Preliminary Comments Development Team (PCDT) Presentation:

Identifying a Pathway Toward Maximizing Participation in Population-Based Total Cost of Care (PB-TCOC) Models

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September 16, 2024

Objectives of This Theme-Based Meeting

- Discuss the vision for future accountable care relationships and identifying pathways toward having all Medicare beneficiaries with Parts A and B in them by 2030
- Understand the necessary components for success in developing PB-TCOC models for different types of providers
- Discuss the organizational structure, payment, and financial incentives needed to support PB-TCOC models
- Identify approaches for addressing key issues and challenges – such as performance measures, attribution, benchmarking, and risk adjustment – related to facilitating accountable care relationships in PB-TCOC models

Context for This Theme-Based Meeting

- PTAC has received 35 proposals for physician-focused payment models (PFPMs).
- Nearly all of these proposals addressed the potential impact on costs and quality, to some degree.
- Committee members found that 20 of these proposals met Criterion 2 (Quality and Cost), including five proposals that were determined to meet all 10 of the criteria established by the Secretary for PFPMs.
  - Additionally, at least nine other proposals discussed the use of TCOC measures in their payment methodology and performance reporting.

Agenda

Background

Analysis of Beneficiary and Geographic Area Characteristics

Potential Factors for Forming a Vision for Future PB-TCOC Models and Necessary Components for Success

Potential Milestones for Maximizing Participation in PB-TCOC Models

Technical Issues and Challenges Affecting Participation in APMs

PTAC Working Definition of an Accountable Care Relationship

- PTAC is using the following working definition of an 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.*
- This definition will likely continue to evolve as the Committee collects additional information from stakeholders.

PTAC Working Definition of PB-TCOC Models

- PTAC is using the following working definition of PB-TCOC models:
  - *Alternative Payment Model (APM) in which participating entities assume **accountability for quality and TCOC** and receive payments for **all covered health care costs*** for a broadly defined population with varying health care needs during the course of a year (365 days).*
  - *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.*
- This definition will likely continue to evolve as the Committee collects additional information from stakeholders.

*For this purpose, all covered health care costs does not include pharmacy-related costs (Medicare Part D)

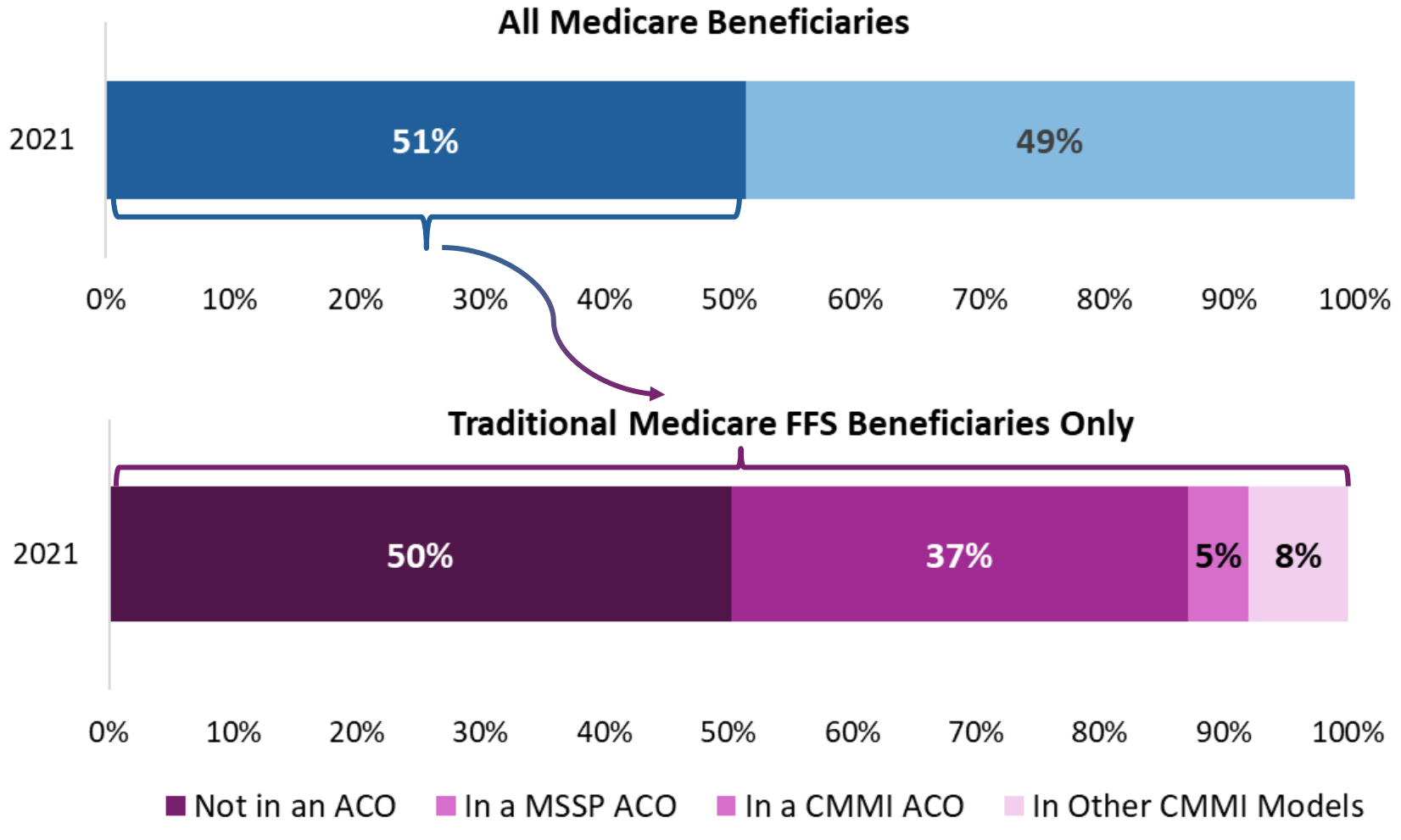
Key Questions for Identifying Pathways Toward Having All Medicare Beneficiaries in Accountable Care Relationships

- PTAC has identified the following key questions for identifying pathways toward having all Medicare beneficiaries with Parts A and B in accountable care relationships:
  - *Categorizing Medicare beneficiaries by the extent to which they are currently in care relationships with accountability for quality and/or TCOC.*
  - *Characterizing geographic areas by the extent to which their providers are participating in value-based care.*
  - *Identifying model characteristics associated with success.*
  - *Developing approaches, models, target timeframes, and intermediary steps for increasing involvement in accountable care relationships for various categories of Medicare beneficiaries (e.g., by dual eligible status, age).*
  - *Identifying and addressing gaps and challenges.*

Medicare Beneficiaries in Alternative Payment Models (APMs), 2021

- As of 2021, half of Medicare beneficiaries (51%) were in traditional Medicare (FFS)

- Half of Medicare FFS beneficiaries (50%) were in APMs in 2021

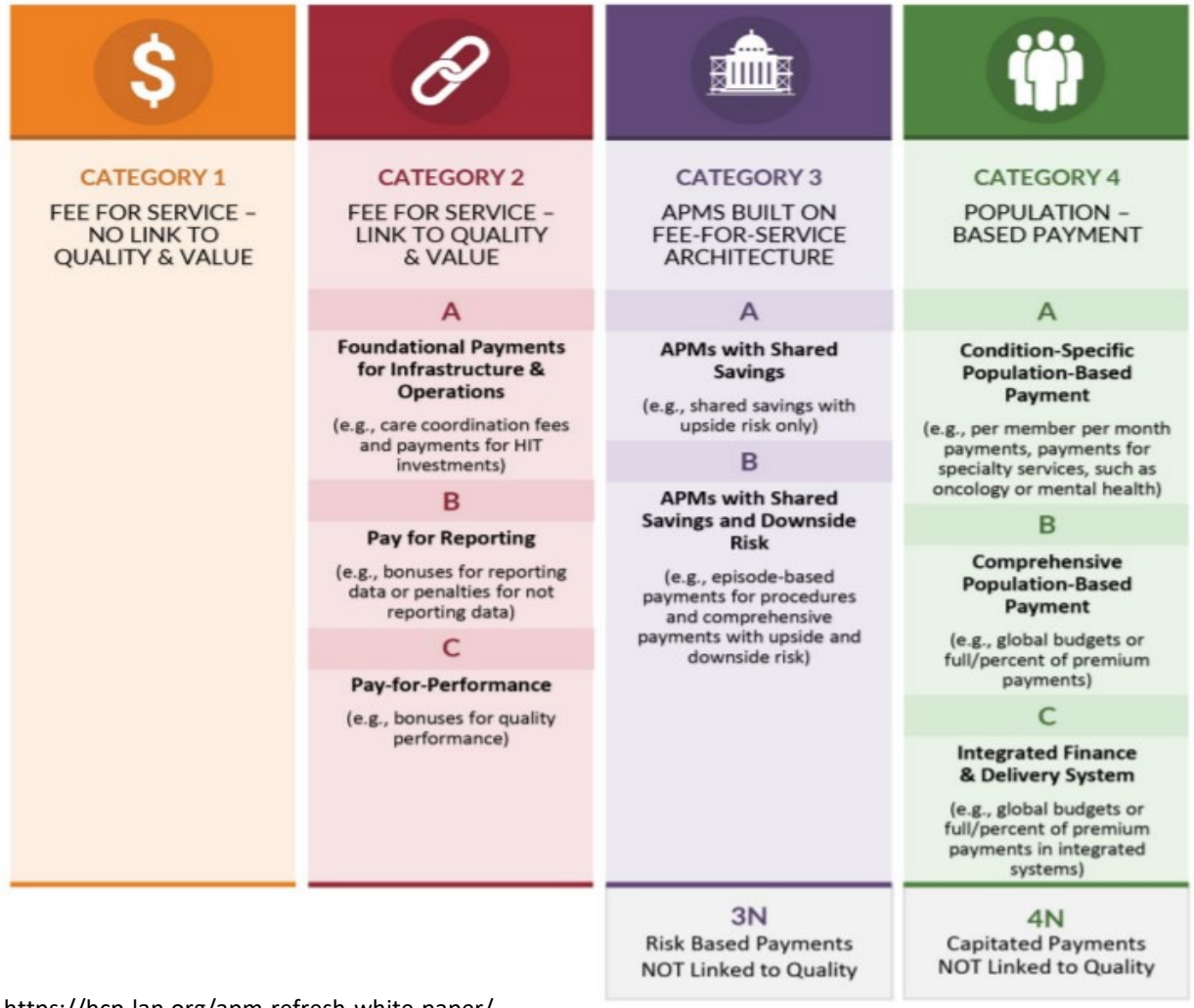


* Note: This analysis includes 21 Advanced Payment Models (excluding Bundled Payments for Care Improvements Initiative (BPCI) and Comprehensive Care for Joint Replacement (CJR) Models)

