

Improving Care Delivery and Integrating Specialty Care in Population-Based Models Request for Input (RFI)

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) is hosting theme-based discussions to inform the Committee on topics that are important for physician-focused payment models (PFPMs). Given the increased emphasis on developing larger population-based Alternative Payment Models (APMs) that encourage accountable care relationships, PTAC conducted a series of theme-based discussions in 2022 that examined key definitions, issues, and opportunities related to developing and implementing population-based total cost of care (PB-TCOC) models. (Please see the Appendix for information about PTAC's working definitions related to PB-TCOC models).

PTAC's 2023 series of theme-based discussions is designed to give Committee members additional information about current perspectives on key issues related to operationalizing PB-TCOC models. This information will be useful to policy makers, payers, accountable care entities, and providers for optimizing health care delivery and value-based transformation in the context of APMs and PFPMs specifically. PTAC will hear from the public and subject matter experts, including stakeholders who have previously submitted proposals to PTAC with relevant elements.

During PTAC's two-day March 2023 public meeting, the Committee began by focusing on issues and opportunities related to improving care delivery and integrating specialty care in population-based models, including PB-TCOC models. Specific topics that were addressed included issues related to improving specialty integration in advanced primary care models and Accountable Care Organizations (ACOs); approaches for structuring coordination between primary care providers and specialists; options for defining and embedding specialty episodes within population-based models, structuring financial incentives, and reducing cost-shifting; the role of health information technology (HIT) and data analytics in specialty integration; addressing challenges affecting safety net providers and rural providers; and identifying appropriate performance measures for specialty integration. Findings from this theme-based discussion will be included in a report to the Secretary of Health and Human Services (HHS). PTAC anticipates covering the following additional topics during the upcoming June and September public meetings:

- The **June 2023** public meeting will include a theme-based discussion on improving management of care transitions. Key topics to be addressed include how PB-TCOC models can improve management of care transitions for patients across primary care, specialty care, acute care, post-acute care, long-term care supports and services, end-of-life care, and community services.
- The **September 2023** public meeting will include a theme-based discussion on key issues for optimizing PB-TCOC models. Key topics to be addressed include different factors affecting PB-TCOC model implementation, such as considerations related to multi-payer participation and technical issues related to attribution, benchmarking, risk adjustment, and performance metrics.

Improving Care Delivery and Integrating Specialty Care in Population-Based Models Request for Input (RFI)

Background:

The Center for Medicare and Medicaid Innovation (CMMI) has set the goal of having all Medicare fee-for-service (FFS) beneficiaries with Parts A and B coverage in a care relationship with accountability for quality and TCOC by 2030.¹ Additionally, the Secretary of HHS has established “Quality and Cost” and “Integration and Care Coordination” as two of the 10 criteria for proposed PFPMs that PTAC uses to evaluate stakeholder-submitted proposals. The goal of the Quality and Cost criterion is to ensure that each proposed model will “improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost” (Criterion 2). The goal of the Integration and Care Coordination criterion is to “encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM” (Criterion 7).²

Within this context, PTAC has assessed previous submitters’ use of proposed model design components related to improving coordination between primary care and specialty providers in population-based and episode-based models while improving quality and reducing TCOC.

Nearly all of the 35 proposals that were submitted to PTAC between 2016 and 2020 addressed the proposed model’s potential impact on quality, costs, and care coordination, to some degree. Additionally, at least 16 previous submitters have addressed issues related to improving care delivery and specialty integration in advanced primary care models and episode-based or condition-specific models as part of their proposal submissions.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides an environmental scan for every proposal reviewed by PTAC to provide background information to inform the Committee’s evaluation. To assist PTAC in preparing for the March 2023 theme-based discussion, an environmental scan was developed with information on topics related to improving care delivery and specialty integration, including the current state of specialty integration in advanced primary care models and other population-based models; best practices for enhancing specialty participation in team-based models; approaches for nesting specialty episodes within PB-TCOC models; provider incentives for reducing costs within PB-TCOC models; the role of HIT and data analytics in supporting specialty integration; and enhancing performance metrics to encourage team-based care and better capture utilization, cost, and quality performance.

PTAC Interests:

¹ Center for Medicare and Medicaid Innovation. *Innovation Center Strategy Refresh*; 2021:32.
<https://innovation.cms.gov/strategic-direction-whitepaper>

² Physician-Focused Payment Model Technical Advisory Committee. *Physician-Focused Payment Models: PTAC Proposal Submission Instructions*. Revised as of November 2, 2022.

Improving Care Delivery and Integrating Specialty Care in Population-Based Models Request for Input (RFI)

During the March 2023 theme-based discussion, PTAC used the following preliminary working definition of the characteristics of specialty integration:

Specialty integration is a desired characteristic of population-based models where:

- *Primary and specialty care provider roles and responsibilities are clearly delineated throughout the care journey for a given condition or episode of care;*
- *Specialist care includes a continuum of responsibilities for a patient or condition, including, but not limited to, single consultation, co-management, and primary management;*
- *Primary and specialty care providers coordinate to provide patient-centered care using bidirectional, synchronous, and asynchronous communication;*
- *Specialists provide consultations and/or ongoing care via multiple modes in a timely manner; and*
- *Primary and specialty care providers have access to use shared real-time data to inform care decisions.*

These definitions will likely evolve as the Committee collects additional information from stakeholders.

PTAC seeks to build upon the insights of stakeholders and use those insights and considerations to further inform the Committee's review of proposals and recommendations that the Committee may provide to the Secretary relating to this topic. PTAC also seeks additional information on stakeholders' experiences related to improving specialty integration in population-based models, including nesting of episode-based or condition-specific models in PB-TCOC models. Therefore, PTAC requests stakeholder input on the questions listed below.

Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Questions to the Public:

1. How do primary and specialty care providers' roles in managing patients' care vary in different contexts (such as those listed below)? What are some reasons for these differences? To what extent are these differences likely to affect best practices for improving specialty integration? Which approaches would be most appropriate in certain contexts, and why?
 - a. Do these roles differ by the type of provider or setting (e.g., independent practice, hospital-affiliated practice, federally qualified health center [FQHC] or other safety net provider, multispecialty practice, integrated delivery system)? If so, how?
 - b. Do these roles differ by the type of specialist involvement (e.g., specialists providing the full range of care for a specialized population, specialists providing

Improving Care Delivery and Integrating Specialty Care in Population-Based Models Request for Input (RFI)

- care to patients during a specific episode of care, and specialists co-managing a patient's care for one or more conditions)? If so, how?
- c. Do these roles differ across the various stages of a patient's health care journey (e.g., primary and preventive care, specialty care, chronic disease management, acute care, procedures, post-acute care, end-of-life care)? If so, how?
 - d. Do these roles differ for different conditions/diseases and their specific care trajectories? If so, how?
 - e. Do these roles differ by geographic location (e.g., region or state; urban, suburban, or rural area)? If so, how?
2. How should the roles of primary and specialty care providers be defined when managing chronic conditions?
- a. In what situations would it be appropriate for a primary care provider to have primary responsibility for managing a patient's care?
 - b. In what situations would it be appropriate for a primary care provider and one or more specialist(s) to share responsibility for managing a given patient's care (e.g., management of a patient's overall care, or management of a specific condition)? How should the roles of the primary care provider and specialist(s) be defined? What chronic conditions would be most appropriate for care delivery models involving shared or cascading responsibility for care management?
 - c. In what situations would it be appropriate for a specialist to assume primary responsibility for managing a patient's care?
 - d. What criteria should be used to determine when shifts in primary management or co-management of a patient's care should occur (e.g., from primary management by the primary care provider to shared management by the primary care provider and one or more specialist[s] to primary management by a specialist)?
 - e. As providers' care management responsibilities change throughout the course of treatment, how can this best be captured in attribution?
3. What approaches are most commonly being used to facilitate coordination between primary and specialty care providers in advanced primary care models? Why are these approaches being used?
- a. What approaches or modalities have been most effective in improving coordination between primary care and specialty providers (e.g., bidirectional, synchronous, or asynchronous communication; telehealth; changes in care

**Improving Care Delivery and Integrating Specialty Care in Population-Based Models
Request for Input (RFI)**

- delivery team composition; use of care coordinators)? Does the effectiveness of these approaches vary in different contexts (e.g., for different specialties/conditions/diseases/procedures, by care setting, by geographic location)? If so, why?
- b. What challenges exist related to improving specialty integration in advanced primary care models? How do these challenges vary by provider characteristics (e.g., type of provider, geographic location, physician employment type)?
 - c. What resources are needed to facilitate improvements in specialty integration in advanced primary care models (e.g., health information technology [HIT] to facilitate interdisciplinary communication)? How do these challenges vary by provider characteristics (e.g., type of provider, geographic location, physician employment type)?
4. What approaches are most commonly being used to facilitate coordination between primary and specialty care providers in ACOs? Why are these approaches being used?
- a. What challenges exist related to improving specialty integration in ACOs (e.g., alignment of incentives, implementation costs, sharing accountability and risk)? How do these challenges vary by the type of ACO (e.g., hospital-based, provider-based, primary care-focused, specialty-focused)³?
 - b. What resources are needed to facilitate improvements in specialty integration in ACOs (e.g., HIT to facilitate interdisciplinary communication)? How do these challenges vary by the type of ACO and by geographic location?
5. What approaches have been used to improve coordination between primary care and behavioral health care providers?
- a. To what extent do these approaches vary by the type of behavioral health care provider (e.g., social worker, psychologist, psychiatrist, substance use disorder treatment provider)?
 - b. Does the effectiveness of these approaches vary in different contexts (e.g., by care setting, by geographic location)?
6. What are examples of organizations that have successfully implemented specialty integration within the context of value-based care? What are some lessons learned regarding best practices for improving specialty integration in value-based care models?

³ Specialty-focused ACOs may include organizations that form under specific CMMI Models, such as End-Stage Renal Disease (ESRD) Seamless Care Organizations (ESCOs) under the Comprehensive ESRD Care (CEC) Model or ESRD-focused ACOs under the Kidney Care Choices (KCC) Model, as well as ACOs that prioritize care for specific populations, such as a long-term care population, under non-specialty focused accountable care models.

**Improving Care Delivery and Integrating Specialty Care in Population-Based Models
Request for Input (RFI)**

7. What role do primary care providers play in specialist selection? Does the scope of the primary care provider's role in assisting patients in selecting a specialist vary based on provider or patient characteristics? If so, how and why?
 - a. What approaches have organizations used to encourage the selection of high-value specialists by primary care providers and patients (e.g., networks, cooperative agreements, sharing performance data, financial incentives)?
 - b. Which of these approaches have been most effective, and why? Does the effectiveness of these approaches vary in different contexts (e.g., for different specialties/conditions/diseases/procedures, by care setting, by geographic location, by ACO participation, by insurance status)?
8. What are best practices for improving equity related to specialty integration in PB-TCOC models (e.g., for underserved populations, patients who receive low-value care, patients with health-related social needs [HRSNs])?
 - a. What approaches have been used to improve coordination between primary care providers and community-based organizations? Which of these approaches have been most effective, and why?
 - b. What approaches have been used to engage specialists in addressing HRSNs? Which of these approaches have been most effective, and why?
9. What is the potential role of telehealth in expanding the number of specialists that are available, particularly in underserved areas?
 - a. What challenges, opportunities, and best practices exist related to using telehealth to expand access to specialty care?
 - b. What are examples of organizations that have successfully used telehealth to expand access to specialty care?
10. Which financial incentives are most appropriate for supporting specialty integration? How should specialty integration be structured to support accountability for quality and TCOC in advanced primary care models and ACOs?
 - a. What are the best strategies for incentivizing specialist participation in PB-TCOC models and incentivizing high-value care?
 - b. How can models encourage ongoing specialist participation, and what are some strategies for encouraging specialist retention in these models?
 - c. How can models engage specialists, patients, and caregivers in shared decision-making, especially regarding the development of patient-centered care plans?

**Improving Care Delivery and Integrating Specialty Care in Population-Based Models
Request for Input (RFI)**

- d. What are examples of organizations that are successfully improving specialist engagement in PB-TCOC models?
 - e. What are some clinical conditions where improved specialty integration could have a significant impact on improving quality and reducing TCOC?
11. What are the best approaches for defining chronic outpatient episodes of care within the context of PB-TCOC models?
- a. What criteria should be used in defining chronic outpatient episodes of care? How do these criteria vary by condition/disease or health care phase?
 - b. How can appropriate boundaries for an episode of care be established for complex patient populations, such as patients with multiple chronic conditions (for example, when some services could count within multiple chronic outpatient episodes of care)?
12. What model design features can help to facilitate the nesting of episodes of care within PB-TCOC models?
- a. Which conditions/diseases have outpatient chronic episodes of care that would potentially be most appropriate for nesting within a PB-TCOC model? What makes these episodes of care most appropriate for nesting?
 - b. How can nesting episodes of care be leveraged to improve care delivery and specialty integration?
 - c. What are some best practices for determining financial incentives/payment for specialists with shared and/or cascading responsibility for managing nested specialty episodes of care?
 - d. How might payment vary based on the type of specialist involvement (e.g., specialists providing the full range of care for a specialized population, specialists providing care to patients during a specific episode of care, and specialists co-managing a patient's care for one or more conditions)?
 - e. Which types of specialties would potentially be most appropriate to receive capitated payments for chronic disease management within a PB-TCOC model – in general, and/or for specific conditions?
 - f. What kinds of data and support would provider organizations and ACOs need to operationally facilitate the management of nested episodes of care within PB-TCOC models?
13. What kinds of performance measures should be used to encourage specialty integration in PB-TCOC models?

**Improving Care Delivery and Integrating Specialty Care in Population-Based Models
Request for Input (RFI)**

- a. What considerations for risk adjustment and benchmarking should be made for performance measures associated with specific episodes of care?

Where to Submit Comments/Input: Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Note: Any comments that are not focused on the topic of APMs and PFPs for PB-TCOC initiatives and efforts by physicians and related providers caring for Medicare FFS beneficiaries, or are deemed outside of PTAC's statutory authority, will not be reviewed and included in any document(s) summarizing the public comments that were received in response to this request.

**Improving Care Delivery and Integrating Specialty Care in Population-Based Models
Request for Input (RFI)**

Appendix: Working Definitions Related to Population-Based Total Cost of Care (PB-TCOC) Models, Care Coordination, and Specialty Integration

PTAC is using the following working definition for population-based models:

Population-based models are models that include the entire patient population served by a given accountable entity or a broad subset of the patient population served by an accountable entity (e.g., Medicare-Medicaid enrollees).

PTAC is using the following working definition for PB-TCOC models:

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 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.

Additionally, PTAC is using the following working definition of TCOC:

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, and is calculated on a per-beneficiary basis for a specified time period.

Within this context, some examples of existing population-based models/programs that include components that are relevant for the development of PB-TCOC models include:

- *Advanced primary care models (APCMs)* that promote the use of Advanced Primary Care, an approach that enables primary care innovations to achieve higher-quality care and allows providers more flexibility to offer a broader set of services and care coordination.
- *Accountable Care Organization (ACO) programs* where physicians or health systems assume responsibility for TCOC associated with a patient population.

While some existing APMs may include shared savings with upside risk only, PTAC anticipates that PB-TCOC models will include glide paths for allowing providers and organizations to gradually assume more downside financial risk over time.

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Improving Care Delivery and Integrating Specialty Care in Population-Based Models Request for Input (RFI)

PTAC is using the following working definition of care coordination, which is drawn from the Agency for Healthcare Research and Quality's description of care coordination:

“Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.”

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