Developing and Implementing Performance Measures for Population-Based TCOC Models Request for Input (RFI) Responses

On March 26, 2024, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public on information that could describe current perspectives on developmenting and implementing performance measures for population-based total cost of care (PB-TCOC) models and physician-focused payment models (PFPMs). PTAC has received two responses from the following stakeholders listed below:

1. Coalition to Transform Advanced Care (C-TAC)
2. American Academy of Otolaryngology-Head andNeck Surgery (AAO-HNS)

For additional information about PTAC's request, see PTAC's solicitation of public input.

C+TAC
COALITION TO TRANSFORM ADVANCED CARE

April 25, 2024

Re: Developing and Implementing Performance Measures for Population-Based TCOC Models Request for Input (RFI)

Submitted electronically to PTAC@HHS.gov

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to respond to this RFI regarding the impact of performance measures for PB-TCOC models on those living with serious illness.

C-TAC is a national non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises more than 200 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC defines serious illness as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life, or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF).

Responses to RFI Questions

1)What should be the main goals of performance measurement for PB-TCOC organizations (for example, to drive change through financial incentives, to ensure quality of care, to provide actionable information for providers, or to inform beneficiary choices)?

The main goals of such measures should be to confirm the quality of the patient's experience. That would encompass the key aspects of care: access, affordability, timeliness, and clinical components addressing the person's quality of life, their ability to be a partner in the plan of care and treatment plan, and their satisfaction with communication and information being provided. We also advocate for assessment and support of the family caregiver since they are a key partner in ensuring people with serious illness get the care they need.

We do not see the need for PB-TCOC models measurement to differ from those of other APMs.

2) *What are the most important desired performance characteristics that should be measured at the organizational level for PB-TCOC models*?

We recommend that PB-TCOC models should consider a range of performance characteristics including:

- Demographics of those accessing and utilizing services, including race/ethnicity, socioeconomic status, gender, and geography
- Completion and timeliness of assessments including those for cognitive and physical function, caregiver status and burden, pain, goals for care, and health related social needs
- Beneficiary and caregiver experience of care
- Provider and care team experience of care
- Health services utilization and costs, including primary care provider visits, inpatient admissions, readmissions, timeliness of care delivery/delays in care, pharmacy benefit utilization, access to home-based services, and hospice length of stay
- Quality, including transitions of care and advance care planning

3) *What types of measures should be used to monitor and incentivize PB-TCOC models' performance related to these desired performance characteristics (for example, quality measures, outcome measures, process measures)?*

We recommend:

- A mixture of process, outcomes, and quality measures to ensure that there is appropriate and timely access to appropriate services and transitions of care between settings, timely access to screenings and referrals to address a person's clinical and non-clinical needs, documentation of encounters or visits provided by a person's care team, and ongoing measurement related to outcomes, quality, patient and caregiver experience, and provider experience of care.
- It is beneficial to have a balanced scorecard of performance, process, and outcomes measures to ensure fidelity to evidence-based care pathways, access to care, health equity, appropriate utilization of services, and patient, caregiver, and provider experience. It is difficult to require healthcare providers to collect data that can be found in administrative claims. This includes measures related to utilization and cost. We recommend that healthcare providers be given more timely access to administrative claims data related to the patients they care for in order to improve performance and inform care delivery processes.
- In addition, while we advocate for the systematic collection of assessment information, clinical documentation of encounters delivered by non-billable providers, and experience of care, it is acknowledged that the majority of electronic medical records do not have this functionality as part of their core function and therefore require healthcare providers to customize or configure these systems to collect these data.
- That healthcare providers participating in PB-TCOC models have access to resources to improve data collection and documentation within the electronic medical record and

that CMS issue guidance and requirements related to how these data are collected. By ensuring these data can be documented systematically and in a standardized format through the electronic medical record, this would ease administrative burden on the healthcare providers participating in these models of care.

