Alternative payment model financial settlements: Preparing for and learning from the process

A case study in the Oncology Care Model

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Alternative payment models (APMs) that shift reimbursement for services from a volume-based to a value-based system have increased in popularity over recent years. APMs aim to align incentives for higher quality and efficiency of service utilization, moving away from a fee-for-service system. APM participants, such as specialty provider groups and other medical providers, often bear some financial risk that is tied to meeting particular financial or health outcomes targets. For instance, some APMs created by the Centers for Medicare and Medicaid Services (CMS), such as the Bundled Payment for Care Improvement (BPCI) models and the Comprehensive Care for Joint Replacement (CJR) model, have settlements contingent on spending targets that are derived from total allowed amounts (the spending by both payers and patients) for services incurred during an episode. In contrast, other APMs tie reimbursement to health outcomes, such as the APM entered into by Harvard Pilgrim and Eli Lilly & Co., which ties reimbursement of the diabetes drug Trulicity to patients' HbA1c levels.[1]

APMs are often difficult to implement given their operational dependence on payment systems designed for fee-for-service (FFS) reimbursement. In addition, moving away from a FFS reimbursement construct can cause underreporting of detailed services performed. Because of this, many APMs are retrospectively reconciled, meaning payments flow as normal during model performance periods and are retrospectively reconciled to a target price or benchmark after the fact (a process we refer to as *financial settlement* hereafter).

Reconciliation of financial settlements presents challenges requiring parties to be intimately familiar with both the APM payment specifications and the data on which the calculations are based. While complicated, this process can provide a valuable learning opportunity to improve the management of key targets moving forward. In a prior publication, "Addressing challenges in the transition to value-based care and alternative payment models," we detailed various types of APMs and their respective methodologies.[2] Given the financial risk inherent in APMs, participants anticipate financial settlement outcomes and are eager to understand where they can influence spending to improve future financial performance. This paper focuses on APM reimbursement methodologies through the lens of the financial settlement process, using the CMS Oncology Care Model (OCM) as an illustrative case study.

Preparing for financial settlement

APMs are both diverse and unique to the conditions and populations involved. APM participants must manage many complicated moving pieces to succeed in these programs, and understanding the methodologies that can affect financial performance is a useful first step. Though APMs differ, their methodologies often share common core components, which we review below.

UNDERSTAND THE METHODOLOGY

In our prior paper, we discussed core components of APM methodologies. We briefly revisit those here as they are integral to preparing for financial settlements.

Comparison population: Some APMs measure a participant's performance against benchmarks derived from the participant's historical experience, a similar population's historical or concurrent experience, or a clinically identified target population's experience. Typically (and ideally), APM participants receive benchmark data early during model implementation, providing insight on management strategies to improve performance.

[1] Stanton. Tracy (June 28, 2016). Lilly's Trulicity joins pay-for-performance trend with Harvard Pilgrim deal. FiercePharma. Retrieved December 1, 2017, from http://www.fiercepharma.com/pharma/lilly-s-trulicity-joins-pay-for-performance-trend-harvard-pilgrim-deal.

[2] http://www.milliman.com/insight/2017/Addressing-challenges-in-the-transition-to-value-based-care-and-alternative-payment-models-A-case-study-in-the-Oncology-Care-Model/

Patient attribution: Identifying which patients contribute to a participant's performance period results is important to APM financial settlements. Understanding how patients are attributed to APM participants enables identification of likely candidates early on in their care, which in turn affords more opportunities to intervene in patient care.

Included services: To effectively design and employ management strategies, parties should be knowledgeable of the scope of services for which they are accountable in the APM financial settlement process. In addition to services furnished directly by the participant, APMs typically include services that the participant does not directly furnish. Understanding and optimizing this service use is important.

Risk adjustment/patient stratification: Patient populations will vary on a number of characteristics, such as age, gender, and comorbidities. To judiciously compare across populations, APMs incorporate risk adjustment methodologies that account for these differences. Understanding the risk adjustment methodologies and what characteristics are associated with variation in outcomes and service use will allow APM participants to better prepare for financial settlements as well as provide direction on where to focus management resources.

Trend factors: Costs and treatment patterns change over time. Trend factors attempt to adjust for these differences and can have an appreciable impact on performance calculations. Practices should continuously evaluate which aspects of care are captured in the APM trend factor and, perhaps more importantly, which ones are not.

Quality metrics: Quality metrics are often included in APMs to measure improvement in patient outcomes and to monitor for unintended consequences that could negatively affect patient care. Understanding performance on quality metrics and tracking patient outcomes is important because most APMs adjust financial settlement calculations based on participant performance against quality measures.

