Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation

Request for Input (RFI)

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) is hosting theme-based discussions to inform the Committee on topics that are important for physician-focused payment models (PFPMs). Given the increased emphasis on developing larger population-based Alternative Payment Models (APMs) that encourage accountable care relationships, PTAC has conducted a series of theme-based discussions that examined key definitions, issues and opportunities related to developing and implementing population-based total cost of care (PB-TCOC) models with accountability for quality and TCOC.[1] Subsequent theme-based discussions have addressed topics related to improving care delivery and integration of specialty care, improving management of care transitions, increasing participation of rural patients and providers, developing and implementing performance measures, addressing needs of patients with complex chronic conditions or serious illnesses, and identifying pathways toward maximizing participation in PB-TCOC models.

These theme-based discussions are designed to give Committee members additional information about current perspectives on key issues related to developing and operationalizing PB-TCOC models. This information will be useful to policy makers, payers, accountable care entities, and providers for optimizing health care delivery and value-based transformation in the context of APMs and PFPMs specifically. The theme-based discussions provide an opportunity for PTAC to hear from the public and subject matter experts, including stakeholders who have previously submitted proposals to PTAC with relevant components.

To assist PTAC in preparing for future theme-based discussions, the Committee is interested in seeking stakeholder input about approaches for reducing barriers to participation in PB-TCOC models and supporting primary and specialty care transformation. Specific topics that are of interest include:

- Understanding factors that affect different kinds of organizations' business decisions about participating in PB-TCOC models;
- Approaches for streamlining models, improving the predictability of benchmarks, and incentivizing the participation of different kinds of organizations in PB-TCOC models;
- Specific incentives for improving clinical integration and supporting primary and specialty care transformation in different kinds of organizations participating in value-based care; and enhancing the sustainability and competitiveness of PB-TCOC models.

[1] Please see the Appendix for PTAC's definition of PB-TCOC models.

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Request for Input (RFI)

Stakeholders will have an opportunity to provide public comments at the end of the second day of the public meeting. Findings from this theme-based discussion will be included in a report to the Secretary of Health and Human Services (HHS).

Background:

There has been an increased emphasis in increasing the number of Medicare fee-for-service (FFS) beneficiaries who are in care relationships with accountability for quality and TCOC. Additionally, the Secretary of Health and Human Services (HHS) has established 10 criteria[2] for proposed PFPMs that PTAC uses to evaluate submitted proposals, including "Scope" and "Quality and Cost." The goal of the "Scope" criterion is to ensure that each proposed model will "aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited." The goal of the "Quality and Cost" criterion is to ensure that each proposed model will "improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost" (Criterion 2).

Among the 35 proposals that were submitted to PTAC between 2016 and 2020, including 28 proposals that PTAC has deliberated and voted on during public meetings, nearly all of the proposals address the potential impact on scope (specifically opportunities for APM participation) and quality and cost, to some degree. Committee members found that 18 of these proposals met both Criterion 1 (Scope) and Criterion 2 (Quality and Cost), including several proposals that were directly related to promoting accountable care, and/or proposed to use waivers to reduce barriers related to participation in APMs.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides an environmental scan for every proposal reviewed by PTAC so that Committee members understand the clinical and economic circumstances within which a proposed model would be implemented, as well as related resource information that can inform their evaluation of each proposal.

Beginning in 2021, PTAC has conducted a series of theme-based discussions to examine topics relevant to PFPMs, with a focus on issues related to reducing barriers to participation in value-based care and PB-TCOC models. Environmental scans have also been developed to assist PTAC

[2] The 10 criteria are scope, quality and cost, payment methodology, value over volume, flexibility, ability to be evaluated, integration and care coordination, patient choice, patient safety, and health information technology.

in preparing for the Committee's theme-based discussions. Within this context, PTAC has developed the following working definitions:

Accountable Care Relationship

- *A relationship between a provider and a patient (or group of patients) that establishes that provider as accountable for quality and total cost of care (TCOC) including the possibility of financial loss/risk for an individual patient or group of patients for a defined period (e.g., 365 days).*

- *Would typically include accountability for quality and TCOC for all of a patient's covered health care services.*

Population-Based Total Cost of Care (PB-TCOC) Model

- *Alternative Payment Model (APM) in which participating entities assume **accountability for quality and TCOC** and receive payments for **all covered health care costs**[3] for a broadly defined population with varying health care needs during the course of a year (365 days).*