- Many healthcare providers, including health systems, are unable to issue experience of care surveys for a subset of their overall population but gathering such information is vital. We therefore recommend that PTAC advocate for the development of experience of care measures that can be used across settings and specialties to ensure their highest adoption and completion rate. This includes patient experience of care measures such as the new MIPS #495 "heard and understood" measure.

4) What data sources would be most effective for collecting data on performance measures (e.g., EHR, claims data, administrative data)? Does this vary depending on the type of performance measure?

We recommend:

- Administrative claims data are the best source of data for cost and health services utilization. We recommend that these data be accessible and timely for provider organizations to intervene and improve quality of care delivery based on these outcomes. Administrative data such as encounter documentation is an ideal approach to ensure that services delivered by non-billable members of a person's care team are valued as part of care delivery. However, electronic medical records are often not adequately configured to collect the level of encounter documentation that would ensure a person's care team and the non-medical assessments completed by these team members are systematically captured. These measures are important to reduce the systematic bias related to incomplete data. Electronic medical records are equipped to capture medical services performed and have the ability to document and collect a person's medical information and health status. However, systematic bias can be found as it relates to the documentation of a person's acuity, as neither the electronic medical record nor claims data collect structured information related to a person's function, social determinants of health, caregiver burden, or stage of disease. These have been found to be critical data points to determine a person's health status and overall burden of disease.
- Digital health information technology is beneficial when data can be systematically collected and extracted from structured fields within claims, administrative data, and electronic medical record data. However, data such as assessment completion, CAHPS scores, and experience of care do not have standard requirements to ensure data can be captured in a normal fashion, or to account for low completion rates for these measures. We recommend that PTAC explore interim measures to document and track the completeness of survey, assessment, quality, and experience data in addition to the actual results found as part of the data collection. This would allow CMS to identify areas of the clinical workflow and areas of healthcare delivery where burdensome data collection and low health services utilization impede accurate and timely collection of these data (e.g. rural practices, practices with low volume, or serious illness care

programs).
- That the timeliness of accessing claims data and the accuracy of administrative and enrollment data (e.g. patient demographics and contact information) be monitored to ensure data usability to impact healthcare quality and utilization.

5) To what extent can current performance measures be used to monitor and incentivize PB-TCOC models' performance on desired performance characteristics?

Performance measures such as assessment completion, referrals to services, encounter documentation, and health services utilization (e.g. inpatient, readmission, transitions of care, facility utilization, emergency department utilization, and measures of polypharmacy) are recommended for use in TCOC models. We recommend that documentation of function (physical and cognitive) and family caregiver burden be also systematically collected and that performance measures that span healthcare delivery settings be tested related to these areas. Currently, these measures are documented and collected in specific settings or as specific components of episode-based payment rather than across all healthcare settings. There is wide variation related to the measurement tools used to document function and family caregiver burden, making it difficult to ensure continuity of care across settings and care transitions.

6) What strategies can be used to improve the development of measures that are meaningful to providers and beneficiaries in PB-TCOC models?

We recommend:
- That, instead of simply using claims data to determine health services utilization, encounter documentation requirements be implemented for PB-TCOC models. This would enable CMS to document the services delivered by care teams, including non-medical providers such as nurses, social workers, community health workers, and nursing assistants/aides and better understand the impact of staffing ratios for beneficiaries of varying acuity and across care settings. This is meaningful for providers and health systems to document to ensure appropriate staffing ratios are utilized and that an adequate number of resources are available to meet the needs of beneficiaries. The most beneficial outcomes measures that are related to the drivers of TCOC include admissions, readmissions, emergency department utilization, and measures of polypharmacy. Measures related to 14-day and 30-day readmissions have been identified as effective to improve care transitions, care follow-up, and delays in care.
- That timely data sharing related to these measures occur for participants in these models to ensure that claims and administrative data can be used to impact care delivery and not simply to evaluate annual performance.

7) How should patient/caregiver experience and patient-reported outcomes be measured?
a) To what extent can patient/caregiver experience measures accurately reflect the provision of patient-centered, coordinated care, relative to direct measures of those processes?

We recommend:

- That population-based experience of care measures that can be implemented across settings and specialties be utilized as often as possible. One such measure set includes the previously noted "patient heard and understood" measure. This is not disease-specific and has been tested across accountable care organizations and in specialty care settings such as palliative care and hospice programs.
- That some flexibility in data collection be allowed to incorporate new modes of data collection, such as text messaging, to ensure a higher and more timely survey response rate.
- That patient-reported outcomes and experience measures be collected such that healthcare providers can improve areas where implicit bias occurs, such as in non-white and female populations, who have historically experienced worse care experience and health outcomes than their white, male counterparts.

8) In which contexts does it make sense to have organization-wide vs. specialty-specific or setting-specific performance measures in PB-TCOC models?

We recommend that PTAC and CMS focus primarily on cross-cutting performance and outcomes measures that are not specialty or setting-specific, in order to better capture overall experience of care. However, measures of clinical quality and documentation of clinical assessments are important to vary by care setting and specialty, so that quality of care be accurately and adequately measured.

9) What are best practices for linking financial incentives with performance measures, including quality of care outcomes and patient experience measures?

We recommend:

- That different types of financial incentives be available to incentivize performance, quality, outcomes, and patient experience. Pay-for-reporting has been successful to help health systems and healthcare providers to begin collecting information that has not been previously collected. Examples of this include documentation for health-related social needs, screenings for social determinants of health, and encounter documentation. However, once these data are being collected.
- That incentives based on performance be utilized to ensure that the data being collected are made actionable, either through payment incentives for referrals and timely follow-up on outcomes from assessments, or incentives based on outcomes, performance, and patient experience of care. It may be possible to incentivize providers to reduce health disparities by incentivizing based on improvement in outcomes for certain populations, disease types, settings, and geographies, utilizing demographic, risk, and geographic data to develop benchmarks for improvement. Performance measures should be adjusted to account for social and functional status, as these demonstrate different indicators of need and change a beneficiary's acuity. By adjusting for social and functional status-related factors, providers would be able to vary staffing ratios and care delivery models to improve timely access to care for those with these specific risk

factors. It would also incentivize providers to collect data related to social risk and functional status, as it could lead to different financial incentives that could be utilized to augment the care team and offset costs for transportation, telemedicine supports, and other services that improve timely access to care.

- Risk score caps can negatively impact specialty care providers with a high volume of seriously ill patients where the majority of their patient panel is high risk at baseline and may increase their level of risk over time due to medical or social acuity. Rural specialty care providers and providers delivering care where there are more critical access hospitals or federally qualified health centers are most impacted, as risk score caps slow the increase in risk scoring for populations with high morbidity and less access to community services, making it difficult for providers to be fairly compensated when participating in total cost of care models. While risk score caps can be helpful to reduce coding inaccuracies, these negative impacts should be taken into consideration in order to ensure that rural and specialty care providers are not negatively impacted financially by these caps.

10) How should the approach to performance-based payment (PBP) differ by the type of entity that is being measured (for example, larger entities vs. small practices, degree of experience with value-based payment)?

C-TAC acknowledges the challenges of smaller and rural practices lacking the infrastructure and sophistication in data collection to participate in performance-based payment. We therefore recommend:

- That for these organizations new to performance-based payment or without the necessary volume to manage risk effectively have the opportunity to participate through submission of and incentives for evidence-based process measures and measures of patient experience.
- While there may be some risk in evaluating small practices on patient experience of care, C-TAC recommends that these patient experience measures be considered for upside financial incentives to ensure that practices are rewarded by improved care experience and workflow optimization, even when outcomes measures might not have enough volume to demonstrate meaningful improvements.
- That process measures and experience measures both be collected to ensure that healthcare organizations are incentivized for ensuring quality of care while also improving care processes that would eventually lead to lower overall cost of healthcare when sufficient volume is achieved.

11) What kinds of challenges exist related to implementing various types of performance measures in different kinds of provider settings (for example, information technology, data collection, data quality, administrative burden)? What approaches can be used to address these challenges?

C-TAC applauds CMMI for offering new programs necessary infrastructure investments in newly released models such as the GUIDE model. We recommend that, in order to improve a

healthcare provider's ability to make investments in information technology, data collection, and data quality that would enable the shift to value-based care. Provider organizations such as home health, hospice, federally qualified health centers, and community health centers do not have the same electronic medical record functionality as larger health systems, and smaller and rural hospitals often have not been able to customize electronic medical records based on department or specialty area of care. This limits their ability to participate in PB-TCOC models and value-based payment models because of the inability to track data related to patient encounters, clinical assessments, and care quality. By continuing to make infrastructure investments in these specific types of organizations and specialty care areas, we hope that these system improvements can be made to accelerate the adoption of value-based care delivery.

Thank you for the opportunity to respond to this RFI. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

Marian Grant and Torrie Fields

Advisors
Coalition to Transform Advanced Care (C-TAC)

AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY®

April 26, 2024

VIA ELECTRONIC MAIL

The Centers for Medicare and Medicaid Innovation
C/O The Physician-Focused Payment Model Technical Advisory Committee
7500 Security Boulevard
Baltimore, MD 21244
PTAC@HHS.gov

Re: Developing and Implementing Performance Measures for Population-Based TCOC Models Request for Input

To Whom It May Concern,

On behalf of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS)[1], I am contacting you in response to the request for information regarding the development and implementation of performance measures for population-based total cost of care models. Thank you for allowing the American Academy of Otolaryngology-Head and Neck Surgery's (AAO-HNS) to provide feedback on the Physician-Focused Payment Model Technical Advisory Committee's request for input. AAO-HNSF agrees with the intent believes the care and cost to be the most important characteristics to be measured at the organizational level for this care model. We remain concerned with the lack of transparency and adequate inclusion of outpatient and specialty driven care models.

The AAO-HNS has been working to develop quality-based models that would facilitate otolaryngologist's participation in population-based care models capable of delivering high-value care through evidence-based outcomes and cost measures. This strategy depends on defining what is "best care" and accurately understanding and measuring the true cost of delivering that care. Most of an

[1] The AAO-HNS is the world's largest organization representing specialists who treat the ear, nose, throat, and related structures of the head and neck. The Academy represents approximately 12,000 otolaryngologist-head and neck surgeons who diagnose and treat disorders of those areas.

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otolaryngologist-head and neck surgeon's care is delivered through outpatient services with the exception of treatment of advanced head and neck cancer.

The AAO-HNS relies on a multipronged quality program including performance guidelines, clinical practice guidelines and our qualified clinical data registry (QCDR), Reg-ent. Reg-ent has the capability of collecting complete outpatient medical records from the EHR/EMR's of our participating physicians and we currently have the most complete otolaryngology registry database in the world with over 50 million encounters. We have a working relationship with OM1, a company capable of complex analytics including the addition of a wide range of additional databases that can be combined with the clinical data acquired by Reg-ent to help determine "best care" through outcomes measures as well as perform cost analytics of that care.

We are also developing "episode groupers" for the most common disease processes in our wide spectrum of care based on established clinical pathways used in the day-to-day care of patients with each disease. Accurate pricing can then be determined using this modeling. Our goal is to combine our registry activities with the value-based arm of the initiative to identify the most effective care and be able to price it accordingly in such a way that it can fit in established primary care models as a modular component for otolaryngology-based care.

I. Questions 4 and 11

Our feedback to PTAC's request for input is through the lens of our specialty. We have answered in a format that provides context to the bigger picture of challenges and considerations.
Data quality and availability remains a determining factor on performance measure implementation. The lack of standardized EHR data sharing and limited interoperability impact the availability of data elements and the incentive a provider or practice receives. This disproportionately affects the smaller and rural practices that utilize smaller, less advanced EHRs. These smaller practices also have limited resources to determine the requirements of each program and model. Complete clinical data captured within the EHR, claims (including pharmacy), and administrative data are critical components to effectively implement performance measures. **The lack of support to resolve data blocking by EHR will continue to cripple current**

and future programs. Clinical data registries require true interoperability and standardization.

II. Questions 3, 5, 6, and 7

In review of the active cost and quality measures inventory for otolaryngology specific measures it does not currently support a PB-TCOC model. [Q5] **That being said, AAO-HNSF encourages the prioritization of outcomes, both clinical and PRO-PMs, to monitor and incentivize TCOC models, followed by quality, cost, then frequency.** [Q3] Collaboration between specialty societies and other stakeholders can offer several benefits. First, it promotes buy-in from all involved parties, ensuring that the developed measures are widely accepted and implemented. Additionally, leveraging the subject matter expertise of specialists in a given field helps ensure that the measures are relevant, accurate, and meaningful for the patient population. Finally, breaking down silos in measure development fosters a more comprehensive and cohesive approach to improving healthcare quality and outcomes.[Q6&7]

By working together, stakeholders can create PRO-PMs that truly reflect the patient experience and provide valuable insights into the effectiveness of healthcare interventions. This collaborative effort ultimately leads to better-informed decision-making and improved patient care across specialties. **We would benefit from funding opportunities to develop, test, and maintain measures to meet the program needs.**[Q6&7]

Regarding cost, transparency in cost measures is vital for providers to understand how they can improve their workflow and reduce costs effectively. Without clear insights into how cost measures are calculated, providers struggle to identify areas for improvement. AAO-HNSF's clinical data registry, Reg-ent, works closely with thousands of providers to improve their quality measure scores within a live dashboard that is refreshed bi-weekly. In contrast, the current cost measure feedback is significantly delayed resulting in little to no impact. Based our feedback from our members, it is near impossible to understand how to impact their own cost score.[Q6&7]

III. Questions 8 and 10

For PB-TCOC to succeed, each specialty should assist in the development of best practice parameters. Recognizing the differences in practice patterns and patient populations among different clinician types is essential for designing appropriate quality and cost measures. Measures should be tailored to reflect the unique characteristics and responsibilities of each specialty to ensure fairness and accuracy in assessment. A primary care model would not apply to specialty driven care.[Q8] When specialty driven models are vetted and implemented, all practices, regardless of size, should be held accountable given equal reimbursement and data blocking issues have been resolved.[Q8&10]

In summary, there is potential for a robust and meaningful total cost of care model to promote quality and efficiency. However, the infrastructure needs to be built first to create the platform to improve patient outcome measurement. At minimum, implementing a performance-based payment model requires a multi-faceted approach:

Investment in Health Information Technology: Policymakers should prioritize initiatives aimed at promoting interoperability, standardizing data exchange protocols, and supporting smaller practices in adopting advanced health IT solutions without additional charges.

Specialty Driven Development: The AAO-HNS supports the specialty-driven development of the PB-TCOC model and urges consideration for funding to support its implementation and associated measures.

Support and Education: Providing support and education to smaller practices on data reporting requirements and quality improvement strategies can help improve data quality and performance outcomes. Simplifying reporting processes and reducing administrative burdens can help alleviate the resource constraints faced by smaller practices.

IV. Summary

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infrastructure needs to be built first to create the platform to improve patient outcome measurement. At minimum, implementing a performance-based payment model requires a multi-faceted approach:

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- **Specialty Driven Development:** The AAO-HNS supports the specialty-driven development of the PB-TCOC model and urges consideration for funding to support its implementation and associated measures.

- **Support and Education:** Providing support and education to smaller practices on data reporting requirements and quality improvement strategies can help improve data quality and performance outcomes. Simplifying reporting processes and reducing administrative burdens can help alleviate the resource constraints faced by smaller practices.

We appreciate the opportunity to collaborate with the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on this important issue. We welcome the opportunity to discuss this and any other issues relating to physician-focused payment models for specialty providers. Should you have any questions, please contact: Jmeyer@entnet.org

Sincerely,

James C. Denneny III, MD
Executive Vice President and CEO