MONITOR EMERGING EXPERIENCE

From day one of a performance period, APM participants need to identify patients who are likely to meet eligibility criteria for the model. Identifying patients early is key not only to enrolling patients in appropriate care management programs but also, in some APMs, to receiving payment for the additional services furnished in the APM and to collecting the necessary data for the APM. Parties should be monitoring patient outcomes and paying attention to the characteristics discussed in the prior section for this identified patient population.

In our prior paper, we discuss the utility of calculating preliminary baseline spending targets over time, and some key points deserve revisiting. Estimation of a baseline spending target relies on the availability of the patient characteristics that inform the financial benchmarks in the APM. Omission of even one key variable, particularly one that might rarely occur but that has a significant impact on the financial benchmark, can make such a calculation futile. As such, development of probability distributions of patient characteristics will enable realistic estimation of financial benchmarks.

Nonetheless, key patient characteristics can change over time. A patient attributed to a participant at the onset of a performance period might transfer to another participant by the end of that performance period. A patient assigned to one risk strata during the first performance period could shift to a different risk stratum in a subsequent performance period. Quality metrics, which typically measure use of key services, can be flagged and tracked as time goes on. As such, it is important to have a systematic approach that periodically re-evaluates patients to adjust estimates of financial benchmarks.

Understanding the data

Because APMs typically include services furnished by both participants and other providers, APM participants often receive interim data files before financial settlements. Analyzing these files from multiple perspectives (e.g., clinical and financial) gives participants a global view of their patients' experience before a financial settlement. At financial settlement time, participants also typically receive data files to support financial settlement calculations. When used correctly, these data files will provide necessary insight on progression, both that of particular patients and that of the participant organization as a whole.

Attribution of claims to risk period: To effectively monitor and use APM data files, it is necessary to understand how services accrue to an APM (for the time period the data covers). Differences between claim header dates of service and line-level dates of service can be relevant when a claim includes multiple dates of service. For example, inpatient admissions usually span multiple dates of service and could extend beyond the end of the APM risk period (the timeframe for which the APM participant bears financial risk for a given patient's outcomes). Some APMs might consider the entire facility claim billed by the hospital if the date of admission occurred before the end of the risk period whereas some APMs would exclude the entire claim because the discharge date occurred after the end of the risk period. Alternatively, some APMs prorate claims based on services furnished before the risk period ends. It is imperative to understand how services accrue to risk periods and how the individual claims in the data the APM participant receives are counted. APM participants will want to ensure that the data is provided in such a way that all relevant services are included.

Claims run-out: Claims run-out, or the time period after a service is incurred/billed and before the data is pulled, also plays a role in what information is available in the data APM participants receive. Claims incurred but not adjudicated by the end of the run-out period will not be included in claims data, which can skew calculations performed on the data. As such, understanding how the claims adjudication process works provides insight to the reliability of calculations using APM data files.

HIPAA restrictions: With the introduction of the Health Insurance Portability and Accountability Act (HIPAA) in 1996, data governance rules impact the dissemination of health claims data, which is still considered Personal Health Information (PHI), even when de-identified. A key tenet of HIPAA stipulates that access to data should be limited to the minimum information required for the business use. As such, the claims data provided to APM participants will only contain the variables deemed minimally necessary for the task at hand and will deliberately be censored to remove all extraneous information. If participants require additional information, they will need to make specific requests for the provision of additional variables, citing a direct business need. Furthermore, certain conditions may require a claim's omission from data submissions altogether. For example, CMS does not release claims data for Substance Abuse or Mental Health (SAMH) encounters. These claims may be key to establishing eligibility for the APM, and they may be high cost. As a result, APM participants should anticipate at least some surprises and calculation mismatches at financial settlement.

Future management and financial settlements

The process of reconciling a financial settlement affords the opportunity to become well versed in the APM methodology and data processes. Reconciliation of financial settlement calculations could uncover mistakes made in the implementation of the APM. By reviewing these calculations, participants should gain a level of comfort and familiarity with how the APM has been implemented. Participants may also have the opportunity to contest perceived errors and to request changes to the APM methodology.

After financial settlement, APM participants should also have a better understanding of how patients are attributed to them and which patients are likely to be attributed to future financial settlements. APM participants should review patients whose ultimate attribution to the participant was not already anticipated by an internal process. Seeing where the current process generated results different from what was expected can inform future refinements. Because any intermediate data reports provided are historical by time of receipt, participants should use them in combination with real time internal records for the most accurate recalibration of any calculations.

