Identifying a Pathway for Maximizing Participation in Population-Based Total Cost of Care (PB-TCOC) Models

Request for Input (RFI) Responses

On September 17, 2024, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public on information that could describe current perspectives on identifying a pathway for maximizing participation in population-based total cost of care (PB-TCOC) models and physician-focused payment models (PFPMs). PTAC has received two responses from the following stakeholders listed below:

1. No Health without Mental Health (NHMH)
   American Association on Health & Disability
   Lakeshore Foundation
   Mental Health America
   National Disability Rights Network
   Policy Center for Maternal Mental Health
2. National Association of ACOs (NAACOS)

For additional information about PTAC's request, see PTAC's solicitation of public input.

No Health without Mental Health
www.nhmh.org • 501(c)(3) organization

November 14, 2024

TO: PTAC/OS/ASPE

FROM: NHMH – No Health without Mental Health
American Association on Health & Disability
Lakeshore Foundation
Mental Health America
National Disability Rights Network
Policy Center for Maternal Mental Health

RE: RFI on Identifying a Pathway Toward Maximizing Participation in Population-Based Total Cost of Care Models

I MAIN MESSAGE:

The integration of behavioral health (mental health and substance use) services in primary care must be an essential foundational component of a high-quality accountable care relationship, including in population-based total cost of care (PB-TCOC) models. (Bipartisan Policy Center, 2021). The quality and reduced cost benefits of integrated care are well documented (AHRQ, 2023). Value-based payment models have structural elements that make them ideal for integrated physical-behavioral health care delivery. Existing payment mechanisms in Medicaid Managed Care Organizations, Medicare Accountable Care Organizations and Medicare Advantage plans have well-defined quality metrics, delivery standards, and payment methodologies through which integrated care ban be applied, enforced and incentivized. What is needed is financial incentives and requiring accountability in order to build integrated care delivery into existing value-based payment models (BPC).

The October 2024 PTAC/OS/ASPE Request for Information (RFI) re "Identifying A Pathway Toward Maximizing Participation <of all Medicare beneficiaries with Parts A and B> in Population-Based Total Cost of Care Models" did not include any reference to the role of the integration of behavioral health and primary care in those Medicare beneficiary accountable care relationships aimed at quality and total cost reduction.

Yet data and studies show that CMS will not achieve accountable quality care, as evidenced by improved health outcomes and reduced cost, for the most seriously ill, highest-cost, and chronically ill patients without inclusion of integrated medical-behavioral care (BPC; HHS/SAMHSA/CMS; NASEM 2022; Milliman 2018).

Nearly 30% of Americans (55 million) suffer from some behavioral health condition and half of them receive no care at all (HHS/SAMHSA). At the same time, for those patients with chronic medical conditions (e.g. diabetes, cancer, heart disease) who also have a mental health issue, their cost of care, across Medicare, Medicaid and commercial insurers, is *doubled* (Milliman 2014, 2018). For patients with

a chronic medical and behavioral condition AND a substance use condition, their total cost of care is *quadrupled* (Ibid). This leads to over $400 billion in additional societal social and economic costs. The opioid epidemic and COVIC pandemic have intensified these stark realities creating the national mental health crisis we now confront.

The federal government has in the past three months stated that integrated care 'is the future of healthcare.' The Department of Health & Human Services stated in August 2024 that 'integrated care is now the future of health care' and specifically that: 'The integration of primary and behavioral health care is considered the future of health care because it uses systematic, evidence-based approaches to improve the delivery of person-centered comprehensive care; increases access to preventive care and screenings; coordinates care to address mental, physical, social, and substance use related needs; and reduces overall costs of care for patients, providers, and health care systems.' https://www.samhsa.gov/newsroom/press-announcements/20240829/biden-harris-administration-awards-81-point-3-million-funding-further-advance-presidents-unity-agenda

II RESPONSES TO RFI's QUESTIONS TO THE PUBLIC:

Our feedback responds to the numbered questions listed in the RFI:

1)a)**:** Goals of a Medicare Quality PB-TCOC Accountable Care Relationship:

-- comprehensive, continuous, coordinated whole-person care
-- use of a collaborative, communicating, specially trained integrated care team
-- patient at center of care team and actively engaged in the co-creation of care goals and treatment plans
-- continuous care with stress on early **i**dentification, assessment, treatment and prevention
-- longitudinal trusted patient-provider-team therapeutic relationship
-- wide reach through population-based patient panels
-- delivery of evidenced-based care, in case of integrated care: primary care behavioral health model (PCBH); collaborative care model (CC); and short brief intervention and referral to care model (SBIRT) and
-- high level of patient shared-decision-making and engagement throughout care.

1)b**):** Kinds of Models Best Able to Support Accountable Care Relationships:

Models that allow for financial flexibility and incentives to practices/health systems including alternative payment models (APMs) providing prospective upfront payment for medical and behavioral health care, such as in Medicaid MCO programs, Medicare ACOs**,** and Medicare Advantage plans, are best able to support accountable care relationships (BPC). These programs have well-defined quality metrics, delivery standards and payment approaches incentivizing **i**ntegrated care. Models able to support

accountable care relationships also need technical assistance programs and specialized integrated care training, and health information technology that allows for interoperability and real-time information between medical and behavioral health providers.

3)c)**:** Features Needed to Incentivize Beneficiaries to Align with Providers in APMs:

-- delivery of accessible integrated medical and behavioral care in same place with same day services
-- elimination of additional co-pays for mental health encounters in medical settings
-- demonstrate to patients that their physical and mental health providers work in close cooperation, coordination, and communication with each other and engage in seamless real-time sharing of patients full personal health information data.

4)a)**:** Barriers to Providers Participating in TB-TCOC Models:

-- inadequate reimbursement to providers
-- mandatory reporting of unclear, overly complicated, burdensome quality metrics
-- lack of upfront payment to practices for initial set-up expenditures and ongoing operational expenses required to provide evidence-based integrated care – which is a wholly new way of providing quality, accountable healthcare and which affects every aspect of the practice
-- need for specialized technical training programs for clinicians to be able to deliver evidence-based integrated care.

4)c): Why Some Providers Cease Participation in TB-TCOC Models:

It is very challenging for practices/health systems to financially sustain integrated care delivery services beyond grant or demonstration program periods, and provide clinicians and staff with needed integration education, training, coaching, plus continuous quality improvement monitoring integrated care processes and activities, in today's health care workforce shortage, burnout, low employee reimbursement, and staff turnover, environment. The place where most accountable care relationships are now being envisioned, i.e. primary care and family practice, have been underinvested and underfunded for decades. An essential re-visualization and rebranding of what is quality primary care, in the eyes of the healthcare workforce, patient/consumers, and policy makers, must take place to underpin sustained accountable care relationships.

5:) Gaps in Current VBP models and Features Needed to Close Gaps:

-- integration of behavioral health care should be mandatory service requirement in all value-based payment programs
-- behavioral health providers should be core providers in VBP programs
-- involvement of patients and caregivers in design of VBP models and monitoring of outcomes

-- VBP models are not going to work unless patients and caregivers and frontline providers are involved in future
-- insufficient payment for practices/systems
-- clearly defined, reliable, valid quality metrics for delivering evidence-based integrated care
-- allowance for sufficient time for practices to demonstrate the value, in terms of patient health outcomes and total care cost, of integrated care, e.g. 5-7 years in lieu of 2-3 years.

6): Most Effective Payment Approaches for Fostering Accountable Relationships:

-- transitional approaches that balance prospective payment with existing fee for service payment
-- adequate upfront investment payment to cover first-time setting-up costs
-- adequate payment to cover hiring of trained integrated care providers
-- payment that is tiered so as to reward practices that make progress in steadily achieving higher levels of evidence integrated care services across evidence-based implementation framework domains.

6)c): Structures Needed for Organization-Level v Provider-Level Financial incents:

-- primary care *sites* participating in delivery of integrated care services should directly receive financial incentives instead of such payments only going to the healthcare system of which it is a part
-- payments to primary care site providers should be tiered and tied to attaining progress in advancing in integration implementation levels.

8)b): Implementation Challenges with Implementing Specialty, Condition, or Setting-Specific Measures in PB-TCOC Models:

-- accountability among providers: medical provider, behavioral health provider, prescriber, patient, insurer … where should accountability lie, should accountability be shared among providers, and if so, how?
-- patient-centered measures: values and patients should be taken into account and patient behavioral activation and active engagement prioritized
-- patient-centered measures: including patient-reported outcomes (PROs), a core element to quality measurement work and foundational to consumer/patient/family advocacy and accountability efforts
-- adequacy of health information sharing, analytical and reporting data bases
-- addressing the question of whether measurement leads to improvement.

9): Best Practices for Establishing Benchmarks for Use in TB-TCOC:

-- use of consensus standards of care and evidence-based strategies
-- team-based care of collaborating, trained medical and behavioral providers
-- seamless physical and behavioral data information systems' HIT interoperability and data-sharing in real time
-- integrated communications systems among medical and behavioral clinicians
-- fully engaged patients playing key role in care team

11): What Should Relationship between TB-TCOC and Other Medicare VBP Programs Such As MA Plans, MSSP, Look Like:

--MA and MSSP already have well-defined quality metrics, care delivery standards, and payment strategies through which behavioral health integration can be enforced and incentivized (BPC).

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From: Aisha Pittman <aisha_pittman@naacos.com>
Sent: Friday, November 15, 2024 12:40 PM
To: PTAC (OS/ASPE) <PTAC@hhs.gov>
Cc: David Pittman <dpittman@naacos.com>
Subject: Identifying a Pathway Toward Maximizing Participation in Population-Based Total Cost of Care (PB-TCOC) Models

November 15, 2024

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Submitted electronically to: PTAC@HHS.gov

RE: Identifying A Pathway Toward Maximizing Participation in Population-Based Total Cost of Care (PB-TCOC) Models Request for Input (RFI)

Dear Members of the Physician-Focused Payment Model Technical Advisory Committee:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the request for input on identifying a pathway toward maximizing participation in population-based total cost of care (TCOC) models. NAACOS is a member-led and member-owned nonprofit of more than 470 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost. NAACOS represents over 9.1 million beneficiary lives through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs).

We share PTAC's goal of increasing participation in TCOC models like ACOs. Participation has plateaued in recent years, so we must focus on bringing in new participants while retaining others who face barriers to continued participation. To accomplish this, we need models that are stable and predictable, meet providers where they are, reduce regulatory burden, and are aligned across payers to better encourage system-wide transformation.

NAACOS and our ACO members have previously provided detailed input on how to increase participation in TCOC models, particularly among unique provider types. We outline our thinking on various topics below.

Specialist Providers

We know from experience that concurrent participation in episode-based payment models and TCOC models results in a complex set of overlap rules, leading to provider and patient confusion and increased burden. Specialty payment approaches should be designed within TCOC arrangements so that they can create the proper incentives to encourage coordinated care across the care continuum. There must be a focus on allowing providers to work together to achieve optimal patient outcomes. We recommend:

- Sharing data on cost and quality performance for specialists with ACOs.
- Supporting TCOC models with shadow or nested bundled payments for those who elect these arrangements.
- Addressing policy and program design elements that currently prohibit specialty integration, including quality measure reporting, the high-low revenue distinction in MSSP, and National Provider Identifier (NPI)-level participation.

Complex or Seriously Ill Populations

Many of today's TCOC models were designed based on the traditional Medicare population writ large. For organizations that serve a high proportion of patients with complex chronic conditions or serious illnesses participate, challenges with financial benchmarks, attribution methodologies, and performance measurement arise, creating barriers to their APM participation. In a letter earlier this year to the PTAC, NAACOS recommended several considerations in model development to account for high-cost, high needs beneficiaries, including:

- Design alternative program policies to account for high-cost, high needs beneficiaries who are significantly different from the average traditional Medicare beneficiary.
- Use beneficiary-level criteria to define high-needs beneficiaries, and if the APM entity exceeds a certain threshold of high-needs beneficiaries, it would qualify as high needs and all of its beneficiaries would be subject to the high needs program policies.
- Adjust attribution models to account for the care delivery models employed by organizations serving complex and seriously ill patients, which heavily emphasize a team-based approach.
- Design financial methodologies specifically for these populations to ensure sustainability and predictability for the participating organizations that serve them.

