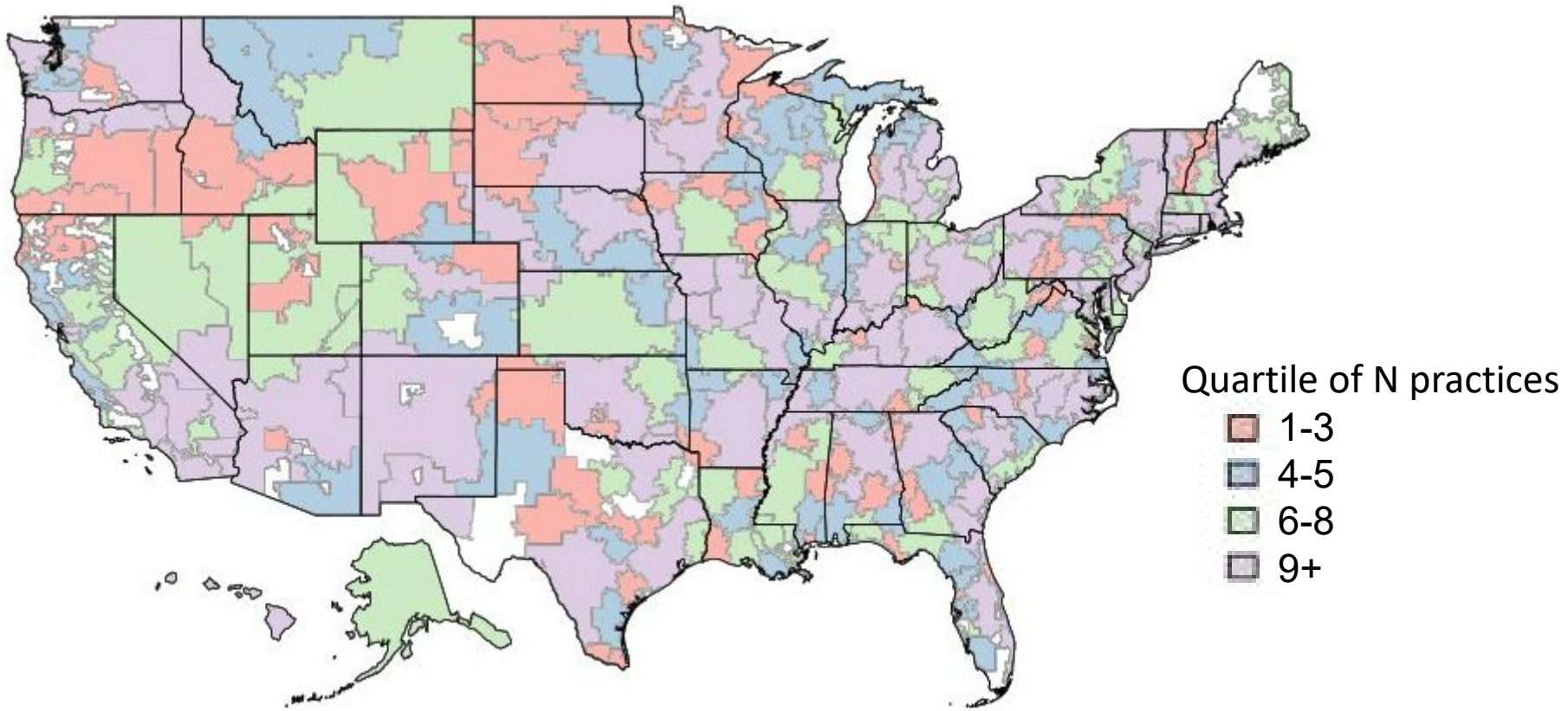
Among patients who received more than one treatment modality (surgery, chemotherapy, radiation), % who received all modalities from the same practice



Gondi et al, Am J Man Care, 2019

Can ACOs Select High-Value Oncology Practices?

Number of Practices Providing Oncology Care by Hospital Referral Region



Landon et al, in preparation

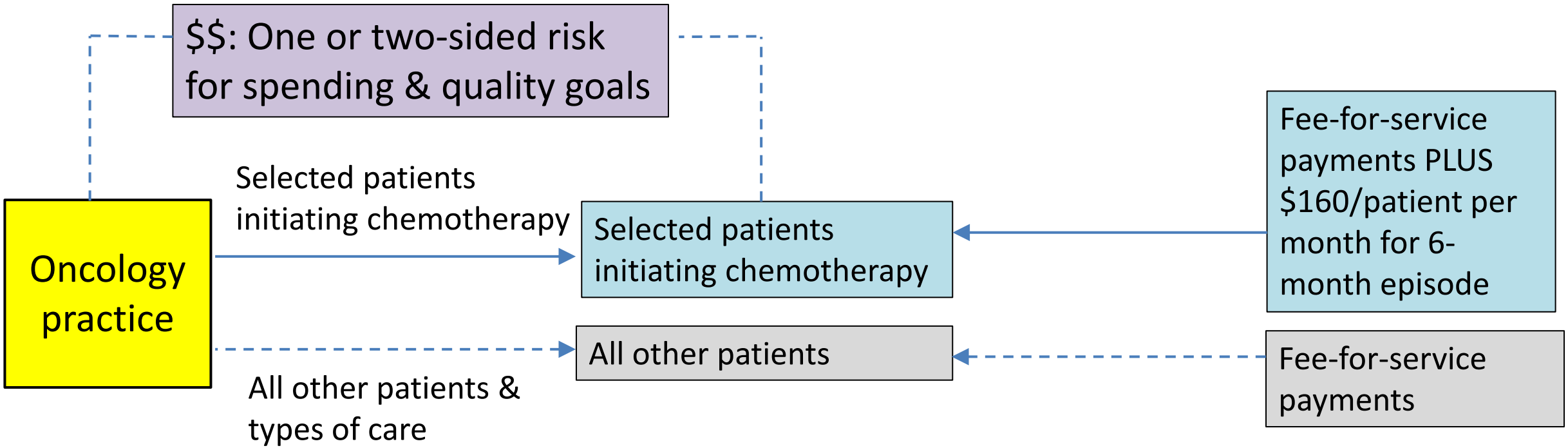
Lessons from Episode Models: CMS Oncology Care Model

