Questions/Topics to Guide the Subject Matter Expert Roundtable Panel Discussion for the June 2022 Theme-Based Meeting

Subject Matter Expert (SME) Roundtable Panel Discussion: To assist in grounding the Committee's theme-based discussion, this portion of the theme-based discussion will examine the following areas.

A. Improving care delivery and addressing total cost of care (TCOC) in the context of accountable care relationships.

B. Operationalizing the inclusion of screening and referrals for addressing health-related social needs (HRSNs) in population-based TCOC models.

C. Balancing trade-offs related to designing population-based TCOC models.

D. Key issues regarding data and performance metrics.

PTAC believes these topics are important for developing population-based TCOC models. At the beginning of the roundtable 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 then ask the italicized questions below and will invite the panelists to answer the questions. For most questions, the facilitator will begin by inviting two SMEs to provide their particular expertise and perspectives foreach topic. Other panelists will have an opportunity to provide their perspectives on a given topic, time permitting. 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. Improving Care Delivery and Addressing TCOC in the Context of Accountable Care Relationships

Question 1: *The Center for Medicare & Medicaid Innovation (CMMI) has set the goal of having every Medicare fee-for-service (FFS) beneficiary in a care relationship with accountability for quality and TCOC by 2030. What do you see as the potential for accountable care relationships and models to improve quality of care and health outcomes while reducing TCOC? What changes are needed in order to maximize the ability of these models to achieve these objectives?*

1.1. What are the major characteristics of an "accountable care relationship"? Does accountability primarily relate to patient attribution, financial risk, care coordination, outcomes, patient-centeredness, or are there other important factors that should be considered? Do these characteristics differ by type of provider (e.g., primary care vs. specialty care – including secondary, tertiary, quaternary)?

1.2. Looking at the "big picture" what are the most important considerations for incentivizing accountability for quality and cost in a population-based, longitudinal model of care? How can population-based TCOC models ensure that accountability is focused on the providers who are

most directly affecting patient outcomes and costs when this is likely to vary by condition, by patient, and by other factors (such as access to specialists in a given community)? Can accountability be shifted or shared? What are the most important performance metrics for incentivizing accountability?

1.3. What do you see as the main aspects of accountability that are affected by the model design, and what are the best approaches for integrating accountability for episodes of care within broader population-based TCOC models?

1.4. How can accountability be addressed in cases where patients may be seen by multiple providers (including patients whose care may be primarily managed by specialists due to their chronic conditions)? How should population- based TCOC models address this situation in terms of patient attribution, responsibility for coordination, and accountability for patient-centered care?

1.5. What options exist for integrating episode-based or condition-specific models within a broader population-based accountable care model? What are the pros and cons of various approaches, and how can they be addressed?

Question 2: *What are the most important aspects of care delivery that need to be addressed by population-based TCOC models in order to achieve the objectives of improving quality, reducing costs, and ultimately encouraging delivery system transformation? From your perspective, what are some of the barriers to optimizing care delivery in these models? Which care delivery innovations and features have contributed most to the ability of organizations to reduce TCOC and improve outcomes?*

2.1 What are the most important types of care delivery innovations that can have an impact on quality and cost for broad population-based TCOC models (including those targeting patients with limited use of specialty services)?

2.2 What are the most important types of care delivery innovations that can have an impact on quality and cost for specific patient populations with chronic conditions? What opportunities exist for enhancing care delivery and coordination across providers?

- **a.** What are some innovative approaches for addressing unmet needs for severely ill patients, and ensuring coordination across specialists as well as primary care?
- **b.** To what extent are there likely to be similarities or differences in innovative approaches for managing different conditions, such as oncology, kidney disease, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), etc.?

2.3 What are best practices for coordinating care for the acutely ill home-based population (including those with Alzheimer's or Dementia)? Are there specific strategies that would work best for assuring continuity of care for patients with serious illnesses that require hospice care?

2.4 What factors are most important for ensuring the success of alternative payment models in improving quality and reducing TCOC?

2.5 How much do we know about how Medicare Advantage (MA) plans approach encouraging engagement, coordination, and alignment between primary care and specialists? What can population-based TCOC models learn from MA plans?

B. Operationalizing the Inclusion of Screening and Referrals for Addressing Health-Related Social Needs in Population-Based TCOC Models

Question 3: *In your opinion, what are some best practices for integrating efforts to screen and provide referrals for health-related social needs into population-based TCOC models?*

3.1 What are some of the options for operationalizing the inclusion of screening and referral for HRSNs and SDOH in population-based TCOC models?

3.2 Which provider(s) should conduct the screening(s), collect the data, assess the data, make the referral(s), and follow-up on the referral(s)? What HRSNs and SDOH are most important for reducing TCOC and improving outcomes?

3.3 What screening tools, data collection methods and software are most effective for this purpose? Is there a need for additional targeting of interventions for specific patient populations?

3.4 What resources are needed to support the ability of providers to conduct the screening and referrals (and any follow-up), and how can population-based TCOC models help to incentivize the development of the necessary infrastructure, data collection, and coordination to ensure that patients receive the services they need?

3.5 What are best practices for encouraging the development of databases of community-based resources related to addressing HRSNs and SDOH?

C. Balancing Trade-offs Related to Designing Population-Based TCOC Models

Question 4: *Our discussions to date have highlighted trade-offs relevant to design decisions for population-based TCOC models. For example, there may be a trade-off between maximizing beneficiary choice of providers and providing flexibility for accountable entities in managing costs they are able to control (for example, through the use of provider networks)? What are some best practices for balancing these trade-offs?*

4.1 What are some of the trade-offs related to provider choice and the use of provider networks – both in terms of beneficiary experience / access, and in terms of holding a specific entity accountable for overall cost and patient-centered care? What are some options for addressing this trade-off? Is there a role for improving beneficiary engagement or incentivizing provider participation in accountable care organization (ACO) networks?

4.2 Current population-based Medicare APMs typically include accountability for Medicare Part A and Part B expenditures. Does the exclusion of other costs (such as Part D covered pharmaceuticals) create unintended incentives to shift clinical decisions? Should population-based TCOC models include more than Medicare Part A and Part B costs and services? If so, what additional aspects of care would be most important to include? If so, what do you see as options for addressing this issue (e.g., for example, through use of new performance measures related to patient-centered decision making and/or pharmaceutical stewardship)? Are there lessons that can be learned from Medicare Advantage plans related to these issues?

Question 5*: What are the potential trade-offs between including more structure regarding the requirements for accountable entities in population-based TCOC models and allowing more flexibility for accountable entities to organically determine how to incentivize providers?*

5.1 What are the pros and cons associated with allowing more flexibility for accountable entities that are participating in population-based TCOC models regarding determining financial

incentives for various types of providers? Are there some areas where it might be more appropriate to require standardization, and other areas where it might be more appropriate to allow flexibility? If so, where?

5.2 What are the potential equity implications associated with holding APM entities accountable for TCOC in population-based models, and increasing financial risk for providers? Are there issues related to the ability of safety net providers to participate in these models? Are there potential issues related to access to services? What are some options for addressing these concerns? Are there opportunities to encourage providers that serve underrepresented and underserved populations to participate in population-based TCOC models?

D. Key Issues Regarding Data and Performance Metrics

Question 6*: What data and performance metrics are most important for optimizing the implementation of population-based TCOC models? How should measures address patients shifting from primary care to specialty care, if at all?*

6.1 What quality and cost metrics are most important in an accountable care model? What aspects of patient-centered care are not adequately addressed by current measures?

6.2 Are there opportunities to develop measures that address unintended consequences of incentives that may result from the design of population-based TCOC models?

6.3 How can performance metrics address accountability for different providers who may be treating a given patient?

6.4 What data and analytic capabilities do providers need in order to take on two-sided financial risk with accountability for quality and cost? Can these needs be sufficiently addressed through administrative data (e.g., claims data), or are other sources of data also necessary (e.g., clinical encounter data)? What types of investment and expertise are needed to ensure access to relevant data analytic tools?

6.5 How can efforts to advance the use of patient-centered quality measures (such as patient-reported outcome measures) be balanced with the burden associated with collecting these measures?

E. Conclusion

Question 7*: Are there any final insights you would like to share about population-based TCOC models and their potential for optimizing outcomes for patients and transforming value-based care?*