Based on Analysis by ASPE and Acumen LLC in support of PTAC

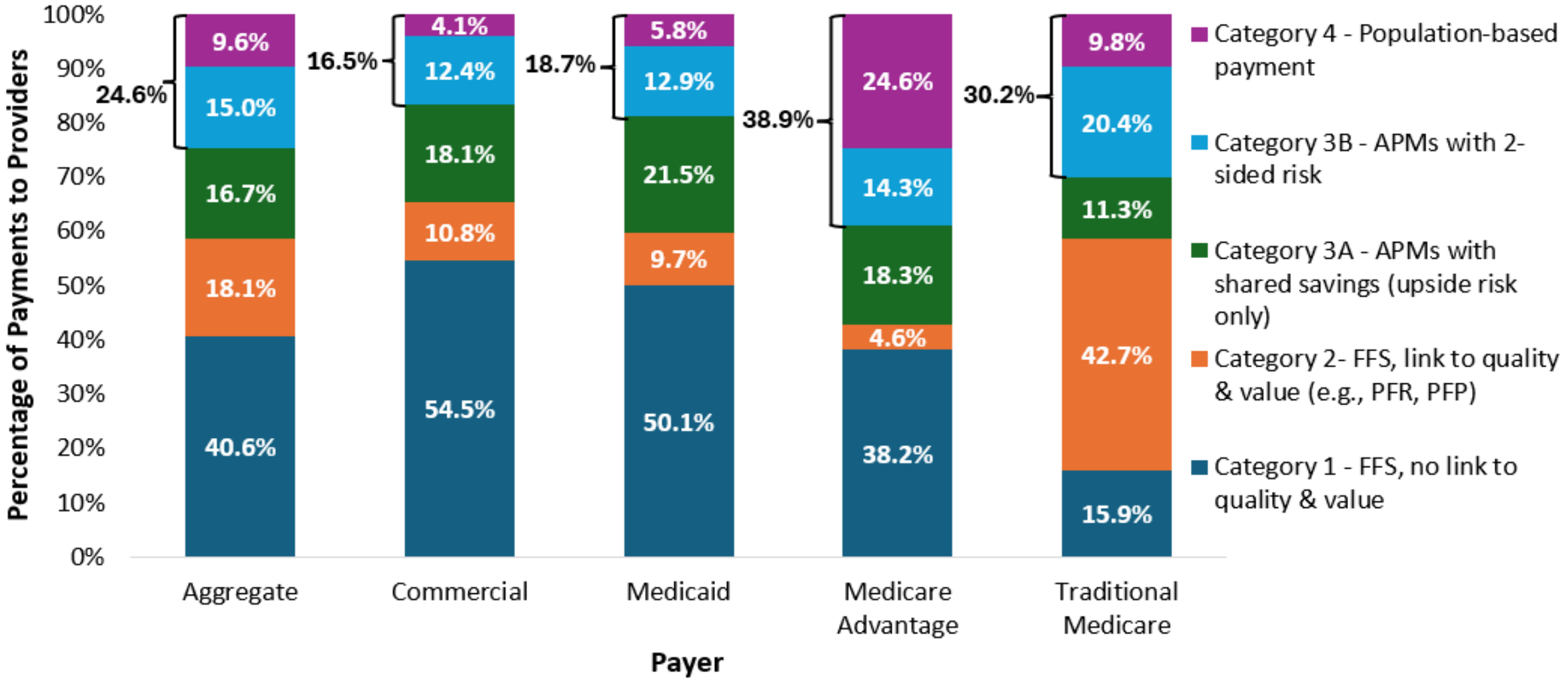
HCP-LAN APM Framework for Supporting the Transition to Population-Based Payment

- The HCP-LAN APM Framework[2] is aligned with the goal of moving payments away from FFS and into APMs with upside and downside risk (Category 3), and population-based payment (Category 4).
- PTAC anticipates that the transition toward population-based payment will help to support accountable care relationships.



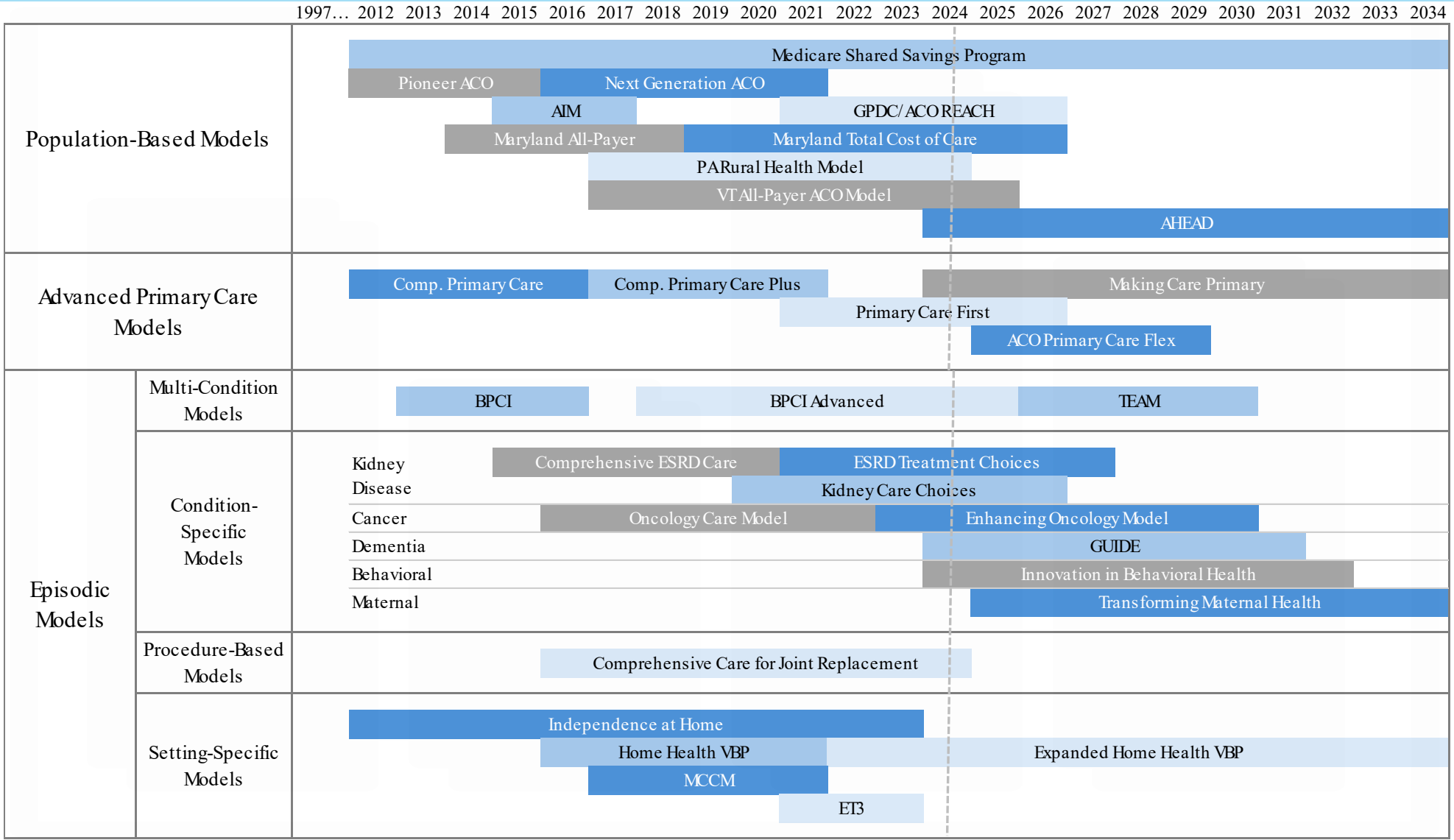
[2] Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Model (APM) Framework: https://hcp-lan.org/apm-refresh-white-paper/

Percentage of Payments to Providers by Alternative Payment Model (APM) Payment Category* and Payer Type, 2022



* Payment categories and data are from the Health Care Payment Learning & Action Network (HCP-LAN)

The Evolution of CMS and Innovation Center Models

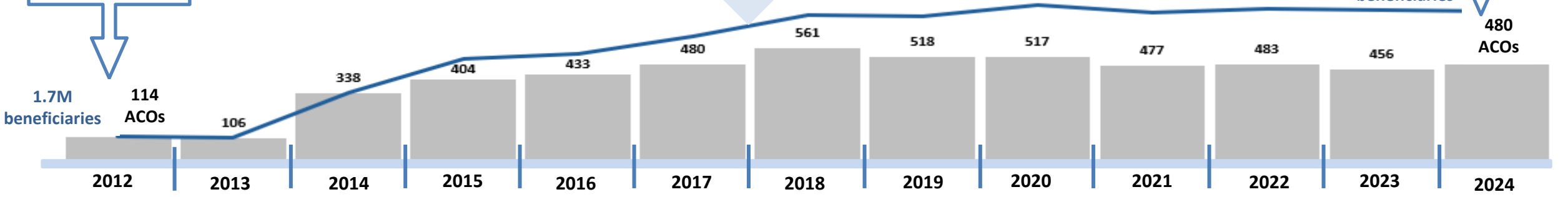


The Evolution of the Medicare Shared Savings Program

July 2012
114 ACOs and 1.7M Beneficiaries

January 2018
Addition of Track 1+
- Two-sided risk model with *less* downside risk than Tracks 2 and 3
- Designed to encourage more practices, especially small practices, to advance to performance-based risk

Jan 2024
480 ACOs and 10.8M Beneficiaries



July 2012
Medicare Shared Savings Program established
- **Track 1**: One-sided risk only
- **Track 2**: Two-sided risk, with moderate level of downside risk

January 2016
Addition of Track 3
- Two-sided risk model with higher levels of downside risk than Track 2
- Incorporates elements of the Pioneer ACO Model

July 2019
Pathways to Success redesign
- **BASIC Track**: Eligible ACOs start with one-sided risk (Level A/B), shift to two-sided risk (Level C/D/E), phasing in higher levels of risk over time
- **ENHANCED Track**: Highest two-sided risk option, intended for more experienced and higher-revenue ACOs.
- ACOs automatically advance to the next step on the glide path at the start of each performance year.