Case study: Oncology Care Model

One of the APMs currently being implemented is the Oncology Care Model (OCM) administered by CMS.[3] This is an episode-based model centered on administration of chemotherapy. Each episode, the risk period for this model, is triggered by a Part B or Part D chemotherapy treatment and lasts for six months from the date of service of the chemotherapy trigger. In February 2018, OCM participants received notification and data supporting the APM's first financial settlement.

There are two components to this APM's payment methodology:

- A monthly care management fee which applies to all OCM episodes and is designed to compensate participants for enhanced services required by the APM
- A retrospective performance-based payment

The performance-based payment is a retrospective comparison of actual FFS payments (excluding patient responsibility) against a discounted risk-adjusted financial target, with potential adjustments for the participant's performance on key quality metrics. The performance-based payment is available for 21 high-volume cancer types.

Our prior paper explored how to monitor emerging episodes in the OCM. Similarly, the OCM financial settlement experience provides an example of the types of useful information that can be learned from reconciling a financial settlement.

For the OCM, CMS distributes interim performance feedback reports throughout the performance period, which are constructed differently than the financial settlement reports provided when the financial settlement is reconciled.

Performance feedback reports are supplied quarterly and report medical and pharmacy claims incurred in the current and prior quarter. Patients are included if they incurred an evaluation and management (E&M) claim with a cancer diagnosis billed by a participant in the current or prior quarter and a chemotherapy claim in the same time period. In these reports, CMS does not construct episodes, calculate episode spending, or attribute episodes.

Financial settlement reports are supplied at the time of financial settlement (after the conclusion of a performance period). In these reports, CMS constructs episodes and provides supporting information, including their determination of eligible claims for attributed episodes. These reports exclude information on beneficiaries who CMS ultimately did not attribute to the participant, even if the beneficiaries had been part of interim reports.

[3] See: https://innovation.cms.gov/initiatives/oncology-care/ for more information.

The different methodologies and attributes of these reports present both pros and cons. The flexibility of broader inclusion criteria in the performance feedback reports allows OCM participants to monitor progress for those patients most likely to be attributed for financial settlement as well as track other patients who might be attributed based on future experience. However, the lack of episode-level variables related to preliminary attribution and risk-adjustment present limitations in calculating estimated financial performance from these reports.

The first OCM financial settlement reports included six-month episodes occurring between July 1, 2016, and January 1, 2017, (Performance Period 1). The calculations and data reflected claims paid by August 31, 2017, a two-month claims run-out period. CMS will recalculate the financial settlements for Performance Period 1 twice to account for additional claims run-out. The first financial settlement report enabled participants to validate their understanding of OCM methodologies and reconcile differences between CMS and internal calculations. Through this exercise, participants could improve and correct internal processes and gain a deeper understanding of the OCM methodology.

After analyzing initial settlement reports, some OCM participants identified potential methodology refinements to better reflect coding and treatment practices. One such refinement was incorporated in the first true-up of the OCM financial settlement, retroactively adjusting the first financial settlement. This refinement expanded the pool of episode triggers to include chemotherapy encounters with both a line-level diagnosis code indicating an encounter of antineoplastic chemotherapy or immunotherapy and a claim-level cancer diagnosis code in any position on the claim (instead of requiring a cancer diagnosis code on the same line as a chemotherapy infusion code to trigger an episode). The impact of this methodology change will vary by participant depending on coding practices.

The first set of financial settlement reports also enabled OCM participants to compare patients included in interim reports to those patients included in the first financial settlement report. This comparison provided insight on patients who received treatment from an OCM participant, but who ultimately did not have an attributed episode. OCM participants were able to review the patient claims history available in the interim data to review cases where attribution results were not expected. This longitudinal view of patients provided additional insight on how CMS determined if a claim accrued to an episode, if the patient could have been treated earlier or managed differently, and what the patient's next six months (potentially their next episode) looked like.

Summary

As more providers engage in APMs, the need for business intelligence to understand, support, and maximize reimbursement is clear. Such intelligence can be gained from multiple sources. Interim reporting provides insights on patients potentially attributable to an APM and allows a more comprehensive view of patients' total medical service utilization. These insights can be maximized by use of a multi-disciplinary team (e.g., data analysts, practice managers, and clinicians) that has a comprehensive understanding of all aspects of patient care. APM financial settlement data provide opportunities to validate financial calculations, to understand methodology, to identify opportunities to enhance patient management, and to gain insight on other revenue drivers such as patient retention. While APMs are complex and their financial settlements may seem daunting, participants who capitalize on their data assets will gain a better level of comfort with them.

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