

Physician-Focused Payment Model Technical Advisory Committee

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

Subject Matter Expert (SME) Roundtable Panel Discussion: To assist in grounding the Committee’s theme-based discussion, the first presentation of the theme-based discussion will identify issues that PTAC believes are important for developing population-based total cost of care (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. All panelists will have an opportunity to provide their perspectives on a given 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. Key issues regarding defining TCOC in the context of population-based models or approaches:

Question 1. In Medicare Alternative Payment Models (APMs), all Medicare Part A and Medicare Part B services are typically included in benchmarks labeled TCOC. Based on your experience, what types of services are typically included in this calculation? What kinds of additional services could be appropriate for inclusion in future population-based TCOC models, and what would be the rationale for including these services?

- Are costs for both medical and non-medical services (e.g., those that are related to screening and providing referrals for health-related social needs and addressing social determinants of health) typically included in existing population-based TCOC models or approaches? Why or why not?
- Are treatment costs for prescription drugs -- such as physician-administered drugs (e.g., Medicare Part B), drugs prescribed by primary care physicians and specialists but obtained through pharmacies (e.g., Medicare Part D), or specialty pharmacy drugs -- typically included in existing population-based TCOC models or approaches? Why or why not?
- Are some types of services more likely to be excluded or “carved out” than others in existing population-based TCOC models or approaches? If so, what are some examples of such services?
- Are treatment costs for behavioral health included in existing population-based TCOC models or approaches? Why or why not?
- Is there an ideal set or basket of services that should be included in future population-based TCOC models or approaches that can help to maximize the quality and affordability of patient care?
- To your knowledge, do the components or elements of TCOC calculations currently differ across payer types, provider or practice types or specialties, or geographic regions? If so, how?
- *Question 2. In your opinion, do you think there should be a single, standardized definition of TCOC in future population-based TCOC models? Why or why not? If you believe there should*

be a single, standardized definition of TCOC that can be universally applied across all population-based models and approaches, what elements or components of TCOC do you think would be most appropriate to include under that definition?

- If a single definition is not appropriate for all settings, what do you think are the considerations or factors for why or how TCOC determinations may be allowed to differ by (for example, payer type) while still maximizing the quality and affordability of patient care?
- Are there any conditions or types of care that should not be integrated into population-based TCOC models because they are so unique?

B. Enhancing provider readiness to participate in population-based TCOC models:

Question 3. Next, I'd like to discuss how to enhance provider readiness to participate in population-based TCOC models. From your perspective, what are some of the provider-level barriers to participating in these models?

- What type(s) of entities or provider organizations should be accountable for TCOC in population-based TCOC models? How should accountability for TCOC be addressed in these models when multiple providers are providing care to a patient?
- Are some types of providers more likely than others to participate in population-based TCOC models? Are there differences in readiness by specialty or other characteristics?
- What could be some approaches for integrating primary care and specialty care under population-based TCOC models (e.g., along the lines of patient attribution, payment disbursement)?
- To what extent might the appropriate incentives for encouraging provider participation in models with two-sided risk vary by type of providers (e.g., level of experience with Alternative Payment Models)? How can APMs be designed to apply incentives at the individual provider level while also managing the level of financial risk?
- What are some of the most important training and infrastructure needs of providers to enable them to effectively participate in population-based TCOC models?

Question 4. Thinking of the population-based TCOC models that you are familiar with, how have they structured payments to influence provider participation?

- What types of incentives have been offered in existing population-based TCOC models to motivate providers to participate?
- Are there other new or innovative strategies or mechanisms that could be embedded into payment models to further motivate providers to participate?
- How can population-based TCOC models further incentivize broader changes in care delivery patterns (in addition to focusing on reducing hospital admissions) that can help to improve quality and reduce costs?
- What types of measures are appropriate for inclusion in population-based TCOC models to measure provider performance and accountability?

C. Addressing equity in population-based TCOC models:

Question 5. In your opinion, what are the potential equity implications of holding APM entities accountable for TCOC in population-based models—both in general and for beneficiary sub-populations, such as historically underserved populations and individuals with chronic conditions?

- What are the potential implications for providers who serve historically underserved populations, such as safety net providers, in participating in population-based TCOC models? What are the most significant obstacles for safety net providers who want to participate in these kinds of models?
- What are the equity implications (challenges and opportunities) of different types of population-based TCOC payment methodologies?
- Are there opportunities to design population-based TCOC models to incentivize participation, maximize equity, and manage risk?
- Are there opportunities to improve collaboration with community-based organizations and other entities to increase the reach of value-based models to underrepresented and underserved populations?
- Can Alternative Payment Models be effective in incentivizing screening and referrals for health-related social needs?

D. Conclusion:

Question 6. 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?