Key Changes in CMMI Model Design Over Time

Increasing Financial Accountability	• Introduced more financial risk over time, such as the MSSP Pathways to Success redesign, global budget models (e.g., PARHM, AHEAD), and capitation options (e.g., GPDC/ACO REACH).
Accommodating Providers Less Able to Take on Risk	• Added lower risk options, including Track 1+ in MSSP, payment floors for CAHs in AHEAD, and new Entrant track in GPDC/ACO REACH.
Reducing Provider Burden	• Streamlined administrative burden (e.g., quality reporting) across programs and payers (e.g., VT All-Payer, AHEAD, MCP).
Increasing Duration of Models	• Announced four models since 2023 that have performance periods of 8 years or more (e.g., IBH, MCP, AHEAD, TMaH) in contrast to earlier models of approximately 5 years in duration.
Supporting Low-Revenue ACOs (Small and Rural Practices)	• Incentivized ACOs for small and rural areas using advanced global budgets to cover inpatient and outpatient services (PARHM) and a PPCP monthly payment in lieu of a fee-for-service payment (ACO PC Flex).
Incorporating Health Equity	• Recent models (e.g., Accountable Health Communities, PARHM, VT All-Payer, REACH, and AHEAD) include more explicit health equity and population health goals as part of the model outcomes.
Incorporation of Specialists	• Initiated a deliberate strategy to incorporate specialist consultations and focus on specialty care in addition to primary care (e.g., GUIDE, TMaH)

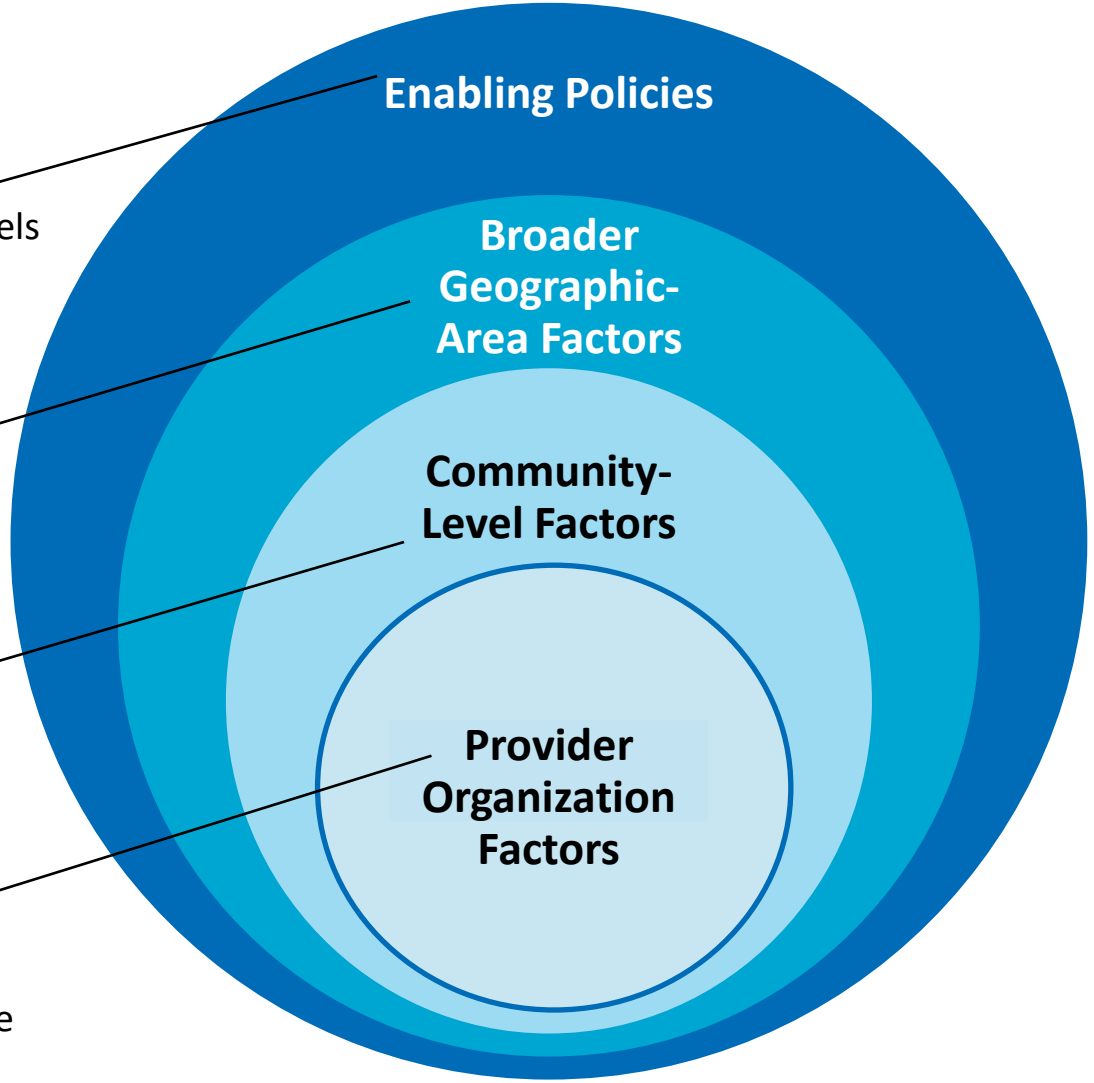
Factors Affecting Medicare FFS Beneficiary Alignment with APMs

- Predictability of APM models (duration, incentives)
- Availability of APM models for different types of providers
- Relationship between APM models and other options

- Medicare Advantage (MA) penetration
- MSSP penetration
- Socioeconomic status (Area Deprivation Index)
- Rurality

- Primary care provider capacity
- Provider market consolidation
- Community-based organizations addressing SDOH

- Provider type (panel size, clinical integration)
- Experience with value-based care Infrastructure and processes



Evidence From Published Literature

ACO Participation More Likely	ACO Participation Less Likely
Urban location	Rural location
Northeast, South, Midwest	West
Moderate MA penetration	Lower MA penetration
Multispecialty practice	Single specialty or solo practice
Hospital-owned	Physician-owned
Involves PCPs	Does not involve PCPs
Integrated EHR system	Non-integrated EHR system
Previous risk experience	No previous risk experience

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New ASPE Analysis on Characteristics of Medicare FFS Beneficiaries Attributed to APMs and Geographic Participation in APMs

Research Questions

- ❑ Which providers are participating in various types of APMs (MSSP/CMMI), where are these providers located, and how it changed in the last decade?
- ❑ How does provider participation affect the number and characteristics of beneficiaries in APMs?
- ❑ What opportunities exist to increase participation in APMs across all geographic regions?

Goals

- ❑ Examine trends in Medicare FFS beneficiaries attributed to APMs
- ❑ Analyze demographics, HCC risk scores, healthcare spending, and utilization patterns
- ❑ Examine the geographic distribution of APM participation by county, CBSA, and socioeconomic status (ADI).

Sample

- ❑ Medicare FFS beneficiaries, 2012-2022 (100% Sample, 30 million beneficiaries each year)
- ❑ Data on beneficiaries attributed to 21 APMs (excluding BPCI and CJR)
- ❑ Excludes beneficiaries in MA for any part of the year

Based on Analysis by ASPE and Acumen LLC in support of PTAC

The ASPE Analysis Includes Data on Medicare FFS Beneficiaries Attributed to 21 APMs*

APM Categories	List of APMs Included in the Analysis*
MSSP ACO *(2 models)*	MSSP Only, MSSP with Comprehensive Primary Care Plus (CPC+)
CMMI ACO *(3 models)*	Pioneer, NGACO, GPDC/ACO-REACH
Advanced Primary Care *(6 models)*	Physician Group Practice Transition Demonstration, Multi-payer Advanced Primary Care Demonstrations, Medicare Health Care Quality Demonstration – 646 Demonstration for North Carolina, Comprehensive Primary Care Initiative (CPCI), Comprehensive Primary Care Plus (CPC+, non-MSSP participants), Primary Care First
Maryland Global Payment	Maryland Total Cost of Care (MDTCOC): Primary Care Program
Vermont Global Payment	Vermont All-Payer Model
Chronic Conditions *(4 models)*	Comprehensive ESRD Care, Kidney Care Choices, Value in Opioid Use Disorder Treatment Demo, ESRD Treatment Choices Model
Other CMMI *(4 models)*	Medicare-Medicaid Coordination Office Financial Alignment Demonstration (Duals), Community Based Care Transition, Medicare Health Quality Demo (646 Demonstration for Indiana), Independence at Home Practice Demonstration

* Note: This analysis does not include beneficiaries attributed to the Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) models.

Based on Analysis by ASPE and Acumen LLC in support of PTAC

Half of All Medicare FFS Beneficiaries With Parts A and B Were Attributed to APMs in 2021

	Number of Beneficiaries (millions)	% of FFS in APMs
Total FFS Beneficiaries with Parts A and B	**29.45**	
Total FFS Beneficiaries in APMs	**14.64**	**49.7%**
Total FFS Beneficiaries ACOs (MSSP + CMMI ACOs)	**12.27**	**41.6%**
CMMI ACO (Pioneer,Next Gen,GPDC)	1.43	4.9%
MSSP ACO (MSSP Only, MSSP with CPC+)	10.84	36.8%
Total FFS Beneficiaries Other CMMI Models (Adv PC, Chronic Cond, Global Payment, Other)	**2.37**	**8.1%**
Advanced Primary Care	1.65	5.6%
Maryland Global Payment	0.43	1.5%
Vermont All-Payer Model	0.05	0.2%
Other CMMI	0.04	0.1%
Chronic conditions	0.21	0.7%

Note: APM models includes 21 CMMI/MSSP models used in this analysis. Does not include BPCI and CJR.

Based on Analysis by ASPE and Acumen LLC in support of PTAC

Characteristics of FFS Beneficiaries Who Were Attributed to APMs in 2021*

- Beneficiaries in MSSP, CMMI ACOs and Advanced PC models were **more likely to be NH White, female and living in Metropolitan areas.**
- Beneficiaries in Chronic Condition models were **disproportionately more likely to be Black, Hispanic, male, and to have significantly higher mortality, and higher average HCC Risk Score**
- In 2021, **roughly 38% of FFS beneficiaries had no history of APM attribution between 2012-2020** for the 21 models in this analysis. They were more likely to be Black or Hispanic, Dual eligible, living in Micropolitan or Rural (Noncore) areas, and to have lower HCC Risk Score.