201 practices and 10 payers

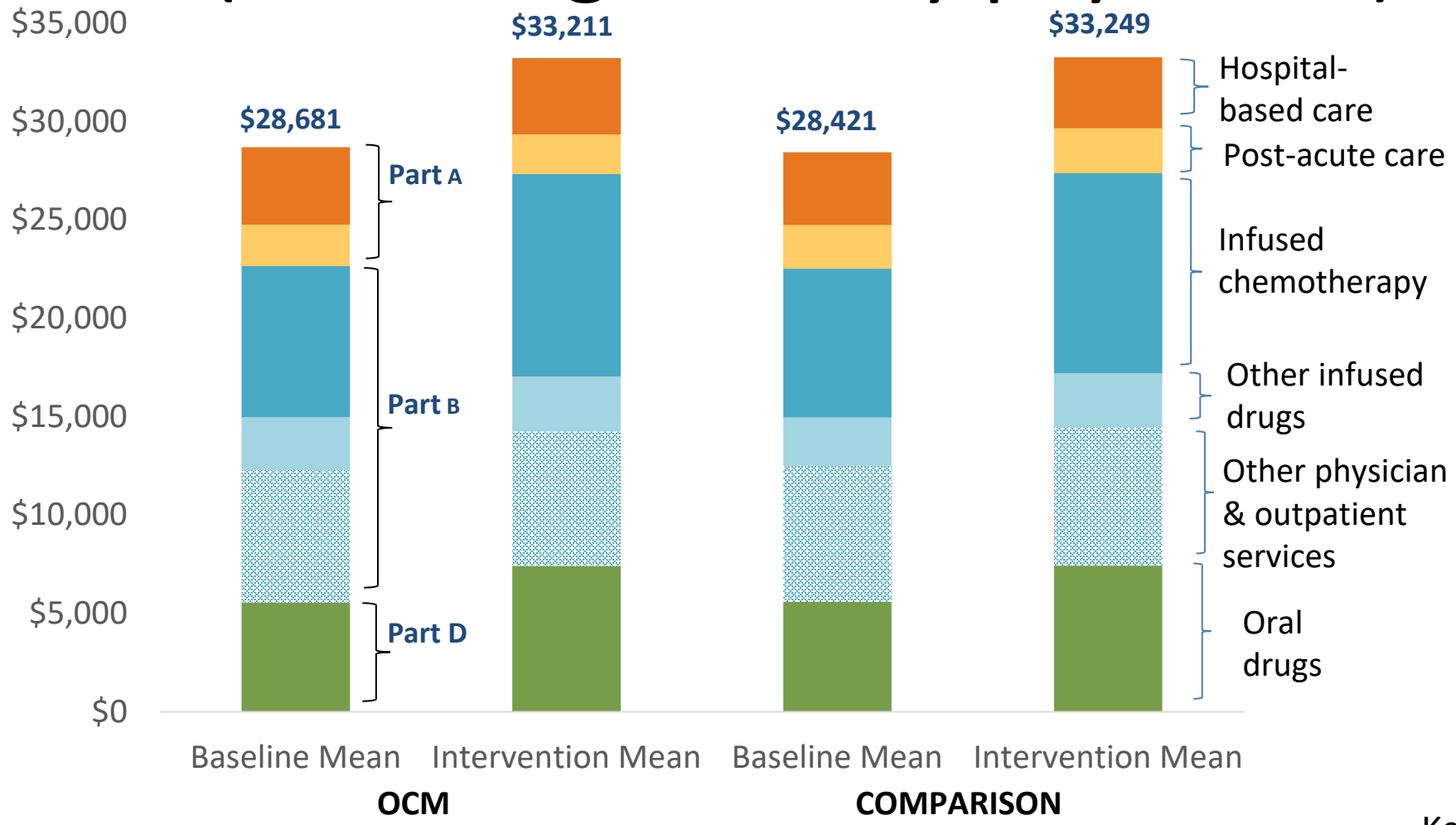
Source: Centers for Medicare & Medicaid Services

716,992 patient episodes initiated through 2019

CMS Oncology Care Model Payments



Impact: Total Episode Payments (excluding monthly payments)