Rural and Underserved Communities

Special considerations need to be made for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Critical Access Hospitals (CAHs) because of their unique payment structures. CAHs are paid under a cost-based reimbursement system. FQHCs and RHCs are paid a pre-set amount for each patient visit, which can limit the delivery of care management services, and often deal with face-to-face requirements. Because of these barriers, NAACOS has recommended a new paradigm where safety-net-minded APMs focus on increasing or maintaining access rather than purely reducing costs. Judging performance on savings achieved compared to historical spending is

inappropriate for rural and lower-cost settings. Additional recommendations include:

- Provide waivers from the current encounter-based or cost-based reimbursement system.
- Offer lower discounts or minimum savings rates for rural providers in risk-bearing models.
- Waive the current restriction that prevents providing multiple services in one visit and along with face-to-face billing requirements for FQHCs and RHCs in APMs.
- Modify attribution approaches to account for facility-based billing, high patient turnover, and disproportionate number of advanced care providers that rural and safety-net providers employ.

Benchmarks

Additional work needs to be undertaken to address the long-term financial viability of TCOC models. TCOC models face the unsustainable dilemma of lower financial benchmarks over time as they continue to lower the cost of care on their patient populations. This "ratchet effect" is introduced because benchmarks are based predominantly on historical spending. Policies that aim to reduce the impact of the ratchet (e.g., prior savings adjustment, regional adjustment, accountable care prospective trend (ACPT)) do not go far enough. Models, like ACO REACH, that employ a rate book-approach to benchmarks do not appear to achieve actuarial savings required by law. Comparing APM performance to a dwindling fee-for-service (FFS) population limits innovative model design. Instead, CMS should seek multi-stakeholder input on the overall financial goals of APMs, reasonable comparison groups for defining success, and redesigning benchmarks to attract new participants and maintain current participants.

Multipayer Alignment and Adjustments

Because traditional Medicare APMs can be such a small percentage of a health system's or physician practice's revenue, many have value-based care contracts across lines of business. Complying with multiple value arrangements across several payers with different policies can be burdensome. As such, CMS should work with stakeholders to identify elements that can be aligned, to the extent possible, with TCOC model elements, including quality measurement and reporting, financial benchmarking and risk adjustment, beneficiary alignment, and data collection and reporting. CMS should implement this approach in their models and build incentives for Medicare Advantage plans to rapidly do the same. Such alignment would reduce duplicative work for providers and streamline efforts to maximize patient outcomes. NAACOS in partnership with the American Medical Association (AMA) and AHIP developed a playbook of best practices to spur adoption and alignment.

Data Transparency

TCOC model participants need actionable, timely, and reliable data to help inform proactive care decisions, which are critical to succeeding in TCOC arrangements. NAACOS,in partnership with AMA and AHIP best practices for data sharing. Relevant recommendations include:

- Creating an interoperable data ecosystem by adopting consistent content and exchange standards to simplify and expand data sharing.
- Empower model participants by sharing complete, accurate, and consistent data that paints a more comprehensive picture of a patient or population.
- Collect and share data to identify and address health disparities as well as barriers to care

beyond the clinical setting.
- Share data early, often, and in accessible ways, to improve care.
- Make available detailed information on how data were derived to foster trust in data received, used, and by which performance is measured.

Beneficiary Engagement

Increasing beneficiary engagement in accountable care and effectively communicating the benefits of these models is critical to expanding participation. However, currently patients in ACOs or other APMs often are unaware of their inclusion in models and the benefits they provide. NAACOS and the Health Care Transformation Task Force (HCTTF) convened a roundtable of ACOs and patient and consumer advocacy organizations, which developed recommendations to improve beneficiary education and engagement. Key recommendations include:

- Tailor beneficiary communications to different patient populations.
- Improve voluntary alignment and expand waivers that provide direct benefits to patients.
- Incorporate input from patients, family caregivers, and communities to promote person-centeredness and advance population health goals.

Conclusion

NAACOS looks forward to continuing to work with the Innovation Center, CMS, and PTAC on this issue to find ways to maximize participation in TCOC arrangements. We thank PTAC for its attention to this issue. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,
Aisha T. Pittman

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