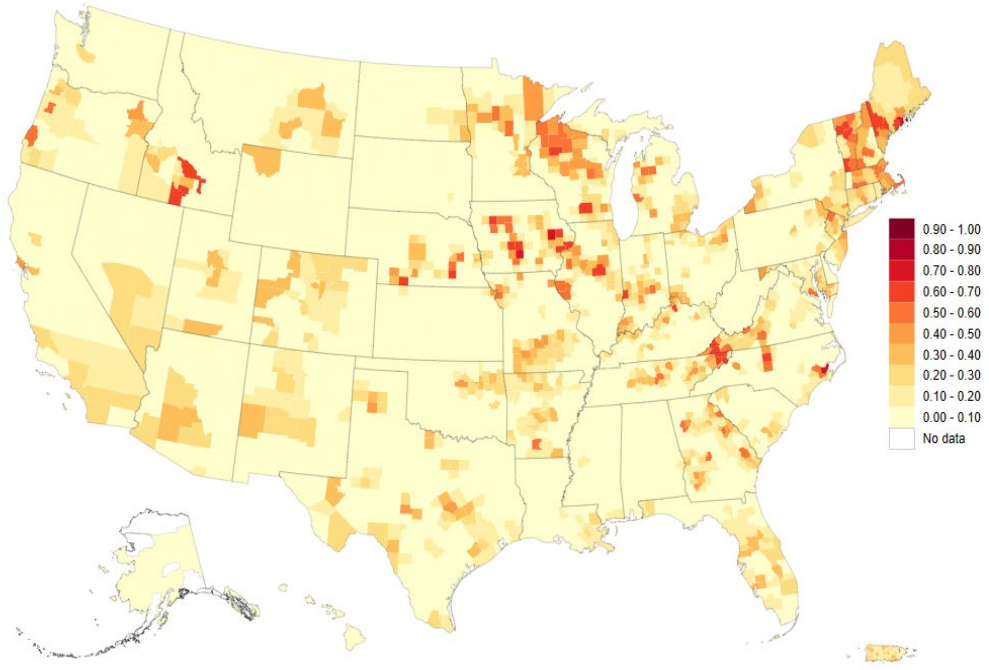
	FFS Total	MSSP ACO	CMMI ACO	Adv PC Model	Chronic Cond	NEVER In an APM
Average Age	72	73	73	73	67	70
White NH	80.4%	84.3%	83.9%	85.8%	51.8%	76.2%
Black NH	7.7%	6.6%	5.8%	4.6%	28.1%	8.6%
Hispanic	5.6%	3.9%	4.0%	3.0%	11.6%	7.6%
Other(API, AI/AN other)	6.3%	5.1%	6.3%	6.6%	8.5%	7.6%
Dual	16.0%	13%	12%	10%	35%	19%
Male	45.2%	43.1%	43.0%	42.2%	55.0%	48.8%
Female	54.8%	56.9%	57.0%	57.8%	45.0%	51.2%
Metropolitan(%)	79.1%	82.0%	87.4%	83.8%	84.8%	74.7%
Micropolitan	11.9%	10.8%	7.4%	11.0%	9.3%	13.8%
Rural (Noncore)	9.0%	7.2%	5.2%	5.2%	5.9%	11.3%
Mortality Rate	4.7%	3.8%	4.0%	4.0%	17.0%	4.1%
Avg Risk Score	1.2	1.3	1.3	1.2	3.3	1.0

*** Note:** APM models includes 21 CMMI/MSSP models used in this analysis. Does not include BPCI and CJR. Used OMB's CBSA definitions to distinguish between Metropolitan, Micropolitan and Rural (Noncore) counties.

Based on Analysis by ASPE and Acumen LLC in support of PTAC

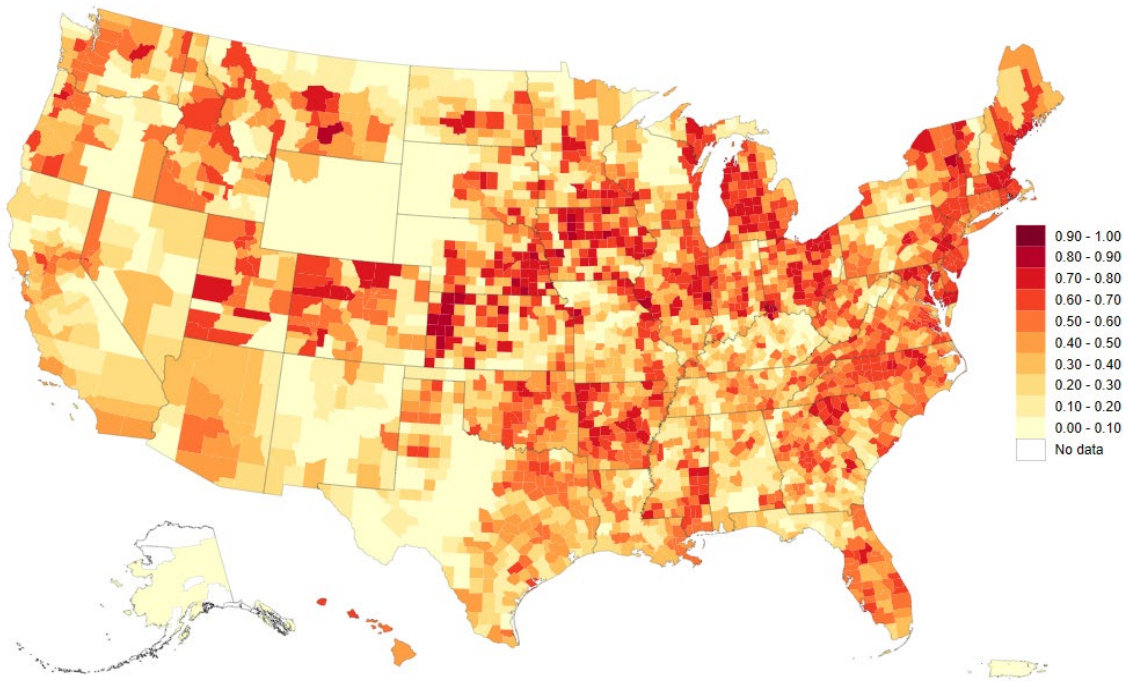
Significant Growth and Variation in APM Penetration Among Medicare Beneficiaries Across the United States, 2013-2022

CMMI or MSSP Penetration by County, 2013



Average APM penetration rate in 2013 was 15%. Significant variation across counties (p10=0.5%, p50=11%, p90=35%).

CMMI or MSSP Penetration by County, 2022



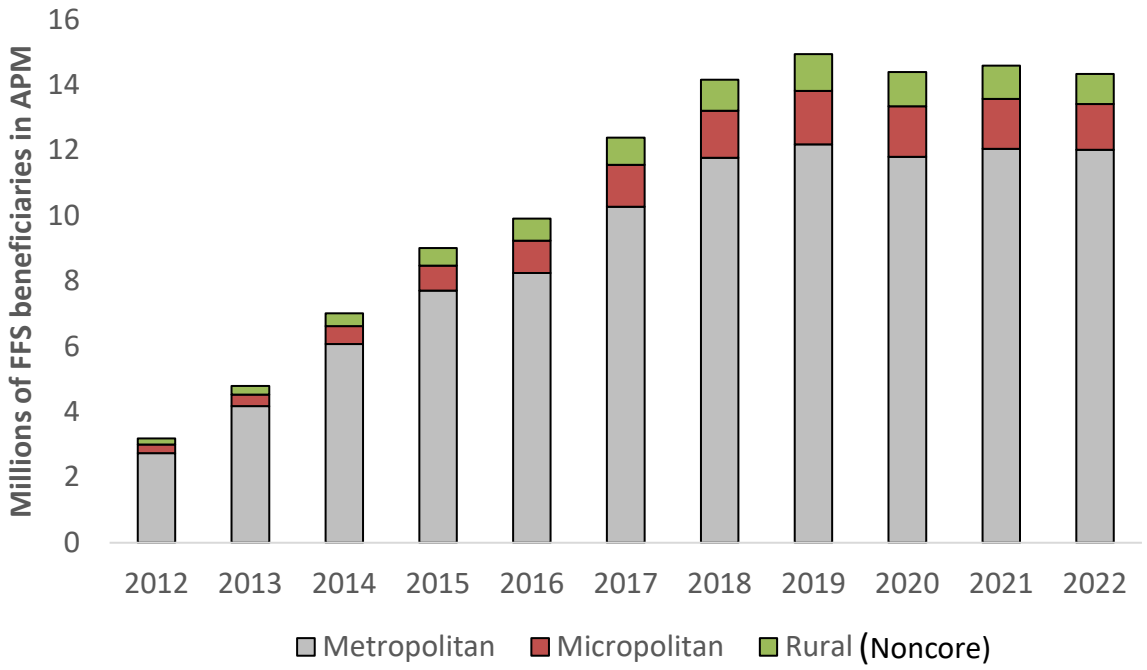
Average APM penetration rate in 2022 was 49%. Significant variation across counties (p10=20%, p50=51%, p90=70%)

Note: APM models includes 21 CMMI/MSSP models used in the analysis. Does not include BPCI and CJR.

Based on Analysis by ASPE and Acumen LLC in support of PTAC

Although There Has Been Growth, Rural Areas Still Have Lower APM Penetration Rates

- The annual growth rate (2012-2022) in APM model penetration was high: 16% in Metropolitan, 18% in Micropolitan, and 18% in Rural (Noncore) Areas



- Still significantly lower penetration of CMMI models in Rural (Noncore) and Micropolitan Area in 2022

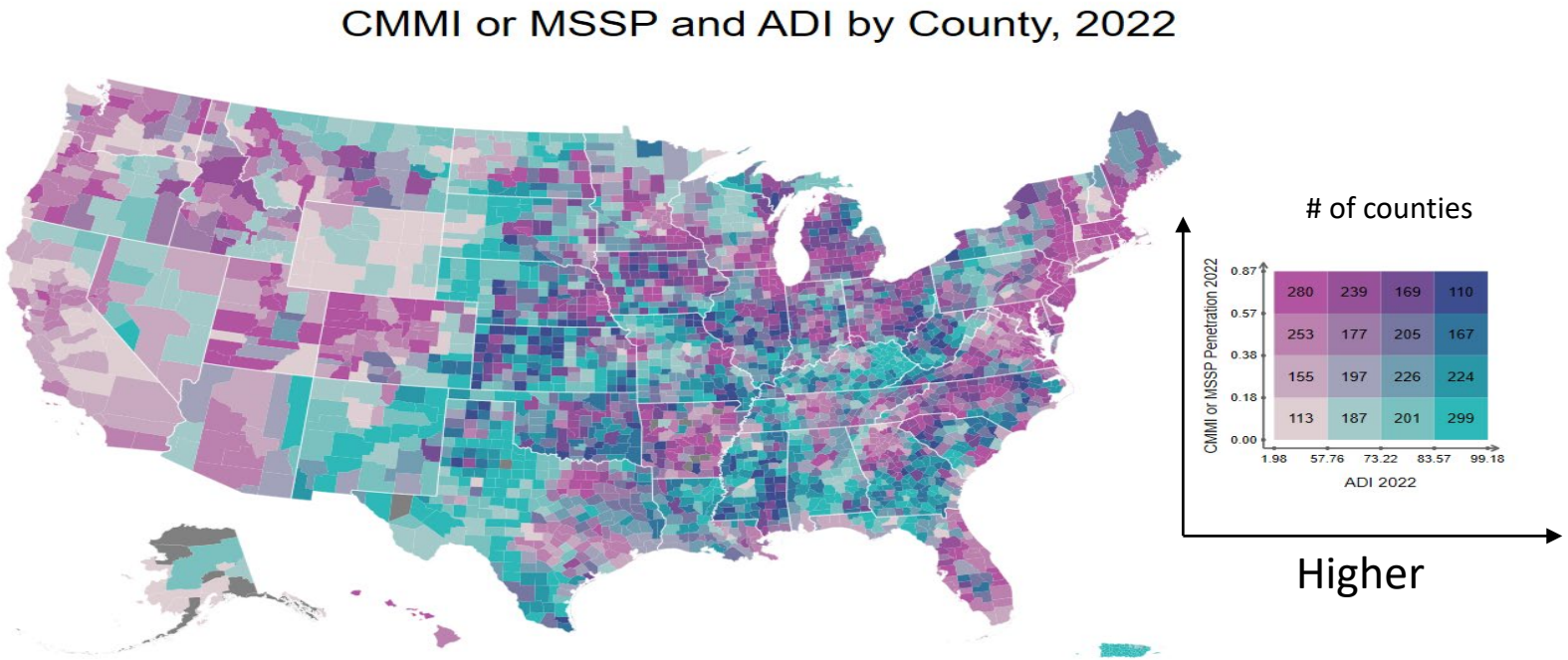
APM Participation (2022)

	CMMI	MSSP	CMMI/MSSP
Rural (Noncore)	10%	26%	34%
Micropolitan	13%	29%	41%
Metropolitan	20%	35%	52%

Note: APM models includes 21 CMMI/MSSP models used in the analysis. Does not include BPCI and CJR.

Based on Analysis by ASPE and Acumen LLC in support of PTAC

There is Significant Variation in APM Penetration Rates and Area Deprivation Index (ADI) Rates Across U.S. Counties



113 counties: Low APM - Low ADI

110 counties: High APM- High ADI

280 counties: High APM- Low ADI

299 counties: Low APM- High ADI

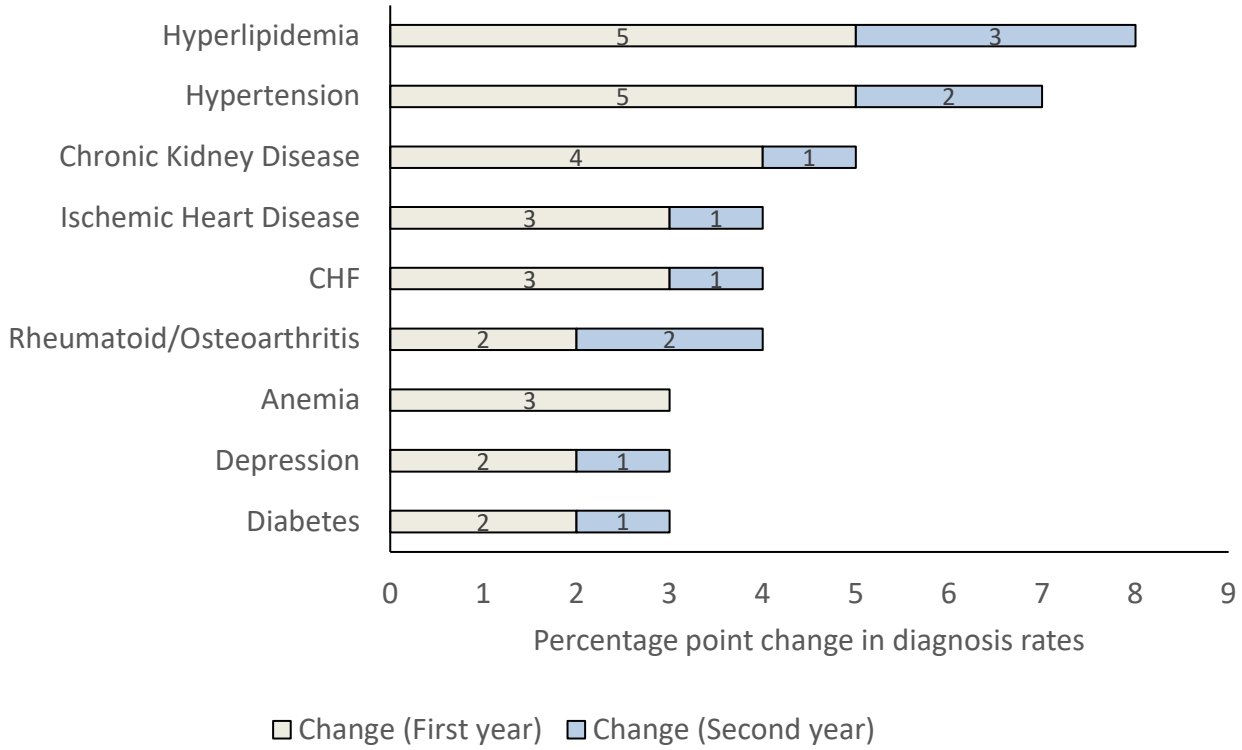
- Low negative correlation between APM penetration and Area Deprivation Index (Correlation coefficient =-0.12*, p<0.05)
- There are roughly 300 counties in the US with Low APM participation and High ADI rate, and perhaps potential target for CMMI health equity models
- Disproportionately high number of these High-ADI/Low-APM penetration counties are in the South and Mid-West region

Note: APM models includes 21 CMMI/MSSP models used in the analysis. Does not include BPCI and CJR.

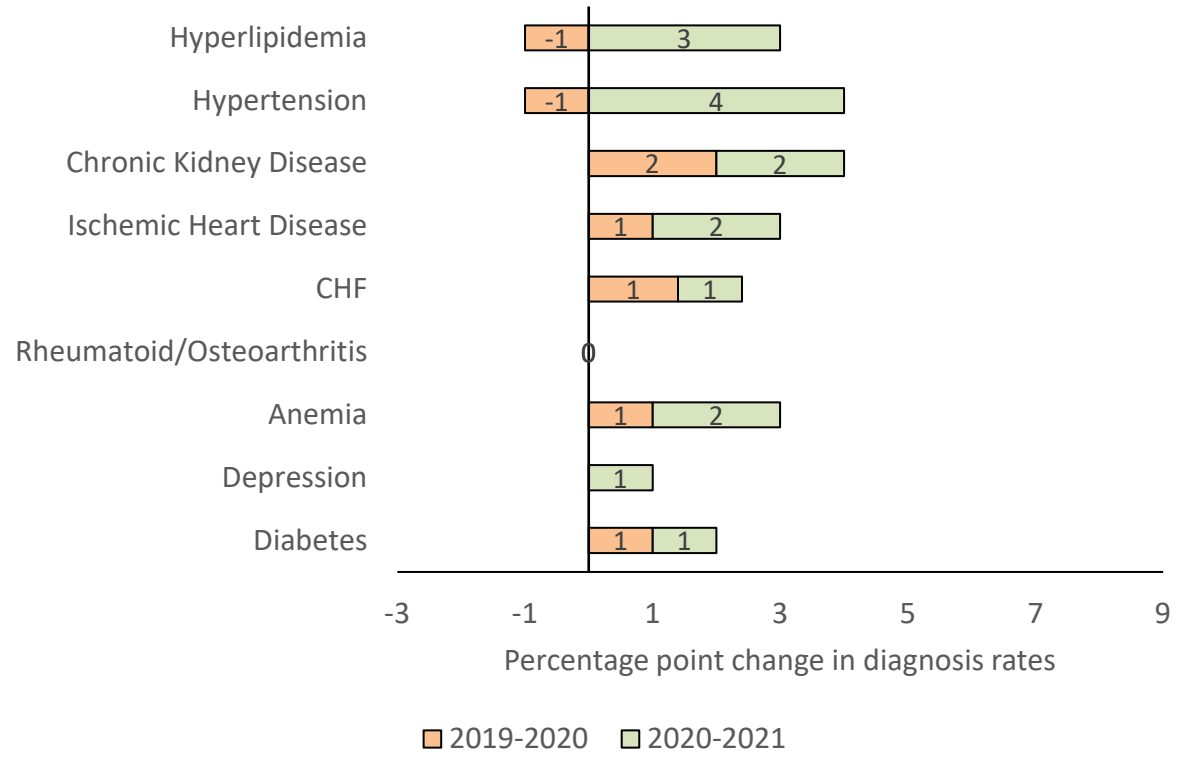
Based on Analysis by ASPE and Acumen LLC in support of PTAC

APM Model Participation on Average Increases Diagnoses of Certain Chronic Conditions

- Beneficiaries entering APM models, on average, have more diagnoses of Cardiovascular risk factors, Chronic Kidney disease, and some other chronic conditions within the first two years of participation.



- In 2021, beneficiaries who had Never been attributed to one of the 21 APMs in this analysis between 2012 and 2021 had a smaller increase in diagnosis of these conditions



Note: APM models includes 21 CMMI/MSSP models used in the analysis. Does not include BPCI and CJR. Data include beneficiaries present in all 3 years

Based on Analysis by ASPE and Acumen LLC in support of PTAC

Key Takeaways From the ASPE Analysis

- Nearly half of all Medicare FFS beneficiaries were not in APMs in 2021.
- Significant growth and variation in APMs over the last decade among Medicare FFS beneficiaries across the United States counties.
- Rural (Noncore) counties are still significantly behind in APM participation.
- Many high ADI counties still have low APM penetration rates and can be a potential target for CMMI health equity models.
- APM participation on average increases diagnoses of certain cardiovascular risk factors and chronic conditions.

Note: APM models includes 21 CMMI/MSSP models used in the analysis. Does not include BPCI and CJR.

Based on Analysis by ASPE and Acumen LLC in support of PTAC

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Potential Factors for Forming a Vision for Future PB-TCOC Models

- Implement a comprehensive framework for PB-TCOC models encompassing population-based models and advanced primary care models
- Develop multiple pathways with varying levels of risk for different types of organizations to encourage participation in PB-TCOC models
- Align incentives across PB-TCOC models, other Medicare accountable care programs, and all payers to encourage high-value care in all settings
- Ensure consistency and longevity in PB-TCOC models
- Involve primary and specialty care providers, with clear and complementary roles, in accountable care relationships
- Address disparities and health-related social needs by incorporating health equity-related objectives

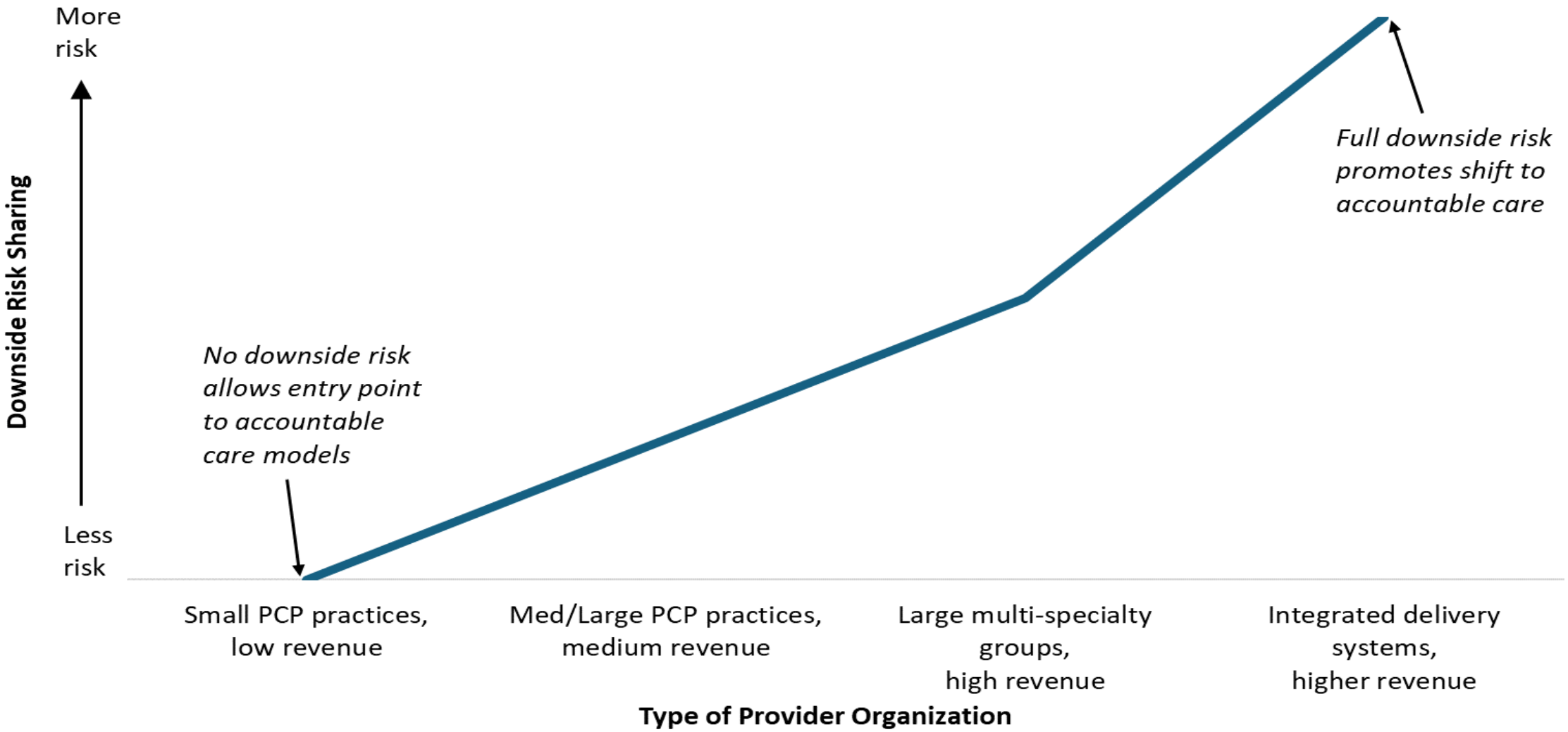
Potential Components for Successful PB-TCOC Models

- Facilitating participation of a full range of providers in different geographic areas (e.g., small/large, rural/urban)
- Integrating specialists with the multidisciplinary patient care team
- Maintaining patient choice
- Attributing each patient to an entity or provider that is accountable for their quality, outcomes, and TCOC
- Providers must have sufficient data to manage patient care
- Ensuring timely and usable data on organization, practice, and provider performance

Potential Components for Successful PB-TCOC Models (continued)

- Providing clear incentives for value-based payment paired with disincentives for FFS payment
  - Should financial risk and savings be shared downstream at the individual provider level?
  - Should downside risk be incorporated where appropriate?
- Aligning financial incentives across types of providers
- Ensuring predictability and adequacy of payments that allow providers and practices to invest in longer-term care transformation activities

Potential Examples of Multiple Participation Tracks with Differing Risk-Sharing Options, Based on Organization Type



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Potential Milestones and Components Needed to Achieve the Accountable Care Relationship Goal

Milestone 1: Care Transformation Support

- Meaningfully engage and integrate primary and specialty care providers in PB-TCOC models
- Provide technical assistance and resources to build infrastructure
- Address technical issues related to attribution, benchmarking, and risk adjustment
- Identify and provide health-related social needs (HRSNs) to applicable beneficiaries

Milestone 2: Increasing Predictability of PB-TCOC Model Elements

- Standardize technical aspects and calculations where possible
- Consider introducing a multi-payer framework into PB-TCOC models
- Require all models to collect the same, or similar, data elements regarding social determinants of health (SDOH)

Milestone 3: Widespread Participation in PB-TCOC Models

- Make accountable care the financially viable choice
- Adapt the level of financial risk based on organizational characteristics
- Simplify administrative and technical burden of participation
- Increase participation in high Area Deprivation Index (ADI) areas

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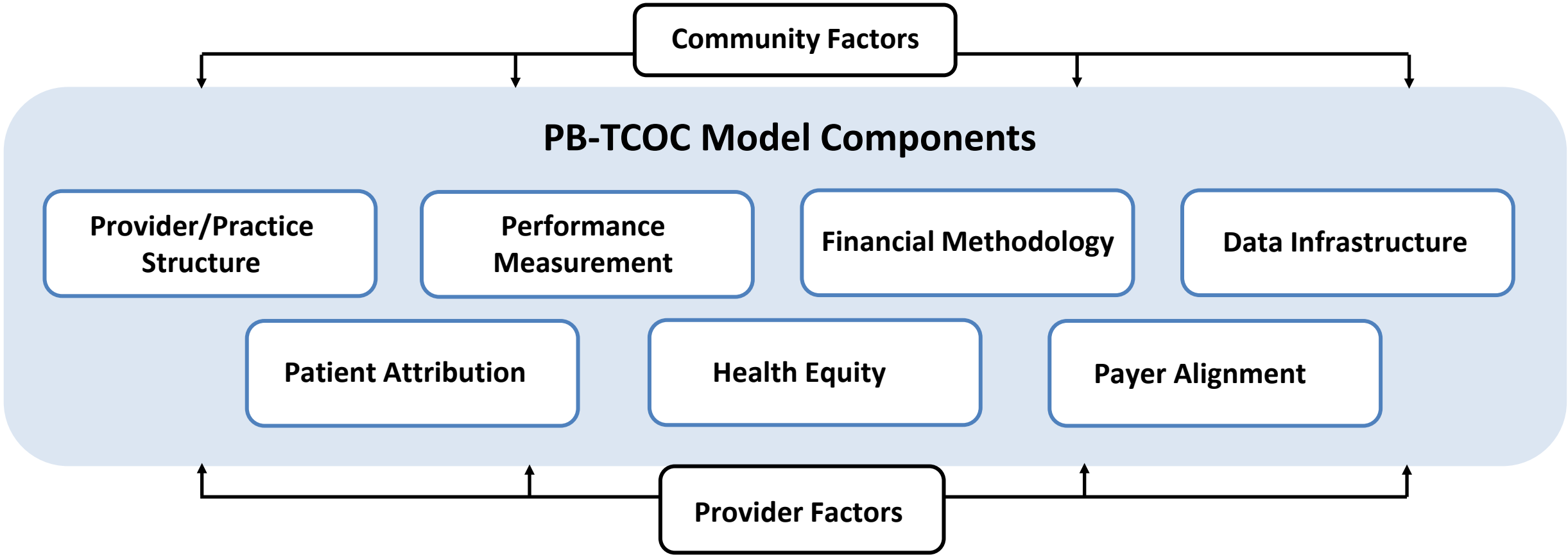
Issues and Challenges Affecting Participation in PB-TCOC Models



Challenges for Increasing Participation in PB-TCOC Models

Complexity of number and types of APMs
Duration of many APMs is not long enough to allow successful implementation
Administrative and infrastructure burden to participation
Traditional FFS is profitable and does not include risk-bearing
Health equity is not a central component of many models
Challenges with expertise, technology, and costs to participation in APMs: • Need to develop new infrastructure (e.g., care management teams) • Financial downside risk involved with cost-sharing in some APMs • Ability to collect and analyze the necessary performance data
Barriers are particularly acute for small, low-revenue, and rural practices

Potential Barriers to Provider Participation in ACOs

- **Size of practice and patient population**
  - Practices with fewer providers, fewer Medicare beneficiaries per provider, and a lower proportion of PCPs were less likely to participate in payment reform programs (including MSSP ACO)
- **Costs associated with ACO participation**
  - Rural health clinics (RHCs) that joined an ACO experienced a substantial increase in mean cost per visit over two years compared with RHCs that did not join an ACO
- **ACO participation decisions may be primarily made by organizations**
  - The majority of physicians are employed by hospitals or corporate entities (increase from 62.2% in January 2019 to 77.6% in January 2024)

PTAC Public Meeting Focus Areas

- Perspectives on Developing a Pathway Toward the 2030 Goal of Having All Beneficiaries in Care Relationships with Accountability for Quality, Outcomes, and TCOC
- Stakeholder Perspectives on a Pathway Toward Developing PB-TCOC Models
- Organizational Structure, Payment, and Financial Incentives for Supporting Accountable Care Relationships
- Developing a Balanced Portfolio of Performance Measures for PB-TCOC Models
- Addressing Challenges Regarding Data, Benchmarking, and Risk Adjustment

Appendix A
Additional Information About Beneficiary and Geographic Area Characteristics

Data – Medicare Fee-for-Service (100% Sample)

Beneficiary (2012-2022) ~ 30 million each year

- **Demographics –** Age, Gender, Race/Ethnicity
- **27 CCW Chronic Conditions**
- **Risk Score**
- **Dual Eligibility**
- **Area Deprivation Index** (5-digit beneficiary zip code)
- **Geographic identifiers**
- County, MSA, State Identifiers
- Metro, Micro, Rural (Noncore) (CBSA definition)
- **Spending, Utilization**
- **High-Low value Cares**
- **Area level vertical integration measures**

APM models include 21 CMMI/MSSP models used in the analysis

- Advanced Primary Care (6 models)
- CMMI ACO (3 models)
- Other CMMI (4 models)
- Chronic Conditions (4 models)
- Maryland Global Payment
- Vermont Global Payment
- MSSP
- CPC+ (MSSP)

Note: APM models includes 21 CMMI/MSSP models used in the analysis. Does not include BPCI and CJR.

Based on Analysis by ASPE and Acumen LLC in support of PTAC

21 APM models used in the analysis

Model #	Model Name	Grouping	Year
7	Pioneer	CMMI - ACO	2012-2016
21	Next Generation	CMMI - ACO	2016-2021
63	Global and Professional Direct Contracting(GPDC) Model , ACO Reach, 2023)	CMMI - ACO	2021-2022
2	Physician Group Practice Transition Demonstration	CMMI - Adv PC	2012
3	Multi-payer Advanced Primary Care Demonstrations	CMMI - Adv PC	2012-2014
9	Medicare Health Care Quality Demonstration – 646 Demo for North Carolina	CMMI - Adv PC	2012
12	Comprehensive Primary Care Initiative (CPCI)	CMMI - Adv PC	2012-2016
22	Comprehensive Primary Care Plus (CPC+), non-SSP Participants	CMMI - Adv PC	2017-2022
57	Primary Care First	CMMI - Adv PC	2021-2022
56	Maryland Total Cost of Care (MDTCOC): Primary Care Program (CMMI)	MDTCOC	2019-2022
53	Vermont All-Payer Model (CMMI)	VT All Payer	2019-2022
11	Medicare Medicaid Coordination Office (MMCO) Financial Alignment Demonstration (Duals)	CMMI - Other	2013-2022
13	Community Based Care Transition	CMMI - Other	2012-2017
14	Medicare Health Care Quality Demonstration – 646 Demo for Indiana	CMMI - Other	2012
1	Independence at Home Practice Demonstration	CMMI - Other	2012-2017, 2019 -2022
18	Comprehensive ESRD Care (CEC)	CMMI - Chronic Condition	2015-2022
66	Kidney Care Choices	CMMI - Chronic Condition	2021-2022
71	Value in Opioid Use Disorder Treatment Dem	CMMI - Chronic Condition	2021-2022
64	ESRD Treatment Choices Model	CMMI - Chronic Condition	2021-2022
8	Medicare Shared Savings Program (MSSP)	MSSP - ACO	2012-2022
23	Comprehensive Primary Care Plus (CPC+), SSP Participants	MSSP - ACO	2017-2022

Note: APM models includes 21 CMMI/MSSP models used in the analysis. Does not include BPCI and CJR.

Based on Analysis by ASPE and Acumen LLC in support of PTAC

Two-Thirds of All Medicare FFS Beneficiaries With Parts A and B Were Either in Medicare Advantage or Attributed to APMs in 2021

Number of Medicare Beneficiaries with Parts A and B in Alternative Payment Models, 2021

Description (not mutually exclusive)	Number of Beneficiaries (Millions)	% of FFS	% of Total
Total Medicare Beneficiaries with Parts A and B	**57.41**		**100.0%**
Total FFS Beneficiaries with Parts A and B	29.45		51.3%
Total in Medicare Advantage (for any part of the year)	27.96		48.7%
Total FFS Beneficiaries in APMs	**14.64**	**49.7%**	**25.5%**
Total FFS Beneficiaries ACOs (MSSP + CMMI ACOs)	**12.27**	**41.6%**	**21.4%**
CMMI_ACO (Pioneer,Next Gen,GPDC)	1.43	4.9%	2.5%
MSSP_ACO (MSSP Only, MSSP with CPC+)	10.84	36.8%	18.9%
Total FFS Beneficiaries Other CMMI Models (Adv PC, Chronic Cond, Global Payment, Other)	**2.37**	**8.1%**	**4.1%**
CMMI_Advanced_Primary Care	1.65	5.6%	2.9%
Maryland (TCOC)	0.43	1.5%	0.7%
Vermont (All Payer)	0.05	0.2%	0.1%
CMMI_Other	0.04	0.1%	0.1%
CMMI_ChronicCond	0.21	0.7%	0.4%

Note: APM models includes 21 CMMI/MSSP models used in the analysis. Does not include BPCI and CJR.

Based on Analysis by ASPE and Acumen LLC in support of PTAC

Beneficiary Characteristics Differ by APM Model Types (2021)

	FFS Total	MSSP_ACO (MSSP Only, MSSP with CPC+)	CMMI_ACO (Pioneer,Next Gen,GPDC)	CMMI Adv PC	MDTCOC	VT All Payer	CMMI Other	CMMI CC	Never APM
Number of beneficiaries	29,450,961	10,836,056	1,429,360	1,645,744	427,475	53,631	40,706	206,900	10,809,986
Age	72	73	73	73	73	72	68	67	70
Dual Eligible	16%	13%	12%	10%	14%	27%	82%	35%	19%
HCC Risk Score	1.2	1.29	1.28	1.22	1.18	1.13	2.49	3.25	1.00
County MA Penetration rate	43%	43.3%	46.0%	45.4%	19.1%	20.1%	42.8%	45.0%	43.1%
Mortality	4.7%	3.8%	4.0%	4.0%	3.2%	3.9%	16.5%	17.0%	4.1%
Gender									
Female	55%	57%	57%	58%	59%	57%	64%	45%	51%
Male	45%	43%	43%	42%	41%	44%	36%	55%	49%
CBSA									
Metro	*79.1%*	82.0%	87.4%	83.8%	95.8%	39.3%	83.1%	84.8%	74.7%
Micro	*11.9%*	10.8%	7.4%	11.0%	2.3%	41.4%	12.1%	9.3%	13.8%
Rural (Noncore)	*9.0%*	7.2%	5.2%	5.2%	2.0%	19.4%	4.8%	5.9%	11.3%
Enrollment Reason									
Aged	*79.5%*	82.8%	83.7%	84.5%	82.4%	75.3%	44.9%	45.8%	0.76
Disability	*19.9%*	16.8%	15.8%	15.3%	17.4%	24.5%	52.9%	22.1%	0.228
ESRD	*0.4%*	0.2%	0.3%	0.1%	0.1%	0.0%	1.1%	23.3%	0.2%
ESRD + Disability	*0.2%*	0.2%	0.2%	0.1%	0.1%	0.2%	1.1%	8.8%	1.2%
Race/Ethnicity									
NH White	*80.4%*	84.3%	83.9%	85.8%	70.0%	92.2%	71.3%	51.0%	76.5%
NH Black	*7.7%*	6.6%	5.8%	4.6%	21.5%	1.4%	9.4%	28.1%	8.6%
Hispanic	*5.6%*	3.9%	4.0%	3.0%	2.2%	1.4%	7.7%	11.6%	7.6%
NH API	*2.8%*	2.1%	3.1%	2.7%	2.8%	0.2%	7.4%	4.0%	3.3%
NH AI/AN	*0.5%*	0.2%	0.1%	0.8%	0.1%	0.0%	1.9%	1.8%	0.9%
Other	*0.8%*	0.7%	0.7%	1.0%	1.0%	0.0%	0.6%	1.7%	0.8%
Unknown	*2.1%*	2.1%	2.3%	2.1%	2.5%	4.9%	1.7%	1.7%	2.3%

Note: APM models includes 21 CMMI/MSSP models used in the analysis. Does not include BPCI and CJR.

Based on Analysis by ASPE and Acumen LLC in support of PTAC

ASPE Analysis Geographic Area Definitions – Metropolitan, Micropolitan and Rural

- The ASPE analysis uses the Office of Management and Budget (OMB's) county-level core-based statistical area (CBSA) definitions to distinguish between Metropolitan, Micropolitan and Rural (Noncore) areas.

OMB CBSA Classification	Description
Metropolitan	Metropolitan counties consist of at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.
Micropolitan*	Micropolitan counties have at least one urban cluster of at least 10,000 but less than 50,000 population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.
Rural (Noncore)*	Noncore counties are those that do not have an urban core population of 10,000 or more. These counties are considered the most rural of this designation.

* OMB's definition of Rural areas includes both Micropolitan and Noncore counties.

Based on Analysis by ASPE and Acumen LLC in support of PTAC

Geographic Area Definitions – U.S. Census Bureau Regions and Divisions

Region	Division	States
Northeast	New England	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Northeast	Middle Atlantic	New Jersey, New York, Pennsylvania
Midwest	East North Central	Illinois, Indiana, Michigan, Ohio, Wisconsin
Midwest	West North Central	Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
South	South Atlantic	Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
South	East South Central	Alabama, Kentucky, Mississippi, Tennessee
South	West South Central	Arkansas, Louisiana, Oklahoma, Texas
West	Mountain	Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
West	Pacific	Alaska, California, Hawaii, Oregon, Washington

Based on Analysis by ASPE and Acumen LLC in support of PTAC

Appendix B
Examples of Issues and Challenges Affecting Participation in PB-TCOC Models

Challenges Related to Provider/Practice Structure

Organizational Structure	• Developing paths to involvement in PB-TCOC models for different organizational types with different priorities • Determining degree of voluntary versus mandatory participation • Ensuring equal opportunities for small and rural practices to participate in addition to larger practices and integrated delivery systems
Participation Requirements	• Small and rural practices may be unable to comply and/or stay in business • Practices with substantial business with alternative payers (e.g., employer/commercial space) may choose to not accept Medicare • Beneficiaries may switch from FFS to Medicare Advantage plans, which may or may not be structured as accountable care relationships
Specialty Integration / Nesting	• Engaging and integrating specialists who cover specific conditions and acute care episodes • Utilizing nesting of specialty/condition/procedure-specific bundles within whole-person accountability models

Challenges Related to Performance Measurement

Balanced Portfolio of Measures	• Selecting the right mix of measures to assess provider performance • Balancing structure, process, and outcome measures • Incorporating patient-reported outcome and patient experience measures (PROMs and PREMs)
Measure Specifications	• Developing a standardized specification for each measure used across payers and models • Minimizing the administrative burden of measurement
Linking Performance to Payment	• Incentivizing organizations to provide high-quality care • Ensuring organization-level payments are shared downstream with individual providers

Challenges Related to Financial Methodology

Financial Incentives	• Aligning financial incentives to increase high-value and high-quality care • Balancing cost-sharing (upside/downside risk) to allow entry into and encourage participation in PB-TCOC models
Benchmarking	• Selecting the most appropriate geographic area (e.g., national, regional) and re-basing methodologies • Ensuring practices are not unfairly benchmarked against themselves • Minimizing the complexity of benchmarking (e.g., number of data sources, statistical computing needs)
Risk Adjustment	• Accounting for greater needs of higher acuity patients while incentivizing high-value care • Ensuring data completeness

Challenges Related to Data Infrastructure

Data Sources	• Ensuring timely access to the necessary data to allow providers opportunities to adapt • Obtaining the technical expertise and resources needed to analyze the data and interpret results
Data Interoperability	• Eliminating or reducing technical and data governance issues
Data Quality	• Ensuring data source completeness for valid measurement results • Capturing the full range of data sources that represent the entire spectrum of patient care • Obtaining data for key health-related social factors

Challenges Related to Other PB-TCOC Model Components

Patient Attribution	• Determining which physicians should be accountable for a patient's care • Ensuring patient alignment and coordination across providers and models
Health Equity	• Ensuring incentives support health equity goals (e.g., via risk adjustment) • Removing opportunities to "cherry pick" healthier patients for greater incentives and payments • Ensuring ability for underserved patients to participate
Payer Alignment	• Ensuring coordination with other payers, including Medicare Advantage, Medicaid, and commercial payers

Appendix C
Value-Based Care Components of Selected CMMI Models

Key Value-Based Care Components of Selected CMMI Models

Model	Clinical Focus	Value Based Care and Technical Components
Global and Professional Direct Contracting (GPDC)/Accountable Care Organization Realizing Equity, Access, and Community Health **(ACO REACH)**	Primary and specialty care	**Overall Model Design Features:** ACO REACH brings together health care providers, including primary care physicians (PCPs), specialty providers, and hospitals, to form an ACO. **Approaches to Improve Specialty Integration:** Higher risk sharing arrangements and risk-adjusted monthly payments for all covered costs under total care capitation option (which includes payment for specialty care services). **Approaches to Address Health Equity:** ACO REACH requires health equity plans, benchmark adjustments, data collection, nurse practitioner services benefit enhancement, and scoring for health equity experience. **Financial Methodology:** Two risk-sharing options: 1) Professional: 50% savings/losses, participants receive a primary care capitation payment (risk-adjusted monthly payment for primary care services; 2) Global: 100% savings/losses, participants can receive either a primary care capitation payment or a total care capitation payment (risk-adjusted monthly payment for all covered services, including specialty care).
Bundled Payments for Care Improvement Advanced **(BPCI-A)**	Cross-clinical focus	**Overall Model Design Features:** BPCI-A requires participants to coordinate care across all providers/settings for the duration of the clinical episode, which begins at the start of an admission or procedure and ends 90 days after hospital discharge or completion of a procedure. **Approaches to Improve Specialty Integration:** Establishes an “accountable party” and shifts emphasis from individual services to clinical episodes **Approaches to Address Health Equity:** Not specified **Financial Methodology:** Participants (or Episode Initiators [EIs]) receive a retrospective bundled payment or are required to pay a Repayment Amount based on reconciliation against the benchmark/target price.

Key Value-Based Care Components of Selected CMMI Models (continued)

Model	Clinical Focus	Value Based Care and Technical Components
Enhancing Oncology Model **(EOM)**	Oncology	**Overall Model Design Features:** EOM participants coordinate care for cancer patients across all their providers and services needed, including health-related social needs and psychosocial health needs. **Approaches to Improve Specialty Integration:** Participants are incentivized to provide additional/enhanced services via Monthly Enhanced Oncology Services (MEOS) payments; additionally, each patient receives a detailed care plan, specifying engagement and preferences surrounding prognosis, treatment options, symptom management, quality of life, and psychosocial health needs. **Approaches to Address Health Equity:** EOM requires health equity plans, risk adjustments by dual-eligible status and Low-Income Subsidy eligibility, and collection and reporting of beneficiary sociodemographic data. Further, participants are provided dashboards displaying metrics stratified by sociodemographic data in order to identify applicable health disparities. **Financial Methodology:** Participants are responsible for total cost of care for 6-month episodes; based on total episode costs and quality performance, participants will earn a performance-based payment (PBP) or owe a performance-based recoupment (PBR). Participants also have the option to bill a Monthly Enhanced Oncology Services (MEOS) payment per beneficiary per month during 6-month episodes for the provision of Enhanced Services. Additional MEOS payments for dually eligible beneficiaries may also be provided to participants.
Making Care Primary Model **(MCP)**	Primary care	**Overall Model Design Features:** MCP provides participants with three options that build upon past primary care models (Comprehensive Primary Care [CPC], CPC+, and Primary Care First [PCF]) to take on prospective, population-based payments, build infrastructure to integrate specialty care and behavioral health, and improve access to care. **Approaches to Improve Specialty Integration:** CMS provides Upfront Infrastructure Payments (UIPs) for participants to build infrastructure needed to integrate specialty care, such as partnering with specialists and social service providers and implementing care management services. **Approaches to Address Health Equity:** MCP requires health equity plans, payment adjustments, and implementation of HRSN screening and referrals. Additionally, participants can reduce cost-sharing for certain patients, as applicable. **Financial Methodology:** Varies depending on the three options, or tracks: Track 1) FFS; however, participants may earn financial rewards for improving patient outcomes, Track 2) 50% FFS and 50% prospective, population-based payments, and Track 3) 100% prospective, population-based payments.

Key Value-Based Care Components of Selected CMMI Models (continued)

Model	Clinical Focus	Value Based Care and Technical Components
Maryland Total Cost of Care (TCOC) Model	Hospital and primary care	**Overall Model Design Features:** The Maryland TCOC Model expands on the Maryland All-Payer Model by providing incentives for providers to coordinate care and holding the state accountable for a sustainable growth rate in per capita TCOC spending. It includes three programs: 1) Hospital Payment Program, 2) Care Redesign Program, and 3) Maryland Primary Care Program. **Approaches to Improve Specialty Integration:** Implementation of care coordination plans and patient-centered care teams **Approaches to Address Health Equity:** Little information is available on how the program addresses health equity; however, payment incentives could improve care management. **Financial Methodology:** Payments differ among the three programs: 1) Hospital Payment Program- each hospital receives population-based payment amount for all hospital services, 2) Care Redesign Program- hospitals may make incentive payments to nonhospital providers who perform care redesign activities for the hospital. Hospitals may only give incentive payments if they have achieved savings under its fixed global budget, and 3) Maryland Primary Care Program- participating primary care practices receive an additional per beneficiary per month payment for care management services.

Appendix D
Value-Based Care Components of Selected PTAC Proposals

Selected PTAC Proposals that Included Value-Based Care Components

Nearly all of the 35 proposals that have been submitted to PTAC addressed the potential impact on cost and quality. Committee members found that 20 of these proposals met Criterion 2 (Quality and Cost), including 5 proposals that were determined to meet all 10 of the regulatory criteria established by the Secretary for PFPMs.

Proposalwq	Clinical Focus	Value Based Care and Technical Components
American College of Emergency Physicians (ACEP) (*Provider association/ specialty society*) Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions	Emergency department (ED) services	**Overall Model Design Features:** AUCM aims to coordinate care post discharge from ED. **Approaches to Improve Specialty Integration:** Ensure follow-up care when barriers exist to primary or specialty care access; mandated physician to physician communication when patients are discharged from the ED, or admitted or placed on observation status **Approaches to Address Health Equity:** Not specified **Financial Methodology:** Episode-based, bundled payment; if spending for eligible and attributed episodes is less than the bundled payment target price, the participant is eligible for a positive reconciliation payment; if it is more, the participant will have to reimburse CMS. Also includes payment waivers for ED acute care transition services, telehealth services, and post discharge home visits.

Selected PTAC Proposals that Included Value-Based Care Components (continued)

Proposal	Clinical Focus	Value Based Care and Technical Components
Avera Health (*Regional/local multispecialty practice or health system*) Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM)	Primary care (geriatricians) in skilled nursing facilities (SNFs)	**Overall Model Design Features:** The ICM SNF APM aims to provide care for nursing facility residents through 24/7 access to a geriatrician care team (GCT) using telemedicine. **Approaches to Improve Specialty Integration:** Addresses multidisciplinary care in SNFs following an acute event, establishing accountability or negotiating responsibility; geriatrician-led, multidisciplinary team where GCT responsible for medication reconciliation, and medication management is handled in coordination with the primary care provider (PCP) **Approaches to Address Health Equity:** Not specified **Financial Methodology:** Two-tier payment: one-time payment for new admission care and an ongoing monthly payment for post-admission care. It also discusses an option to make this a shared savings model.
Icahn School of Medicine at Mount Sinai (Mount Sinai) (*Academic institution*) "HaH-Plus" (Hospital at Home-Plus): Provider-Focused Payment Model	Inpatient services in home setting	**Overall Model Design Features:** HaH Plus aims to provide hospital-level services in a home setting for beneficiaries with certain acute conditions. **Approaches to Improve Specialty Integration:** Multidisciplinary care around an acute care event providing pre-acute, acute, and transition services **Approaches to Address Health Equity:** HaH Plus serves underserved populations and provides culturally sensitive health care. **Financial Methodology:** Prospective, episode-based payment replacing FFS and with flexibility to support non-covered services; shared risk through retrospective reconciliation

Selected PTAC Proposals that Included Value-Based Care Components (continued)

Proposal	Clinical Focus	Value Based Care and Technical Components
Renal Physicians Association (RPA) (*Provider association and specialty society*) Incident ESRD Clinical Episode Payment Model	End- stage renal disease (ESRD)	**Overall Model Design Features:** The Incident ESRD Clinical Episode Payment Model proposes care coordination and renal transplantation, if applicable, for dialysis patients transitioning from chronic kidney disease (CKD) to ESRD (six-month episodes of care). **Approaches to Improve Specialty Integration:** Coordination among medical specialists and dialysis providers **Approaches to Address Health Equity:** Not specified **Financial Methodology:** Episode-based model with continued FFS payments and an additional payment for transplant; one- and two-sided risk options
Personalized Recovery Care (PRC) (*Regional/local single specialty practice*) Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home	Inpatient services in home setting	**Overall Model Design Features:** Home Hospitalization APM is an operational program in Marshfield, Wisconsin where participants provide treatment to commercial and MA patients with certain acute conditions in their home or SNF instead of in the hospital. **Approaches to Improve Specialty Integration:** Multidisciplinary care around an acute care event **Approaches to Address Health Equity:** Not specified **Financial Methodology:** Retrospective bundled payment with two components: 1) risk payment compared with the target cost of care (i.e., the "Target Bundled Rate"); and 2) per episode payment ("Home Hospitalization Payment"). If total costs are more than the Target Bundled Rate, participants are 100% liable (up to 10% of the benchmark rate).

Appendix E
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Slide 7 – Medicare Beneficiaries in Alternative Payment Models (APMs), 2021

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Slide 9 – Percentage of Payments by Alternative Payment Model (APM) Payment Category* and Payer Type, 2022

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