Keating et al, JAMA 2021

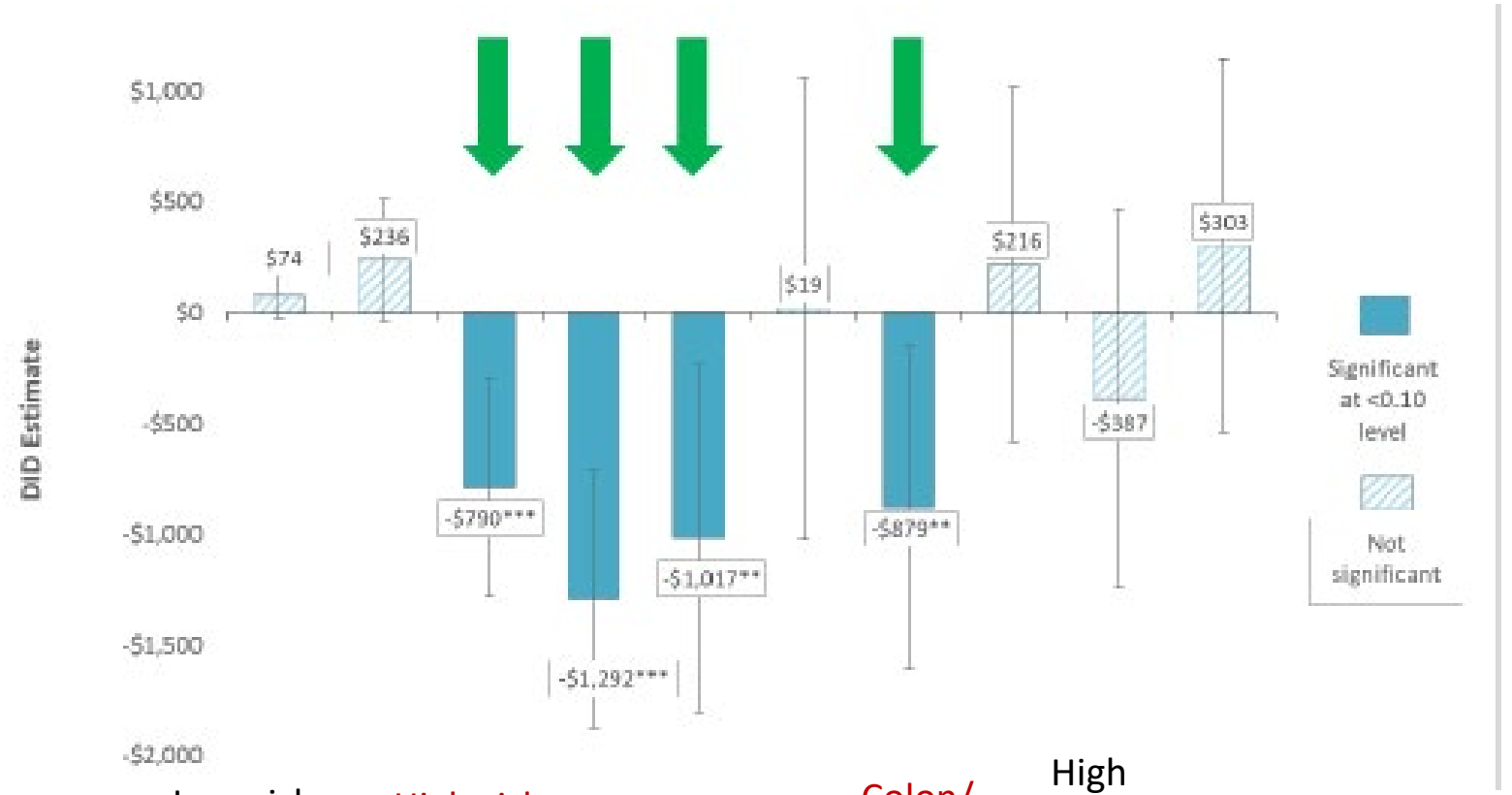
Impact: Total Episode Payments (excluding MEOS)

	OCM		Comparison		Impact Estimate		
	Baseline	Intervention	Baseline	Intervention	DiD	90% CI	% change
Overall	$28,681	$33,211	$28,421	$33,249	-$297**	-$504, -$91	-1.0%
Higher-risk episodes	$39,934	$46,697	$39,441	$46,707	-$503***	-$802, -$204	-1.3%
Lower-risk episodes	$7,226	$7,510	$7,329	$7,461	$151**	$39, $264	2.1%

*p<0.10, **p<0.05, and ***p<0.01

Keating et al, JAMA 2021

Total Episode Payment Savings Focused Among 4 Cancer Type



Low-risk breast

Low-intensity prostate

High-risk breast

Lung

Lymphoma

Multiple myeloma

Colon/ rectal

Other

High intensity prostate

Chronic leukemia

Keating et al, JAMA 2021

OCM Quality Measures

OCM Measure Number	Measure Name	Measure Source
OCM-2	Risk-adjusted proportion of patients with all-cause emergency department visits or observation stays that did not result in a hospital admission within the 6-month episode	Claims
OCM-3	Proportion of patients that died who were admitted to hospice for 3 days or more	Claims
OCM-4a	Oncology: Medical and Radiation – Pain Intensity Quantified (MIPS 143, NQF 0384)	Practice Reported
OCM-4b	Oncology: Medical and Radiation – Plan of Care for Pain (MIPS 144, NQF 0383)	Practice Reported
OCM-5	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CMS 2v8.1, NQF 0418)	Practice Reported
OCM-6	Patient-Reported Experience of Care	CMS-Acquired Data

OCM Overview. CMS OCM Website

Did Quality Improve for OCM Participants?

3 OCM Performance Measures that Could be Assessed in OCM and Comparison Practices

	OCM		Comparison		Impact Estimate	
	Baseline	Intervention	Baseline	Intervention	DiD	90% CI
% ED visit	23.6%	23.5%	24.3%	24.2%	0.0%	-0.3%, 0.3%
Hospice enrollment ≥ 3 d before death	58.5%	59.8%	59.8%	58.0%	0.5%	-0.4%, 1.4%
Overall rating of care	9.3	9.3	9.3	9.3	0.0	-0.1, 0.1

