

# Physician-Focused Payment Model Technical Advisory Committee

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March 10, 2023

Xavier Becerra, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Becerra:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's report on optimizing population-based total cost of care (PB-TCOC) models in the context of Alternative Payment Models (APMs) and physician-focused payment models (PFPMs). Section 1868(c) of the Social Security Act directs PTAC to: 1) review PFPMs submitted to PTAC by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary.

Within this context, from time to time, it may be beneficial for PTAC to reflect on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in APMs and PFPMs. In some cases, the importance of an emerging topic may lead PTAC to consider how proposals the Committee has reviewed in the past may inform that emerging topic. For example, PTAC may wish to assess information in previously submitted proposals and other sources that could serve to further inform the Secretary, as well as PTAC itself on these topics. This is the case regarding the topic of PB-TCOC models.

From 2016 to 2020, PTAC received 35 proposals for PFPMs and voted on the extent to which 28 of these proposals meet the Secretary's 10 regulatory criteria. Nearly all of the 35 proposals that were submitted to PTAC between 2016 and 2020 address the proposed model's potential impact on costs, to some degree. Additionally, at least 10 previous submitters have discussed the use of TCOC measures in their payment methodology and performance reporting as part of their proposal submissions.

Given this, PTAC now sees value in reviewing PB-TCOC-related elements within these proposals, along with current information on PB-TCOC models and value-based transformation. To ensure that the Committee was fully informed, the Committee conducted a series of theme-based discussions in 2022 relating to this topic. During PTAC’s two-day March 2022 virtual public meeting, the Committee began by focusing on key definitions, issues, and opportunities related to developing and implementing population-based TCOC models—including potential relationships between larger PB-TCOC models and episode-based or condition-specific models.

PTAC covered additional care delivery and payment issues related to PB-TCOC models during the Committee’s two-day June and September public meetings. These theme-based discussions included listening session presentations by Committee members, previous submitters, and various subject matter experts (SMEs), as well as panel discussions with other SMEs on various issues related to PB-TCOC models. PTAC also requested public input during these public meetings and through a Request for Input (RFI).

This report provides PTAC’s findings and valuable information on best practices for optimizing PB-TCOC models. The information that PTAC has gleaned from a review of previous PFPM proposals and other literature that addressed this important topic, as well as input received during the theme-based discussions, will help to inform PTAC in its review of future proposals. This material has informed the Committee’s comments, which are summarized in the following broad topic areas in this report:

- Topic 1: Desired Vision and Culture for Population-Based Total Cost of Care Models;
- Topic 2: Definitions of Total Cost of Care;
- Topic 3: Care Delivery Features;
- Topic 4: Enablers to Support Care Delivery Features;
- Topic 5: Desired Payment Features;
- Topic 6: Enablers to Support Desired Payment Features;
- Topic 7: Model Design Considerations;
- Topic 8: Desired Performance Measurement Features; and
- Topic 9: Policy Levers.

Key highlights include:

- It is important to foster a culture of accountability for clinical, quality, equity, and spending outcomes in PB-TCOC models.
- PB-TCOC models that have been most effective in improving quality and reducing TCOC for patient populations with multiple chronic conditions emphasize high-touch,

multidisciplinary team-based, proactive patient-centered care that is built around primary care.

