Physician-Focused Payment Model Technical Advisory Committee

PTAC

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Definition and Vision for Population-Based Total Cost of Care (PB-TCOC) Models

HIGHLIGHTS

- Six concepts relate to the desired vision for population-based total cost of care (PB-TCOC) models: 1) a culture of accountability; 2) high-touch, proactive care; 3) eliminating health care disparities; 4) care coordination for underserved populations; 5) evidence-based practices, risk stratification, and data-driven care; and 6) dissemination and uptake of best practices.
- Ten features characterize the ideal care delivery system: 1) multidisciplinary, team-based, patient-centered care; 2) well-coordinated care; 3) seamless management of care transitions; 4) meeting patients where they are; 5) high touch or advanced primary care; 6) balanced use of, and coordination between, primary care and specialty care; 7) targeted population-based interventions to prevent or mitigate populations' risk of developing adverse health outcomes; 8) reducing disparities in care and outcomes; 9) identification of health-related social needs (HRSNs) and connection to appropriate resources; and 10) empowering patients to participate in their care.
- Supporting policies related to payment, performance measurement, specialty integration, risk adjustment and attribution, accessible and actionable data, infrastructure investments, and multi-payer alignment will be critical in the development and implementation of PB-TCOC models.
- There is a need to strengthen a sense of urgency and inevitability surrounding the transition to value-based care. However, some providers may be better equipped than others to take on the costs related to the transition.

INTRODUCTION

Maximizing participation in value-based care will require significant changes to payment and care delivery, implemented through policy informed by the best evidence and stakeholder input available. The Physician-Focused Payment Model Technical Advisory Committee (PTAC) has developed a definition for population-based total cost of care (PB-TCOC) models and a desired vision and culture for how well-coordinated, high-value care should be provided to beneficiaries.[1,2]

[1] Since PTAC's inception in 2015, 10 of the 35 proposed physician-focused payment models submitted to the Committee discussed using TCOC measures. PTAC proposals identified as being relevant to PB-TCOC models between December 2016 and December 2020 can be found in Appendix 2 of Report to the Secretary: Optimizing PB-TCOC Models in the Context of APMs and PFPMs.

[2] For additional information, refer to the Environmental Scan: PB-TCOC Models in the Context of APMs and PFPMs. Additional resources related to PTAC's theme-based discussions on PB-TCOC models can be found in Appendix 3 of Report to the Secretary: Optimizing PB-TCOC Models in the Context of APMs and PFPMs.

DEFINITION OF PB-TCOC MODELS

While there is no single widely accepted definition of PB-TCOC models, PTAC is currently using the following working definition:

> *"A population-based total cost of care (PB-TCOC) model is an 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 population-based 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 population-based TCOC model."*

Typically, total cost of care (TCOC) refers to all direct and indirect costs associated with health care services over a specified time period. However, definitions of TCOC may vary based on whether they include or exclude administrative costs. Furthermore, some definitions of PB-TCOC include the cost of all medical services, while others encompass only costs relating to Medicare Parts A and B.[3] PTAC currently uses the following working definition for TCOC in the context of PB-TCOC models:

> *"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 [representing Medicare Part A and Part B expenditures only], and is calculated on a per-beneficiary basis for a specified time period."*

PTAC expects that PB-TCOC models would include two-sided risk for participating accountable entities.

Whether excluding Medicare Part D and other expenditures from PB-TCOC models leads to unintended consequences related to shifting therapies between Part B and Part D options remains an open question. Thus, consideration should be given to testing PB-TCOC models that include these expenditures. It is important that stakeholders identify and evaluate process measures designed to incentivize overall pharmaceutical stewardship. These measures would allow assessment of whether therapies are selected based on overall value-based care principles rather than financial incentives. Determining how to effectively incorporate pharmaceutical costs in TCOC calculations may ultimately be important for encouraging specialist integration in PB-TCOC models. Finally, beyond costs associated with direct services, costs associated with infrastructure (e.g., care coordination, staff, information technology, data integration) may be needed for effective participation in PB-TCOC models.

DESIRED VISION AND CULTURE FOR PB-TCOC MODELS

Six concepts relate to PTAC's desired vision for PB-TCOC models.

A Culture of Accountability

Creating a culture of accountability is critical for optimizing clinical, quality, equity, and spending outcomes in PB-TCOC models. Coordinating primary care providers, specialists, and other stakeholders is crucial for fostering effective team-based care. This culture of accountability should support high-touch, proactive care that prevents or mitigates a population's risk of developing undesired health outcomes;

[3] For additional definitions of TCOC, refer to pages 19, 20, and Appendix C of the Environmental Scan: PB-TCOC Models in the Context of APMs and PFPMs.

ensures optimal outcomes; eliminates racial and socioeconomic disparities; and fosters continual care coordination focused on all patients, including underserved communities. Data that are timely, interpretable, and actionable play a critical role in upholding accountability and identifying inefficiencies in care. Perceived fairness of attribution methodologies and flexible payment arrangement opportunities also foster accountability by increasing provider buy-in to this culture shift.

High-Touch, Proactive Care

High-touch, proactive care requires providers to build positive, culturally appropriate relationships that encourage open communication with patients. Care coordinators can foster these relationships by proactively engaging with patients. Proactive patient engagement can allow providers to identify problems early and reduce costly late-stage interventions by connecting patients with educational resources, having dialogues with patients, and increasing care visits and preventive screenings.

Eliminating Health Care Disparities

To reduce racial, socioeconomic, and geographic disparities in health outcomes, PB-TCOC models should increase access to care and empower patients to play a more active role in their care journey.[4] These models can mitigate health disparities by integrating primary care and behavioral health, strengthening relationships between providers and community-based organizations, and mandating participation in PB-TCOC models to ensure coverage of underserved populations.

Care Coordination for Underserved Populations

Interdisciplinary, team-based care is critical for identifying the most appropriate and cost-effective interventions and conducting appropriate follow-up. Care coordination is especially critical when episodic or condition-based models are nested into broader PB-TCOC models, or when treating high-risk patients who may need a larger care team.

Evidence-Based Practices, Risk Stratification, and Data-Driven Care

It is critical that practitioners leverage evidence-based diagnostic and treatment protocols that are data-driven and informed by risk stratification when choosing interventions and care paths. Evidence-based practices may be associated with increased spending due to the nature of a given treatment or patient population, necessitating the realization that clinicians may not necessarily make care decisions with the goal of maximizing cost controls.

Dissemination and Uptake of Best Practices

Effective practices that are identified through research, evaluation, and participant experience must be disseminated and adopted appropriately. Doing so can address resource- and knowledge-related gaps and help mitigate health-related disparities. Considering this desired vision and culture for PB-TCOC models, the main features of the ideal care delivery system for PB-TCOC models are:

1. Multidisciplinary, team-based, patient-centered care;
2. Well-coordinated care;
3. Seamless management of care transitions;
4. Meeting patients where they are;
5. High touch or advanced primary care;
6. Balanced use of, and coordination between, primary care and specialty care;
7. Targeted population-based interventions to prevent or mitigate populations' risk of developing adverse health outcomes;

[4] The September 2023 PTAC public meeting focused on encouraging rural participation in PB-TCOC models. More information can be found on the ASPE PTAC website Meetings page.

8. Reducing disparities in care and outcomes;
9. Identification of health-related social needs (HRSNs) and connection to appropriate resources; and
10. Empowering patients to participate in their care.

SUPPORTING POLICIES

There are several policy directions that would support the development and implementation of PB-TCOC models. Many of these policy directions are related to payment, performance measurement, specialty integration, risk adjustment, and attribution, and will be the topics of future PTAC Issue Briefs. Other supporting policies include:

- Real-time access to actionable data and information on best practices;
- Infrastructure investments; and
- Multi-payer alignment on performance measures to incentivize improvements in quality, outcomes, and patient experience.

Real-time data on patient health care utilization give providers the information they need to assume risk. For example, providers cannot influence patient outcomes if they lack information on the hospital or emergency room care their patients receive. Access to data is critical for improving coordination between primary care providers and specialists and for enabling providers to adopt best practices related to medication management, palliative care, advance care planning, and more. Models should provide tools, resources, and infrastructure to enable providers to access real-time data and facilitate data sharing between providers and risk-bearing entities. Beyond providers' access to information from claims data or medical records, it is necessary for providers to have sophisticated analytic capacities to be successful in PB-TCOC models. It is more difficult for smaller organizations than larger organizations to develop and sustain the capacity for using data analytics to improve patient care.