- *Within this context, a PB-TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be "nested" within a PB-TCOC model.*

Additionally, PTAC has identified the following definition related to identifying pathways for increasing participation in PB-TCOC models:

Identifying Pathways for Increasing Participation in PB-TCOC Models

- *Different factors affect different kinds of organizations' decisions about participating in PB-TCOC models.*

- *PTAC is using the following working definition of a "pathway" for incentivizing increased participation in PB-TCOC models:*

    - *A pathway may be thought of as a grouping of health delivery organizations that might be treated similarly with regard to benchmarks, two-sided risk, and how*

[3] For this purpose, all covered health care costs do not include pharmacy-related costs (Medicare Part D).

performance measures affect payment within the context of other incentives. These parameters would be specified for the pathway.

- *A pathway may be thought of as a grouping of health delivery organizations that might be treated similarly with regard to benchmarks, two-sided risk and how performance measures affect payment. These parameters are specified for the pathway.*

See the Appendix for additional definitions relating to PB-TCOC models. These definitions will likely continue to evolve as the Committee collects additional information from stakeholders.

PTAC Areas of Interest:

PTAC is particularly interested in perspectives on reducing barriers to participation in PB-TCOC models and supporting primary and specialty care transformation. Particular topics of interest include examining approaches to reduce organization-level barriers (e.g., improving benchmarking, addressing workforce challenges); discussing primary and specialty care transformation (e.g., identifying providers with primary accountability, developing team-based attribution methods, supporting data sharing in less integrated settings); enhancing the ability of PB-TCOC models to be competitive (e.g., identifying market factors); and offering solutions for sustainability of effective PB-TCOC models.

PTAC seeks to build upon the insights of stakeholders and use those insights and considerations to further inform the Committee's review of proposals and recommendations that the Committee may provide to the Secretary relating to this topic. Therefore, PTAC requests stakeholders' input on the questions listed below.

Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Questions to the Public:

1) What kinds of organizations (e.g., physician-led ACOs, hospital-led ACOs, integrated delivery systems, etc.) are likely to be able to provide the kind of multidisciplinary, team-based, person-centered that will be needed for effective PB-TCOC models?
   a) What types of organizations would be best to serve urban communities, rural communities, or a mixture of communities?

2) What are some specific potential pathways toward maximizing participation of different kinds of organizations in PB-TCOC models?

a) What kinds of organizational characteristics are most important for determining potential pathways toward maximizing their participation in PB-TCOC models?

3) What is the current distribution of providers that are participating in population-based models? What kinds of additional providers and organizations are needed in order to maximize participation of Medicare beneficiaries in care relationships with accountability for quality, outcomes and TCOC?
   a) What kinds of providers are not currently participating in population-based models?
   b) To what extent should providers be formally integrated into the organization (versus contracted by the ACO) to effectively provide team-based integrated care?
   c) What are effective strategies that could be used to fully engage those providers not employed or formally integrated into a given organization?
   d) What kinds of incentives are needed in order to encourage these providers to participate in population-based models? How can incentives be adjusted to reach all providers across the entire organization?
   e) What would an effective multi-payer system look like? How do organizations effectively stratify care when patient mix is split between risk/value-based and FFS?

4) What is the anticipated distribution of types of organizations that are likely to be providing accountable care to Medicare beneficiaries in the future (physician-led ACOs vs. hospital-led ACOs vs. integrated delivery systems, etc.)?
   a) What kinds of payment structures, risk structures and performance measures are needed in order to incentivize each of these different kinds of organizations to participate in PB-TCOC models?
   b) What kinds of payment structures, risk structures and performance measures are needed in order to make it possible for each of these different kinds of organizations to be successful in participating in PB-TCOC models?

5) What are the implications for the design of future population-based models?
   a) If the goal is to streamline and simplify the number of models that are available, what should a more concise portfolio of models look like? How should a more concise portfolio of models vary for different kinds of organizations that are likely to be participating in population-based models?
   b) What kinds of additional models could be designed to work with a more streamlined set of population-based models in order to test innovations in care delivery and payment methodology?
6) What are the best approaches for improving the predictability of ACO benchmarks and to effectively address the ratcheting effect?

a) How can current approaches be modified to more effectively address the ratcheting effect?

