Questions to Guide the Panel Discussion for the September 2024 Theme-Based Meeting:

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

Topic: Perspectives on Developing a Pathway Toward the 2030 Goal of Having All Beneficiaries in Care Relationships with Accountability for Quality, Outcomes, and TCOC

Monday, September 16, 10:00 a.m. – 11:30 a.m. EDT

Panel Discussion Subject Matter Experts (SMEs):

- **J. Michael McWilliams MD, PhD**, Warren Alpert Foundation Professor of Health Care Policy, Professor of Medicine, Department of Health Care Policy, Harvard Medical School
- **Ezekiel J. Emanuel, MD, PhD**, Vice Provost for Global Initiatives and Professor, Department of Medical Ethics and Health Policy, University of Pennsylvania
- **Timothy G. Ferris, MD, MPH**, Founding Senior Vice President of Value Based Performance for Mass General Brigham, Inaugural Chief Transformation Officer for the National Health Service (England), Adjunct Professor of Medicine, Harvard Medical School
- **Alice Hm Chen, MD, MPH**, Chief Health Officer, Centene

Committee Discussion and Q&A Session

To assist in grounding the Committee's theme-based discussion, this portion of the theme-based discussion will examine the following areas:

A. Vision for PB-TCOC Models and Necessary Components for Success

B. Developing Multiple Pathways for Different Types of PB-TCOC Organizations

C. Relationship with Current Portfolio of Value-Based Payment Models – Moving from the Current State to the Future

D. Relationship with Other Medicare Value-Based Payment Programs

At the beginning of the panel discussion, the facilitator will briefly introduce each panelist, noting that full bios are available on the ASPE PTAC website (to be posted before the public meeting). The facilitator will give each panelist an opportunity to provide a brief two to three-minute framing of what they do and their thoughts on the topic.

The facilitator will then ask the italicized questions below and invite the panelists to answer the questions. For most questions, the facilitator will begin by inviting SMEs to provide their expertise and perspectives for each topic. Panelists will also have an opportunity to respond to follow-up questions from Committee members.

NOTE: *In the interest of ensuring balance across different perspectives and questions, the facilitator will encourage all panelists to keep each response to a few minutes.*

A. Vision for PB-TCOC Models and Necessary Components for Success

Question 1: *What should be the vision for developing PB-TCOC models that can help to ensure that every Medicare beneficiary with Parts A and B is in a care relationship with accountability for quality and total cost of care (TCOC)?*

a. What should be the goals and characteristics of an accountable care relationship?

b. What should accountability for TCOC mean in practice (such as Part A and B services, Part D)?

c. Which kinds of models are best able to support accountable care relationships (such as advanced primary care models, accountable care organizations (ACOs), all payer models)?

d. What are the necessary components for PB-TCOC models to be successful in achieving the goal of having all beneficiaries with Parts A and B in accountable care relationships?

e. Is it realistic to be able to have all beneficiaries with Parts A and B in accountable care relationships with two-sided risk by 2030 (such as beneficiaries in rural areas)?

f. What should be the key steps and milestones for developing pathways toward having all beneficiaries with Parts A and B in accountable care relationships by 2030? Is there a need to develop multiple pathways for different types of PB-TCOC organizations?

B. Developing Multiple Pathways for Different Types of PB-TCOC Organizations

Question 2: *Why have some providers not been signing up to participate in PB-TCOC models? What can be done to address barriers to participation?*

a. What are the barriers or challenges for different types of organizations to participate in PB-TCOC models (e.g., rural, small physician practices, integrated delivery systems)?

b. Is there a need to develop multiple pathways for different types of PB-TCOC organizations and, if so, how should these multiple pathways be developed?

c. What financial incentives are needed to encourage providers to participate in models that include two-sided risk?

d. Are there current models that have successfully developed multiple pathways (e.g., one-sided risk, two-sided risk) for different types of organizations, and has it led to increased participation?

e. How can specialty care providers be successfully integrated into PB-TCOC models?

C. Relationship with Current Portfolio of Value-Based Payment Models – Moving from the Current State to the Future

Question 3: *What gaps still exist with the current portfolio of value-based payment models, and what features need to be implemented in future models to close these gaps?*

a. What should the ideal portfolio of models look like to achieve the goal of having all beneficiaries in accountable care relationships?

b. What are the characteristics of providers who have been early adopters of participating in ACOs and other types of alternative payment models (APMs)?

c. What are the characteristics of providers who began participating in APMs, but are no longer participating in these models?

d. What additional actions or incentives are needed to encourage more providers to participate (types of providers, geographic areas)?

e. What kinds of performance measures are most appropriate for PB-TCOC models (such as quality, outcomes, utilization, TCOC), and how should performance be measured?

f. What additional approaches and resources are needed to assist providers in addressing infrastructure challenges (such as data, staffing, ability to address health-related social needs)?

D. Relationship with Other Medicare Value-Based Payment Programs

Question 4: *What should the relationship look like between PB-TCOC models and other Medicare value-based payment programs (e.g., Medicare Advantage (MA), Medicare Shared Savings Program, setting-specific programs)?*

a. What should the relationship look like between PB-TCOC models, other Medicare value-based payment programs, and other payers' value-based payment programs (e.g., Medicaid, commercial)?

b. What, if any, effect does MA penetration have on providers' participation in PB-TCOC models in various geographic areas? Are there lessons learned from Medicare Advantage that can be applied to the development of PB-TCOC models?

c. What approaches can be used to ensure that PB-TCOC model financial incentives (such as continued FFS payments with two-sided risk, global/capitated payments) are not only being paid at the organization-level, but that these financial incentives are also flowing down to the provider-level?

d. Has the existence of the 2030 goal interacted with how other payers are implementing (or considering implementing) value-based care? If so, how?

Conclusion

Wrap-up Question: *Are there any additional insights you would like to share on developing a pathway toward the 2030 goal of having all Medicare beneficiaries in care relationships with accountability for quality and TCOC?*