Multi-payer arrangements can help address the challenge of changing practice patterns only on a limited scale. "One program at a time" approaches may not include enough patient or revenue volume to change care delivery. Multi-payer alignment may be essential to "increase the critical mass" of participation in value-based care models and decrease the burden of adopting such models.

Up-front investments in provider infrastructure are needed to reduce barriers to participation in PB-TCOC models. Infrastructure investments in staff and information technology are particularly important for enabling the transition to value-based care. There are significant start-up costs associated with participating in value-based care, such as building capacity for data analysis, hiring care managers, and educating providers. Up-front payments are especially important to increase participation in PB-TCOC models among smaller and rural practices.

There are several policy levers that could be useful to support the improvement and expansion of PB-TCOC models, including:

- Encouraging sufficient motivation for joining PB-TCOC models;
- Addressing Medicare payment policy; and
- Addressing the number of PB-TCOC models being tested.

The sense of urgency and inevitability of transitioning to value-based care has been lost in recent years. If providers believe there is a sense of eventuality of value-based care, they may be incentivized to invest in the culture change and infrastructure needed to adopt PB-TCOC models. However, providers will have varying abilities to invest in infrastructure depending on size constraints, geographic differences, and other factors.

Different strategies exist for encouraging participation in PB-TCOC models. One strategy includes making traditional fee-for-service (FFS) less attractive than PB-TCOC models. In addition to Medicare FFS, there is a need to reform the Medicare Advantage (MA) program to reduce higher payment relative to the traditional Medicare program. Overpayments can lead some organizations to recruit patients and providers away from traditional FFS, making it more difficult to form PB-TCOC models.

There are several advantages to the CMS Innovation Center limiting the number of harmonized PB-TCOC models. First, being able to test models is important, and multiple models in the same market can complicate evaluation. As APMs are becoming ubiquitous in many markets, it can be difficult in model evaluations to select a comparison group that is not exposed to some form of a PB-TCOC model. Additionally, having a select set of PB-TCOC models to choose from could reduce complexity for providers and patients and encourage multi-payer and multistate participation.

CONCLUSION

The desired vision for PB-TCOC models includes a culture of accountability; high-touch, proactive care; elimination of health care disparities; care coordination for underserved populations; evidence-based practices, risk stratification, and data-driven care; and dissemination and uptake of best practices. The ideal care delivery system for PB-TCOC models includes multidisciplinary, team-based, patient-centered care; meeting patients where they are; balanced use of and coordination between primary and specialty care; implementation of targeted population-based interventions to prevent the risk of developing adverse health outcomes; and addressing HRSNs. Potential policy directions that could support the development and implementation of PB-TCOC models are related to improved payment; performance measurement; specialty integration; risk adjustment and attribution methods; real-time access to actionable data; up-front investments in infrastructure; and multi-payer alignment on performance measures to incentivize improvements in quality, outcomes, and patient experience.

RESOURCES

The following resources are publicly available on the ASPE PTAC website:

- Report to the Secretary: Optimizing PB-TCOC Models in the Context of APMs and PFPMs
- Environmental Scan: PB-TCOC Models in the Context of APMs and PFPMs
- Supplement to the Environmental Scan on PB-TCOC Models
- Second Supplement to the Environmental Scan on PB-TCOC Models

ABOUT PTAC

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to make comments and recommendations to the Secretary of Health and Human Services on proposals for physician-focused payment models (PFPMs) submitted to PTAC by individuals and stakeholder entities. Within this context, PTAC also reflects on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in Alternative Payment Models (APMs) and PFPMs. Accordingly, PTAC has held an ongoing series of theme-based discussions on developing and implementing value-based care. The content in this PTAC Issue Brief is based on publicly available information from PTAC's theme-based discussions, including PTAC presentations and recommendations, presentations by stakeholders and experts, environmental scans, original research, and PTAC reports to the Secretary.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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