7) What specific role may conveners/enablers play in increasing participation of certain kinds of providers in PB-TCOC models?
   a) How can value-based care organizations better utilize conveners/enablers to increase participation?
   b) How should payments to conveners/enablers be made? To what extent should conveners/enablers receive shared savings? How should these payments to conveners/enablers be distributed within the full risk payments of PB-TCOC?

8) Which incentives are most effective for improving clinical integration within different kinds of organizations participating in value-based care?

9) What are best practices for improving attribution in PB-TCOC models?
   a) In what ways might the best approaches for improving attribution vary for different kinds of organizations participating in population-based models?
   b) What are the advantages and disadvantages of attributing the primary care provider to the patient versus using team-based attribution methods?
   c) How do organizations effectively apply team-based attribution methods? How is accountability achieved?

10) What are some approaches that various types of organizations are using to address workforce challenges related to providing person-centered multidisciplinary team-based care in which providers can increase their participation in team-based primary care? What do providers need to successfully perform and thus increase their participation in team-based primary care?
    a) How might the integration of teams differ depending on types of settings (e.g., critical access hospitals, safety-net hospitals, independent practices, integrated delivery systems)?
    b) Have some organizations been successful in increasing the number of medical residents that have been doing rotations in multidisciplinary team-based primary care settings? If so, how?
    c) To what extent do current residency programs teach value-based care when training physicians?
11) How should financial incentives be incorporated to encourage accountability for specialists that are not in integrated systems to coordinate with primary care providers?

a) To what extent might the appropriate financial incentives vary based on the type of organization that is participating in population-based models?
b) What are some effective approaches for ensuring that incentives are provided and shared with all team members?

12) How can organizations best facilitate data-sharing between primary care and specialty providers in less integrated settings?

13) What are the best approaches for operationalizing procedure-based and longitudinal nested episodes in PB-TCOC models?

14) What are the specific market factors that may affect participation in and performance of PB-TCOC models in different geographic areas, and for different kinds of organizations?

15) How can the beneficiary perspective be considered in the context of efforts to increase the competitiveness of PB-TCOC models?

16) What are factors that may influence the effectiveness of and use of current waivers in PB-TCOC models?
    a) Are there other opportunities for enhancing the competitiveness of services and financial incentives in PB-TCOC models (including additional waivers)?

17) What are the financial and operational impacts that multi-payer initiatives could have on increasing participation in PB-TCOC models?
    a) What are specific examples of the kinds of multi-payer initiatives that should be pursued in order to have the greatest impact on increasing participation in PB-TCOC models?

Where to Submit Comments/Input: Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Note: Any comments that are not focused on the topic of reducing barriers to participation in PB-TCOC models, supporting primary and specialty care transformation, and efforts by physicians and related providers caring for Medicare FFS beneficiaries, or are deemed outside of PTAC's statutory authority, will not be reviewed and included in any document(s) summarizing the public comments that were received in response to this request.

Appendix: Working Definitions Related to Population-Based Total Cost of Care (PB-TCOC) Models

PTAC is using the following working definition for population-based models.

> *Population-based models are models that include the entire patient population served by a given accountable entity or a broad subset of the patient population served by an accountable entity (e.g., Medicare-Medicaid enrollees).*

PTAC is using the following working definition for 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).*

Within this context, a PB-TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be "nested" within a PB-TCOC model. Additionally, PTAC is using the following working definition of TCOC:

> *Total cost of care is a composite measure of the cost of all covered medical services delivered to an individual or group. In the context of Medicare Alternative Payment Models, TCOC typically includes Medicare Part A and Part B expenditures, and is calculated on a per-beneficiary basis for a specified time period.*

Within this context, some examples of existing population-based models/programs that include components that are relevant for the development of PB-TCOC models include:

- *Advanced primary care models (APCMs)* that promote the use of Advanced Primary Care, an approach that enables primary care innovations to achieve higher quality care and allows providers more flexibility to offer a broader set of services and care coordination.
- *Accountable Care Organization (ACO) programs* where physicians or health systems assume responsibility for TCOC associated with a patient population.

While some existing APMs may include shared savings with upside risk only, PTAC anticipates that PB-TCOC models will include glide paths for allowing providers and organizations to gradually assume more downside financial risk over time.