- It is important to balance the use of primary care and specialty care; and manage the roles and use of primary care providers (PCPs) and specialty care providers in PB-TCOC models. However, while specialty care accounts for the largest component of the spending for whole-person care, specialty integration in value-based care has not been widespread.
- Having a significant proportion of a provider's patients in value-based arrangements (e.g., 30 to 50 percent) is likely to encourage providers to invest in value-based transformation. Therefore, it is important to develop a comprehensive strategy that includes developing models with multiple tracks and phase-in periods for taking on two-sided risk; balancing providing incentives for voluntary participation with the potential for requiring mandatory participation in certain cases; and multi-payer alignment.
- Placing financial accountability for TCOC at the entity or organization level is appropriate to manage risks for individual clinicians or smaller groups of clinicians, but incentives should be focused at the level of the provider.
- Continue developing payment models that assign accountability for quality and spending to a single entity that would be responsible for actuarial risk, and have flexibility in determining how to manage accountability and incentives for participating PCPs and specialists.
- Increase the use of prospective payment models that can provide participating organizations with certainty about finances and flexibility to implement care delivery changes; and consider options for facilitating more timely payments to accountable entities in order to provide increased flexibility for setting incentives for and providing payment to participating providers
- Consider including performance-based incentives that reward absolute improvements in a given provider's performance with respect to quality, equity and spending outcomes, in addition to incentives that reward absolute performance relative to external benchmarks.
- Infrastructure investments in staff and information technology are important for facilitating participation in value-based care. It is important to ensure the availability of sufficient upfront resources and infrastructure to promote care delivery changes.
- Recognizing that data access affects providers' ability to participate in PB- TCOC models, it is important to align approaches to exchange data in a way that ensures the information shared is actionable.
- Given that the typical health care organization currently monitors hundreds of inpatient and outpatient performance metrics, identifying and encouraging alignment on key performance metrics that drive desired care delivery improvements is particularly important.

- It is important to consider the impact of other Medicare payment policies on the effectiveness of efforts to develop successful PB-TCOC models. For example, providers' decisions about participating in PB-TCOC models are likely to be affected by the relative levels of reimbursement in fee-for-service Medicare and PB-TCOC models.
- Several SMEs discussed the importance of making it more attractive for providers to participate in value-based care arrangements. Additionally, several SMEs noted that the rapid growth of Medicare Advantage enrollment could reduce the number of beneficiaries who are available to participate in PB-TCOC models, reduce the number of providers who are available to care for these beneficiaries, and create selection issues in various markets.

In addition to summarizing the Committee's findings and comments related to these topics, the report also identifies areas where additional research is needed, issues for policymakers and some potential next steps.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the providers who care for them. Committee members would be happy to discuss any of these observations with you. However, the Committee appreciates that there is no statutory requirement for the Secretary to respond to these comments.

Sincerely,

//Lauran Hardin//

Lauran Hardin, MSN, FAAN  
Co-Chair

//Angelo Sinopoli//

Angelo Sinopoli, MD  
Co-Chair

Attachment

## REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

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*Optimizing Population-Based Total Cost of Care (PB-TCOC) Models in  
the Context of Alternative Payment Models (APMs) and Physician-  
Focused Payment Models (PFPMs)*

March 10, 2023

## About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to: 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities; 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS); and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR §414.1465.

Within this context, from time to time, it may be beneficial for PTAC to reflect on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in Alternative Payment Models (APMs) and PFPMs. Given that, in the past, several proposals that were submitted to PTAC incorporated elements relevant for population-based total cost of care (PB-TCOC) models, PTAC now sees value in reviewing these elements within these proposals, along with current information on PB-TCOC models and value-based care transformation. To ensure that the Committee was fully informed, PTAC's March 2022, June 2022 and September 2022 public meetings included a series of theme-based discussions on issues related to PB-TCOC models in the context of APMs and PFPMs.

This report summarizes PTAC's findings and comments regarding optimizing PB-TCOC models in the context of APMs and PFPMs. This report also includes: 1) areas where additional research is needed and some potential next steps; 2) a summary of the characteristics relevant for PB-TCOC models from proposals that have previously been submitted to PTAC; 3) an overview of key issues relating to PB-TCOC models and value-based care transformation; and 4) a list of additional resources related to these theme-based discussions that are available on the Office of the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website.

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## SUMMARY STATEMENT

From 2016 to 2020, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) received 35 proposals for physician-focused payment models (PFPMs) and voted on the extent to which 28 of these proposals meet the Secretary’s 10 regulatory criteria.<sup>i</sup> Nearly all of the proposals that were submitted to PTAC addressed the proposed model’s potential impact on costs, to some degree, including at least 10 proposals that discussed the use of total cost of care (TCOC) measures in their payment methodology and performance reporting. Given this, PTAC now sees value in reviewing TCOC-related elements within these proposals, along with current information on population-based TCOC (PB-TCOC) models and value-based transformation. To ensure that the Committee was fully informed, the Committee conducted a series of theme-based discussions in 2022 relating to this topic.

During PTAC’s two-day March 2022 virtual public meeting, the Committee began by focusing on key definitions, issues, and opportunities related to developing and implementing population-based TCOC models—including potential relationships between larger PB-TCOC models and episode-based or condition-specific models. PTAC covered additional care delivery and payment issues related to PB-TCOC models during the Committee’s two-day hybrid June and September public meetings. These theme-based discussions included listening session presentations by Committee members, previous submitters, and various subject matter experts (SMEs), as well as panel discussions with other SMEs on various issues related to PB-TCOC models. PTAC also requested public input during these public meetings and through a Request for Input (RFI).

This report provides PTAC’s findings and valuable information on best practices for optimizing PB-TCOC models. The information that PTAC has gleaned from a review of previous PFPM proposals and other literature that addressed this important topic, as well as input received during the theme-based discussions, will help to inform PTAC in its review of future proposals. This material has informed the Committee’s comments, which are summarized in the following broad topic areas in this report:

- Topic 1: Desired Vision and Culture for Population-Based Total Cost of Care Models;
- Topic 2: Definitions of Total Cost of Care;
- Topic 3: Care Delivery Features;
- Topic 4: Enablers to Support Care Delivery Features;
- Topic 5: Desired Payment Features;
- Topic 6: Enablers to Support Desired Payment Features;

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<sup>i</sup> The remaining seven proposals were withdrawn prior to the Committee’s deliberation.

- Topic 7: Model Design Considerations;
- Topic 8: Desired Performance Measurement Features; and
- Topic 9: Policy Levers.

Key highlights include:

- It is important to foster a culture of accountability for clinical, quality, equity, and spending outcomes in PB-TCOC models.
- PB-TCOC models that have been most effective in improving quality and reducing TCOC for patient populations with multiple chronic conditions emphasize high-touch, multidisciplinary team-based, proactive patient-centered care that is built around primary care.
- It is important to balance the use of primary care and specialty care; and manage the roles and use of primary care providers (PCPs) and specialty care providers in PB-TCOC models. However, while specialty care accounts for the largest component of the spending for whole-person care, specialty integration in value-based care has not been widespread.
- Having a significant proportion of a provider's patients in value-based arrangements (e.g., 30 to 50 percent) is likely to encourage providers to invest in value-based transformation. Therefore, it is important to develop a comprehensive strategy that includes developing models with multiple tracks and phase-in periods for taking on two-sided risk; balancing providing incentives for voluntary participation with the potential for requiring mandatory participation in certain cases; and multi-payer alignment.
- Placing financial accountability for TCOC at the entity or organization level is appropriate to manage risks for individual clinicians or smaller groups of clinicians, but incentives should be focused at the level of the provider.
- Continue developing payment models that assign accountability for quality and spending to a single entity that would be responsible for actuarial risk, and have flexibility in determining how to manage accountability and incentives for participating PCPs and specialists.
- Increase the use of prospective payment models that can provide participating organizations with certainty about finances and flexibility to implement care delivery changes; and consider options for facilitating more timely payments to accountable entities in order to provide increased flexibility for setting incentives for and providing payment to participating providers
- Consider including performance-based incentives that reward absolute improvements in a given provider's performance with respect to quality, equity and spending outcomes, in addition to incentives that reward absolute performance relative to external benchmarks.

- Infrastructure investments in staff and information technology are important for facilitating participation in value-based care. It is important to ensure the availability of sufficient upfront resources and infrastructure to promote care delivery changes.
- Recognizing that data access affects providers' ability to participate in PB- TCOC models, it is important to align approaches to exchange data in a way that ensures the information shared is actionable.
- Given that the typical health care organization currently monitors hundreds of inpatient and outpatient performance metrics, identifying and encouraging alignment on key performance metrics that drive desired care delivery improvements is particularly important.
- It is important to consider the impact of other Medicare payment policies on the effectiveness of efforts to develop successful PB-TCOC models. For example, providers' decisions about participating in PB-TCOC models are likely to be affected by the relative levels of reimbursement in fee-for-service Medicare and PB-TCOC models.
- Several SMEs discussed the importance of making it more attractive for providers to participate in value-based care arrangements. Additionally, several SMEs noted that the rapid growth of Medicare Advantage enrollment could reduce the number of beneficiaries who are available to participate in PB-TCOC models, reduce the number of providers who are available to care for these beneficiaries, and create selection issues in various markets.

In addition to summarizing the Committee's findings and comments related to these topics, the report also identifies areas where additional research is needed and some potential next steps.

## **I. PTAC REVIEW OF POPULATION-BASED TCOC MODELS IN THE CONTEXT OF APMS AND PFPMS**

In developing the comments in this report, PTAC considered information from three theme-based discussions, an environmental scan, two supplements to the environmental scan, and responses to a Request for Information the Secretary (RFI).

Prior to the first theme-based discussion in March 2022, an environmental scan was developed to provide background information for PTAC on PB-TCOC models in the context of APMS and PFPMS. Prior to the second theme-based discussion in June 2022, a supplement to the environmental scan was developed to provide additional context based on reports and topics mentioned during the March public meeting, and to summarize 10 selected PTAC proposals that included innovative approaches to addressing TCOC. Prior to the September 2022 theme-based discussion, a second supplement was developed to provide information on topics discussed during the June theme-based discussion and other topics related to PB-TCOC models not addressed in the previous environmental scan and supplement.

PTAC formed a Preliminary Comments Development Team (PCDT) for each of the three theme-based discussions. The March 2022 PCDT included Larry Kosinski (Lead), Josh Liao, and Chinni Pulluru. The June 2022 PCDT featured Chinni Pulluru (Lead), Larry Kosinski, Walter Lin, Luran Hardin, Lee Mills. The September 2022 PCDT comprised Josh Liao (Lead), Larry Kosinski, Walter Lin, Chinni Pulluru, and Paul Casale (See Appendix 1 for a list of the Committee members.) The PCDTs reviewed the environmental scan and its supplements and delivered summary presentations to the full Committee during the theme-based discussions. Each theme-based discussion included panel discussions with stakeholders from organizations that previously submitted PFPM proposals that included a population-based TCOC component (one proposal was discussed at each meeting). The theme-based discussions also featured perspectives from a diverse group of subject matter experts (SMEs), and an opportunity for public comments. Additionally, PTAC received nine public comments in response to an RFI that was posted in March 2022. At the end of each theme-based discussion, Committee members identified comments to be included in this RTS.

The Committee synthesized information from PTAC proposals, the environmental scan and supplements, the RFI, and panel discussions with SMEs and previous submitters on the role of PB-TCOC models in health care delivery and value-based care transformation in the context of APMs and PFPMs. This RTS summarizes PTAC's comments from its findings, which are organized around 9 categories:

- Topic 1: Desired Vision and Culture
- Topic 2: Definitions
- Topic 3: Desired Care Delivery Features
- Topic 4: Enablers to Support Desired Care Delivery Features
- Topic 5: Desired Payment Features
- Topic 6: Enablers to Support Desired Payment Features
- Topic 7: Model Design Considerations
- Topic 8: Desired Performance Measurement Features
- Topic 9: Policy Enablers to Support the Development and Implementation of PB-TCOC Models

For each topic, relevant issues are highlighted, followed by a summary of PTAC's comments. Appendix 3 provides a list of additional resources related to PTAC's PB-TCOC models theme-based discussion that are available on the Assistant Secretary for Planning and Evaluation (ASPE) PTAC website. Appendix 4 includes a complete list of the Committee's comments.

## **II. BACKGROUND: DEFINITIONS AND CONTEXT OF POPULATION-BASED TCOC MODELS**

The Center for Medicare and Medicaid Innovation (CMMI) has set the goal of having every Medicare fee-for-service (FFS) beneficiary with Parts A and B in a care relationship with

accountability for quality and TCOC by 2030. Frameworks such as the one developed by the Health Care Payment Learning & Action Network (HCP-LAN) provide one approach for distinguishing between PB-TCOC models and other forms of health care payment. The HCP-LAN APM Framework shows a progression of payment approaches away from traditional FFS (Category 1) and toward population-based models with provider accountability for TCOC (Category 4). However, while many experts reference the development of PB-TCOC models that can transform health care delivery and payment, there is not a widely accepted definition of the characteristics of these models or recognition of a single approach to achieving these aims.

**Increased Emphasis on Developing Models with Accountability for Quality and TCOC.** The Center for Medicare and Medicaid Innovation (CMMI) has set the goal of having every Medicare fee-for-service (FFS) beneficiary with Parts A and B in a care relationship with accountability for quality and TCOC by 2030. Additional priorities identified by CMMI include increasing provider capacity to participate in these models; increasing coordination between providers that are responsible for accountable care relationships and specialty providers that are accountable for delivering episodic and/or complex care associated with high spending; improving patient experience through more person-centered, integrated care; improving quality and outcomes; better aligning provider and beneficiary incentives to increase use of high-value services; improving affordability; increasing access to accountable, value-based care for underserved beneficiaries; and increasing the level alignment across payers on value-based care initiatives.

**Defining PB-TCOC Models.** 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 population-based 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 population-based TCOC model.*

**Defining TCOC.** PTAC is using the following working definition of how TCOC should be defined in the context of PB-TCOC models.

*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 [representing Medicare Part A and Part B expenditures only], and is calculated on a per-beneficiary basis for a specified time period.*

Additionally, PTAC anticipates that PB-TCOC models would include two-sided risk for participating accountable entities.

**Evidence About the Effectiveness of PB-TCOC Models.** Effective population-based TCOC approaches present an opportunity to improve care while reducing spending, especially for high-cost patients. PB-TCOC approaches are more likely to target beneficiaries with the potential for reducing expenditures and utilization. Evaluations of population-based TCOC approaches have yielded promising findings on the impact on avoidable health care utilization. However, there have been mixed results on the impact of population-based payment models on quality of care. There is also limited evidence of the impact of population-based TCOC approaches on outcomes and their effect on patient health and experience with care.

Additional information can be found in PTAC's *Environmental Scan on PB-TCOC Models* (see Appendix 3).

### **III. CHARACTERISTICS OF PTAC PROPOSALS RELEVANT TO POPULATION-BASED TCOC MODELS**

Between 2016 and 2020, PTAC received 35 proposed PFPs submitted by stakeholders.<sup>ii</sup> Of the proposal submissions that were reviewed by PTAC, ten were identified as including components that are relevant for PB-TCOC models. As shown in [Appendix 2](#), the ten proposals included various objectives, performance measures and payment approaches that are relevant for PB-TCOC models.

The PTAC proposals with TCOC components were primarily condition- or episode-specific. One of these proposals had an advanced primary care focus, three of these proposals had a population-specific focus, and six of these proposals had an episode-based focus. None of these PTAC proposed models were intended to serve a broad population, such as those that would be covered under ACOs.

The 10 PTAC proposals with TCOC components varied by clinical focus and setting of care. However, all 10 of these proposals sought to reduce health care spending. Common objectives in these proposals included: decreasing hospitalizations and ED visits, limiting spending associated with a particular episode of care (defined by diagnosis, prognosis, or procedures), and avoiding unnecessary services and medications.

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<sup>ii</sup> The 35 proposals submitted to PTAC represent an unduplicated count (i.e., proposals with multiple submissions are counted only once) of the number of proposals; 28 proposals were voted and deliberated on by the Committee, and seven proposals were withdrawn by submitters prior to deliberation, including one proposal that was withdrawn prior to any review by the Committee.

Physician-focused payment models (PFPMs), including those proposed to PTAC, can help to inform the development of larger population-based models in several important ways. For example, PFPMs can help to identify best practices in care delivery and care coordination; highlight areas where payment incentives may be misaligned; identify potential opportunities for nesting more targeted payment models within a larger population-based TCOC framework; and assist in determining how to enhance provider readiness and incentivize provider participation in payment models with two-sided risk through the development of innovative physician payment models.

Committee members noted several issues for consideration related to use of TCOC incentives in the proposals they reviewed. Notably, Committee members indicated that any given provider's accountability related to TCOC should reflect their specific role in driving health care costs. