Potential Questions for Previous Submitter and SME Listening Session Presenters
March 7, 2022

There will be two listening sessions as part of the March public meeting on population-based total cost of care models. The first session on Monday, March 7 will include four subject matter experts (SMEs). The second session on Tuesday, March 8 will include four SMEs and a previous submitter (Coalition to Transform Advanced Care).[1] Each listening session presentation will be 8-9 minutes. Following the presentations, the Committee members will have the opportunity to pose questions to the presenters.

To facilitate the Committee's discussion with the listening session participants, we have provided some "General Questions" that could potentially be asked of all of the listening session participants. We have also provided some potential questions that may be relevant for each presenter, based on information included in their slide presentations. Committee members can choose to use these questions if desired.

General Questions:

- Can population-based TCOC models and episode based or condition-specific models work in a complimentary fashion to yield optimal results, such as engaging specialists to achieve higher PMPM savings? What criteria should Medicare apply to APMs so that they can work in a more cohesive fashion?
- Since "risk increases with size", how can Medicare as a payer gradually increase the size of the models from episode-based models to entire population-based models and still avoid adverse financial incentives and/ or incentives to cost-shift?
- What are the options for defining and calculating TCOC? How do these definitions differ across models? How, if at all, does the definition of TCOC differ from the perspective of insurers, hospitals, providers, and beneficiaries themselves? Should models consider a standard definition of TCOC?
- How have payment models and incentives influenced physician participation in population-based TCOC models (as defined by the PCDT) to date? What are some of the factors affecting provider readiness to participate in population-based TCOC models? What incentives can be used to encourage provider participation in models based on different levels of readiness?
- What are the potential barriers to physician participation in population-based TCOC models? What are the approaches to help physicians overcome these barriers?
- Given the myriad number of models in play, how can we attribute the benefits to each model and select fewer models? Can the evaluation findings be utilized to create a marketplace with complimentary models?
- What is the potential impact that mandatory participation could have on safety net providers?

[1] During the listening session on Tuesday, March 8, the first two SMEs will present, followed by questions from the Committee members. Then the remaining two SMEs and the previous submitter will present, followed by questions from the Committee members.

March 7 Listening Session

Questions for Michael Chernew "Thoughts on Harmonized APMs"

- How can model participants be incentivized to maintain optimal episode volume for episode-based models?
- What kinds of practices are best suited to support population-based payment?
- What criteria should Medicare apply to select models so that they can work in a more cohesive fashion?

Questions for Cheryl L. Damberg "A Long and Winding Road: Population-based Total Cost of Care Models"

- "*Health systems report not being able to advance care redesign as rapidly as they'd like given the small total share of revenue VBP and total cost models represent of their full "book of business," how* can health systems be incentivized/supported to redesign the model of care for VBP given the fact that it is not a major part of their business?
- How can frontline providers be encouraged to engage in accountable, capitated arrangements? What are some of the specific challenges for smaller, independent practices?
- Are there any antitrust concerns related to provider consolidation under vertical integration?
- What kind of evaluation will be needed for real-time learnings?

Questions for Michael Adelberg, "The Connection between High Value Care and Member Affordability Best Practices in Medicare Advantage Benefits and Services"

- In your opinion, why are ACOs unable to provide for the broad spectrum of social needs for Medicare beneficiaries in the same manner as MA plans?
- How do Medicare Advantage (MA) plans target investment in social needs for Medicare beneficiaries? How do the MA plan actuaries forecast and budget for the socials needs of Medicare beneficiaries? Is it part of the medical loss ratio?
- How are social needs incorporated into care models by MA plans? How do MA plans select Medicare beneficiaries for participation in these initiatives and meet their social needs?
- What is the incentive for MA plans to address high-cost social needs for high-risk Medicare beneficiaries?
- Is there any empirical evidence to demonstrate an optimal return on investment for addressing social needs of Medicare beneficiaries for MA plans?
- Should social determinants of health (SDOH) be included as a factor for MA risk adjustment?
- Are MA plans likely to invest a sizable proportion of the 8 percent increase in their revenues towards meeting the social needs of their Medicare beneficiaries?
- How can health systems be incentivized and supported to redesign the model of care for value-based payment (VBP), given it is not a major part of their business?
- What kinds of evaluation will be needed for real-time insights?

Questions for Chris DeMars, MPH, "Oregon's Health System Reform Journey"

- What steps is Oregon taking to spread VBP across all payers and initiate a regional multi-payer global budget pilot?
- Given the high social needs of the Medicaid population, how does the Oregon Medicaid program use a fixed global budget but still provide flexibility to address social needs?
- How will the state limit health care cost growth to 3 percent every year?
- How does the state support providers' initiatives to focus on social needs? Are there statewide efforts for learning and diffusing best practices for spending on social needs across health systems and providers?