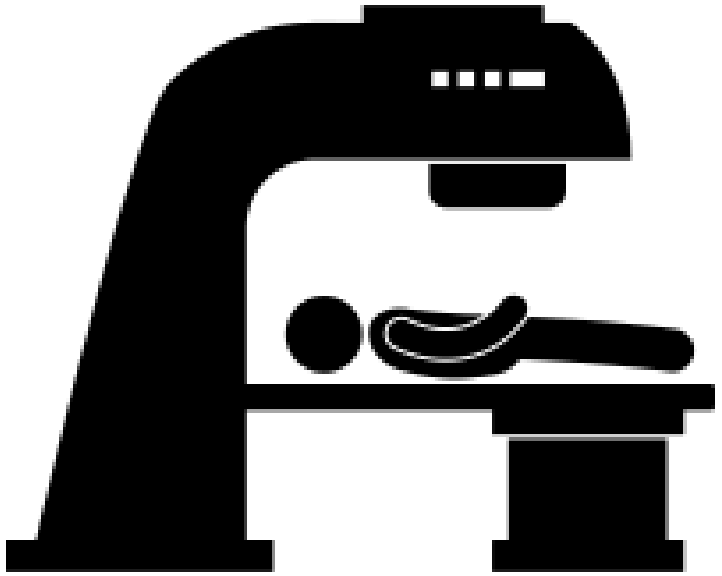
Keating et al, JAMA 2021

ENHANCING ONCOLOGY MODEL

- Voluntary model
- Patients with 7 cancer types receiving systemic therapy
  - Breast cancer, chronic leukemia, colorectal cancer, lung cancer, multiple myeloma, prostate cancer
- Quality
  - Care transformation through redesign activities
  - Quality measures and reporting
  - Advancing health equity

https://innovation.cms.gov/innovation-models/enhancing-oncology-model

Radiation Oncology Model



- Prospective payment for 90-day episodes of care for 15 cancer types in randomly selected areas
- Congress delayed model start

Challenges to Alternative Payment Models in Oncology

- Cancer care is quite heterogeneous—depends on cancer type, stage, and tumor characteristics; also phase of illness
  - Current risk adjustment limited ability to account for differences in case mix
- Patients receive cancer treatment from surgeons, radiation oncologists, medical oncologists
- Quality measurement in oncology care is early in development

How Could Oncology Care be Integrated into ACOs?

- Help ACOs identify high quality/ low-spending practices with whom to contract
  - Choice of practices may differ depending on cancer type and stage and treatments needed
  - But some areas have very few choices
  - Substantial challenges measuring quality given heterogeneity of disease, small numbers of patients

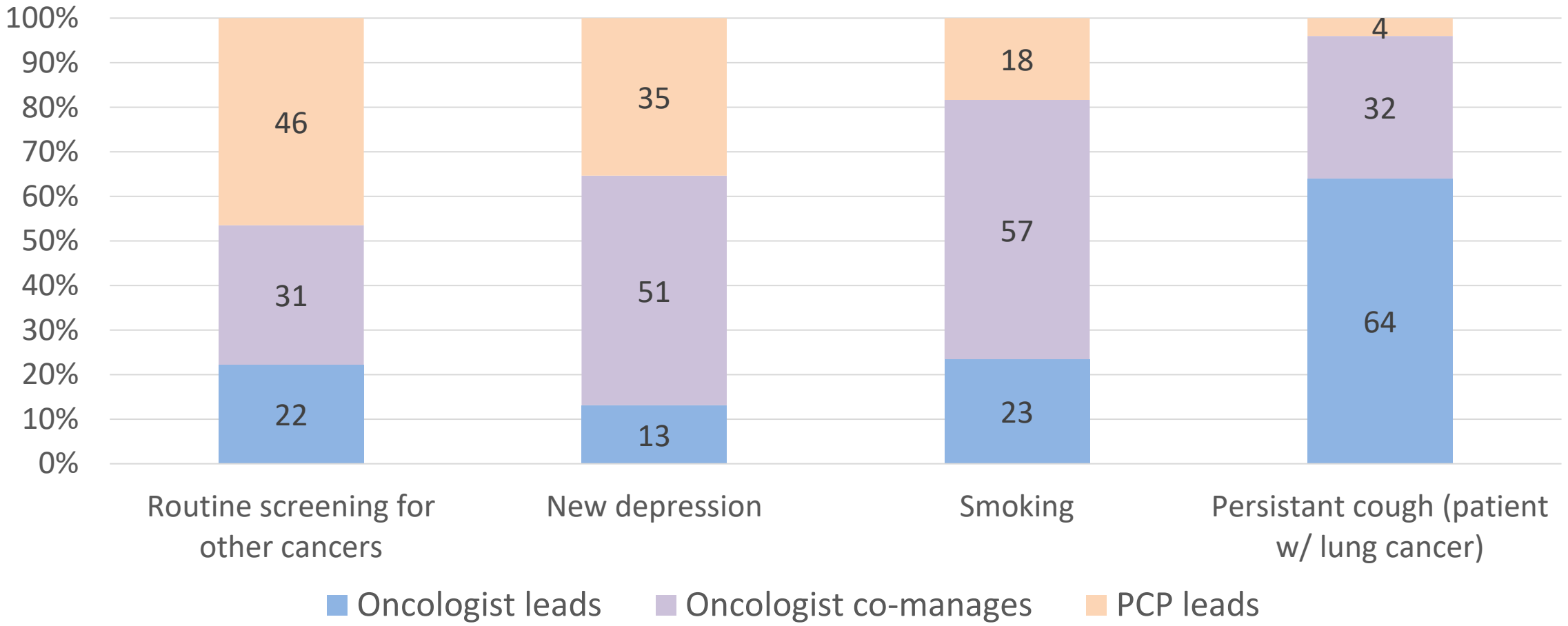
Also Challenges to Episode Models

- Episode models need to focus on specific phases of disease and types of care (e.g., chemotherapy, radiation)
  - Even then, substantial heterogeneity
- Increasingly narrow focus omits many patients and much care delivered (e.g., survivorship care, end-of-life care)
  - Such care may be best shared with PCPs
- Complexities of model overlap

Pressing Needs

- Better data on quality and spending
- Testing of a variety of strategies for episode/carve out models
  - Mandatory models particularly informative
- Testing of models for shared care

Oncologists' Reports on Who Manages Surveillance Care for Patients Following Primary Treatment



Klabunde et al, Eur J Cancer2017

Acknowledgements:

CMS Oncology Care Model Evaluation Team

Funding: CMS contract HHSM-500-2014-00026I

Other research presented funded by AHRQ R01HS026498, NCI CanCORS Study, and Arnold Ventures.

Strategies for Improving Alignment Between PCPs and Specialists in ACOs

Prepared for ASPE/PTAC

Robert Mechanic, MBA

September 20, 2022

Summary

- Specialist alignment is high priority for ACOs, but current level of alignment is generally low
- Progress affected by organizational complexity, limited interoperability, prevailing FFS incentives and culture
- Lack of data and metrics to evaluate specialist performance is a major barrier
- Specialist financial incentives on the margin are unlikely to be key drivers of change

Institute for Accountable Care

Independent 501(c)(3) formed to conduct research to inform policy and promote best practices in accountable care

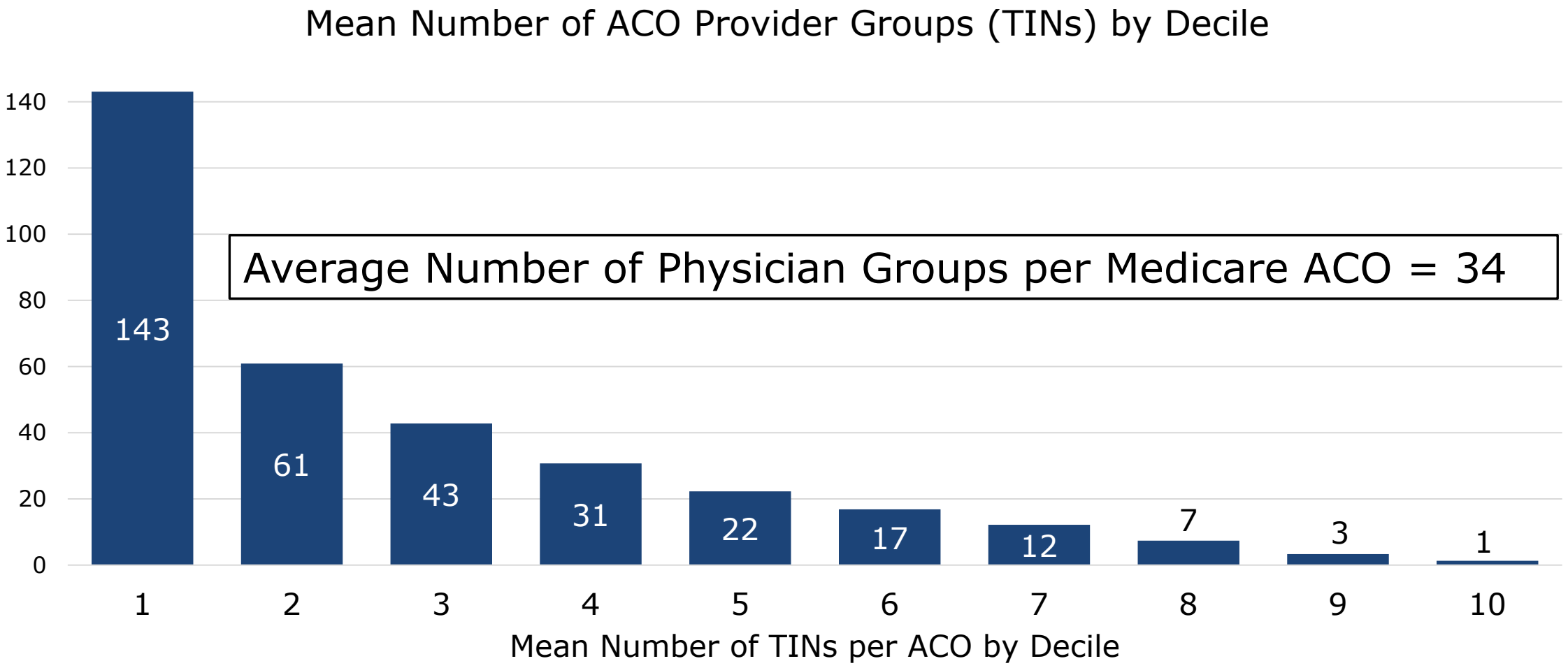
Medicare Data

100% of FFS Claims Through Q2 2022

- Part A, B, D claims
- MDS assessments
- ACO provider file
- ACO beneficiary file
- MD-PPAS
- MA encounters (19)

IAC Institute for Accountable Care

ACOs Combine Multiple Independent Provider Groups



Source: MSSP 2020 Public Use File.

Limited Interoperability Affects Specialist Alignment

TABLE 2. Data Integration and Quality Measure Reporting Capabilities by Number of EHR Systems Within MSSP ACOs

Capabilities	Number of EHR systems within ACO				
	1 EHR (n = 14)	2-5 EHRs (n = 23)	6-15 EHRs (n = 66)	≥ 16 EHRs (n = 60)	*P*[a]
ACOs in each EHR category	9%	14%	40%	37%	
ACO has infrastructure to aggregate EHR data, n (%)	11 (79%)	9 (39%)	10 (15%)	8 (13%)	<.01

Source: Perloff and Sobul, Use of Electronic Health Record Systems in ACOs. American Journal of Managed Care, January 18, 2022.

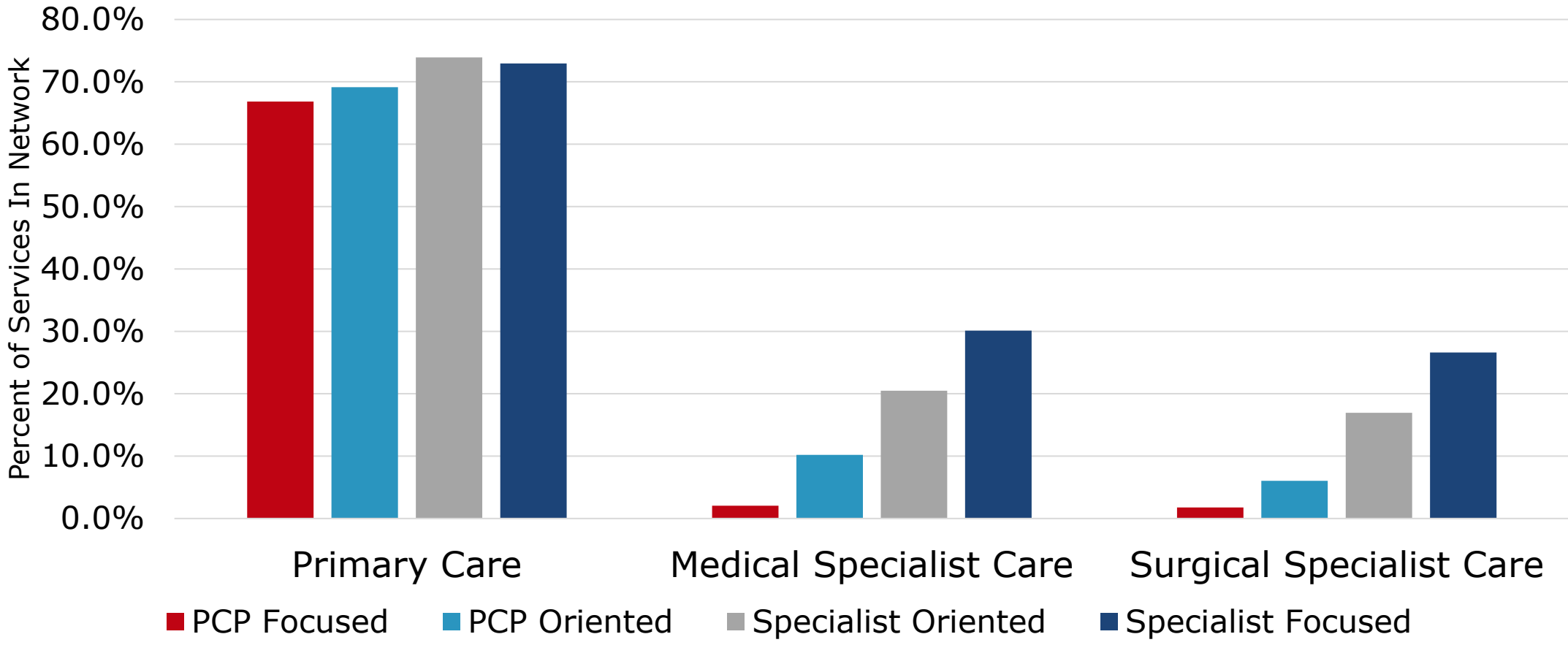
Grouping ACOs for Analysis of Out-of-Network Care

ACO Type	Number	Percent PCP MDs in ACO	Percent w/Hospital	Average #Benes	Percent in AAPM
1. PCP Focused	130	67 - 100%	5%	11,383	35%
2. PCP Oriented	60	50 – 66%	30%	16,403	18%
4. Specialist Oriented	177	34 – 49%	69%	24,379	25%
4. Specialist Focused	157	0 – 33%	76%	24,379	27%

Source: 2019 MSSP Public Use File.

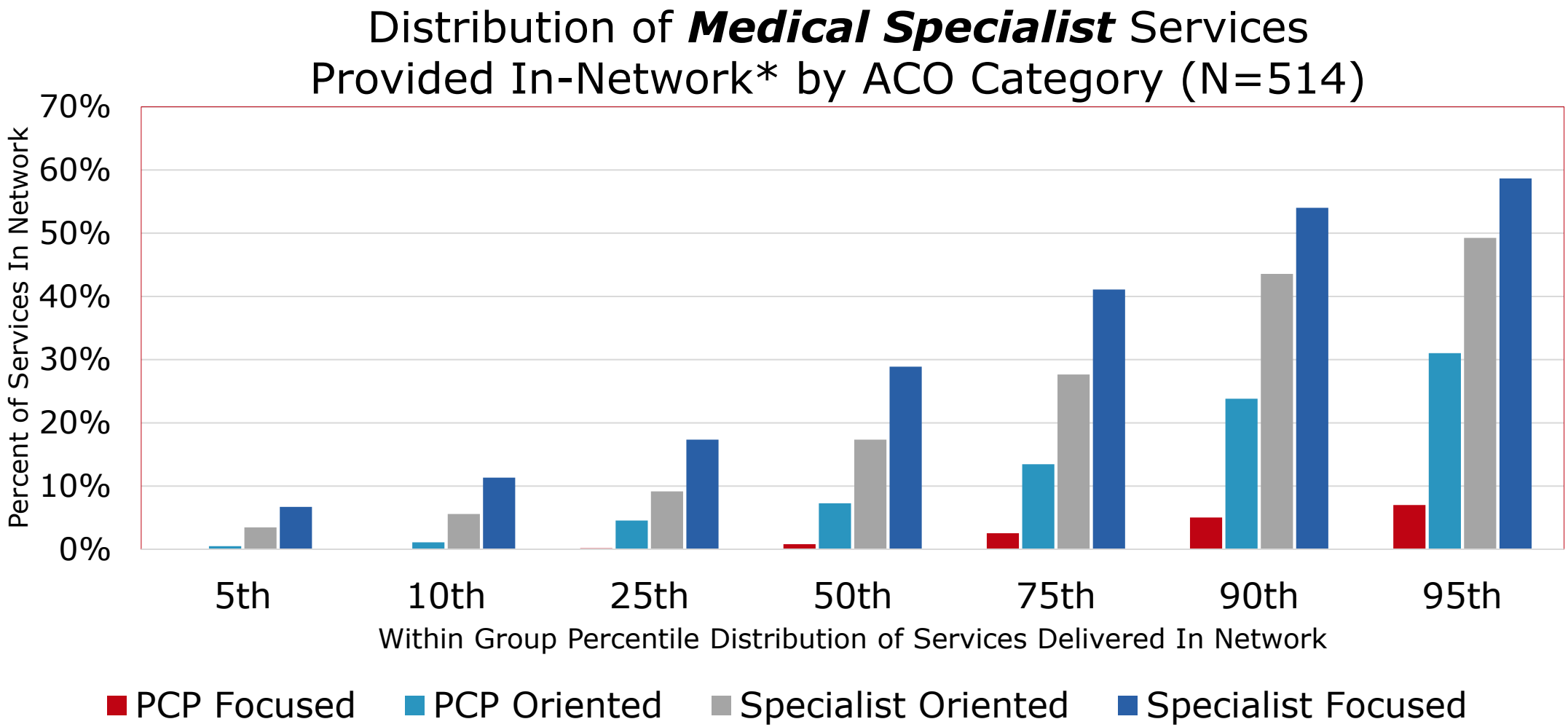
Proportion of ACO Beneficiary Care Provided by ACO Physicians

Based on Medicare Paid Amounts: Excludes Non-ACO Physicians in CIN



Source: Institute for Accountable Care analysis of 2019 Medicare Claims (100% file)

Proportion of ACO Beneficiary Care Provided by ACO Specialists



* Definition excludes specialists in health system CIN who do not participate in Medicare ACO

Source: Institute for Accountable Care analysis of 2019 Medicare Claims (100% file)

NAACOS/IAC Survey of Specialist Engagement

- Surveyed subset of NAACOS members in April 2022
- Responses from 64 ACOs (45% response rate)
- Respondents tended to be large and a majority employ at least 60% of ACO specialists

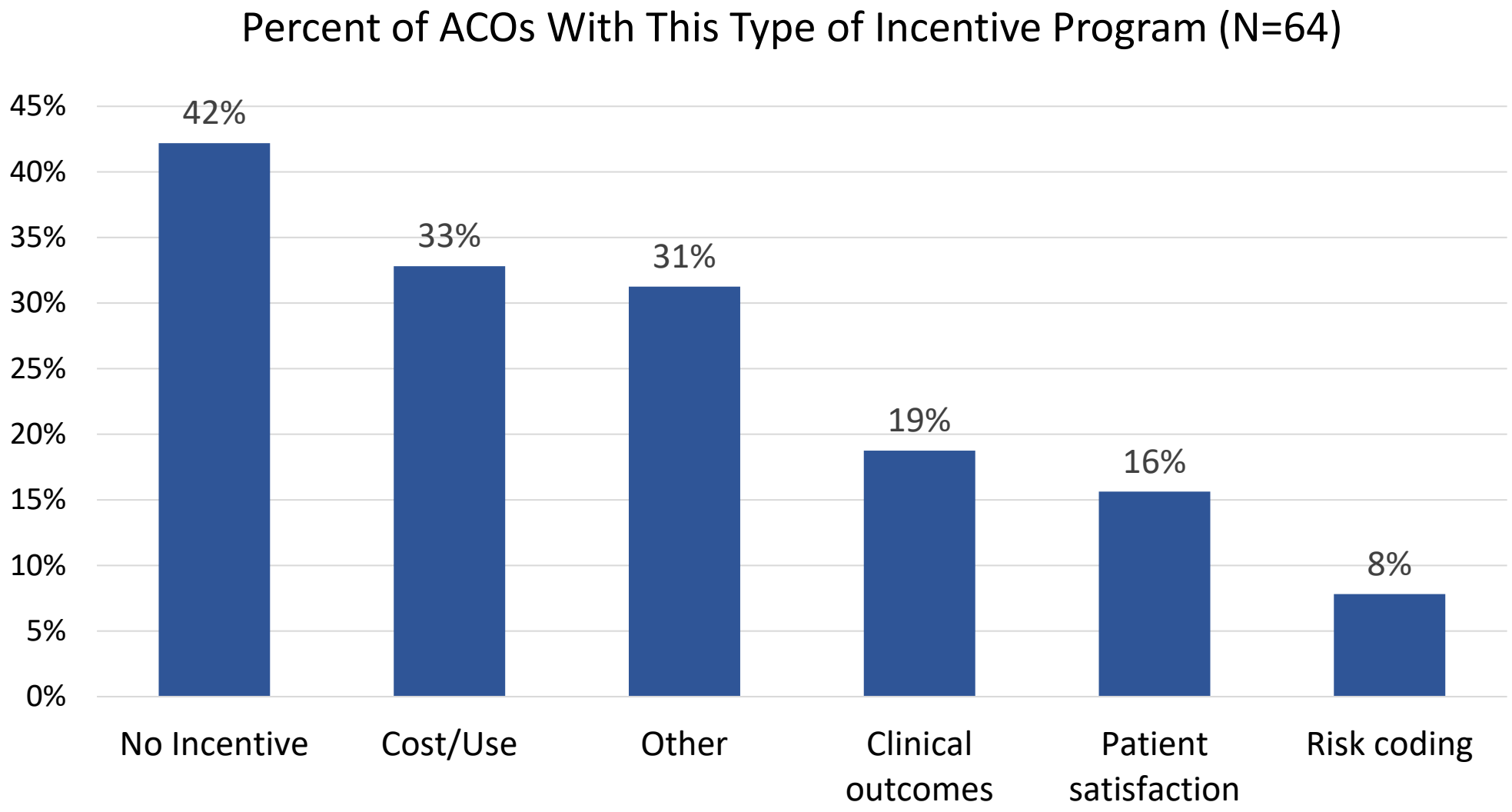
ACO Activities to Improve Specialist Alignment

Percent of ACOs Reporting Activities by Level of Activity

Type of Activity	Major	Minor	No Activity
Convene Specialists to Develop Care Pathways	34%	37%	29%
Give Specialists Unblinded Performance Reports	12%	44%	44%
Direct Referrals to High Performing Specialists	19%	41%	41%
Enter Bundled Payment Contracts	17%	25%	58%

Source: Self-reported survey data from 64 ACOs.

Moderate Use of Financial Incentives to Reward Specialists

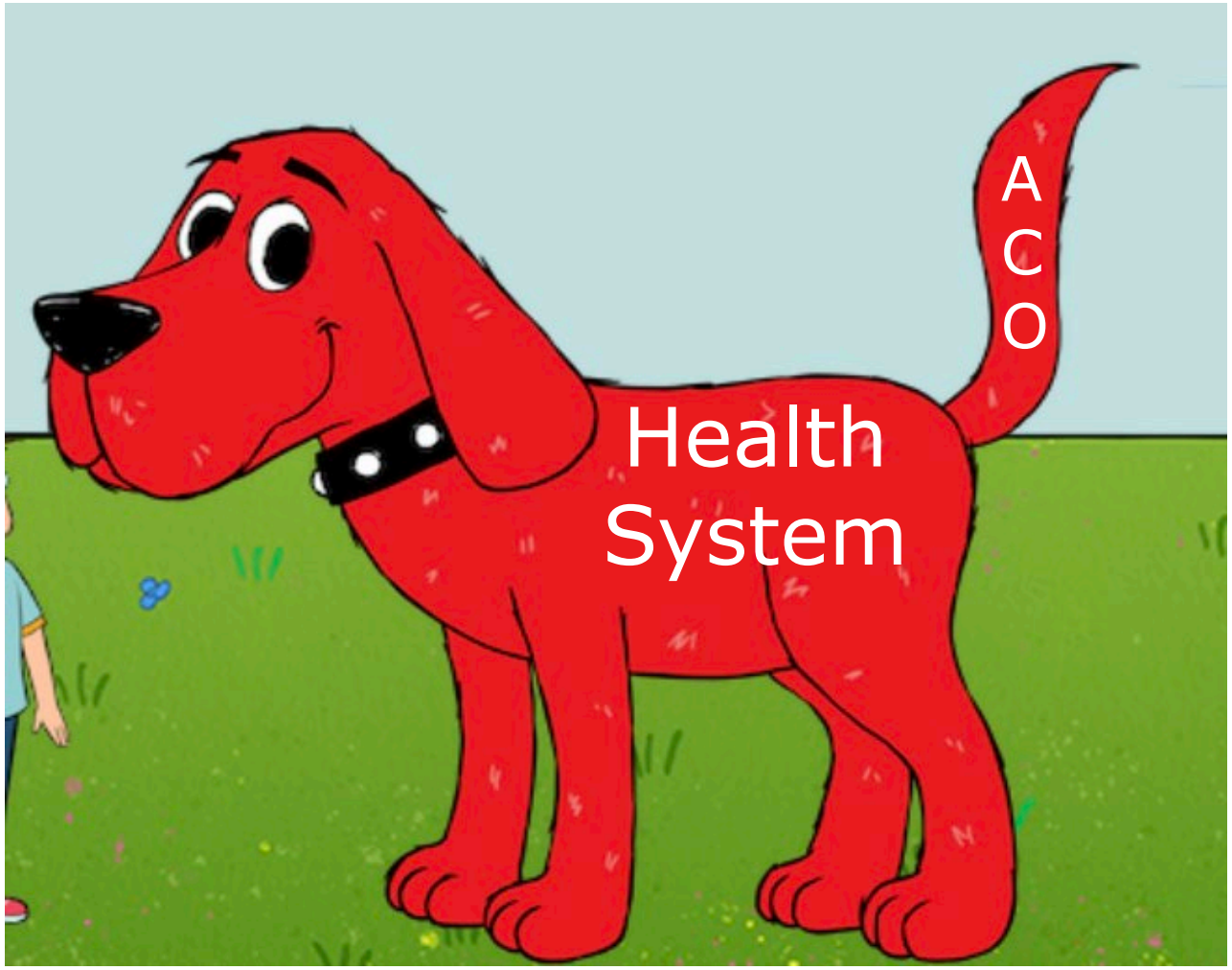


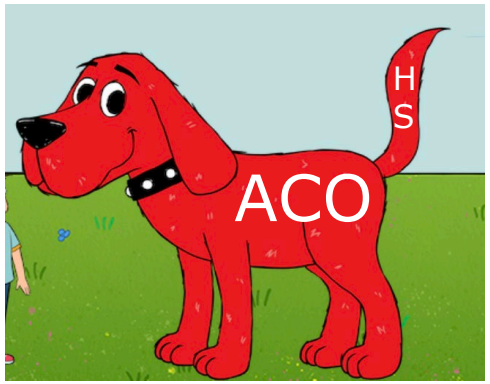
Source: Self-reported survey data from 63 ACOs.

Barriers to Specialist Engagement Reported

1. Lack of data or metrics to evaluate specialist performance (especially quality)
2. Dominant fee-for-service incentives driving specialist behavior
3. Insufficient bandwidth in ACO and among specialist groups to take on engagement efforts
4. Specialist unwillingness to engage
5. Uncertainty about structuring financial incentives given lack of data (also concern about diluting shared savings incentives for PCPs)

Level of Alignment between the ACO and the Health System's Specialty and Hospital Services?





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ACO Strategies

- Educating specialists on ACO goals
- Using episodes to measure specialist resource use
- Surveying PCPs on specialist performance (service level)
- Structuring opportunities for PCP-Specialist collaboration
  - Build PCP expertise in complex patient management
  - Referral "hoops" to force conversations and reduce unnecessary referrals
- Directing referrals to preferred specialists (including specialist tiering models)

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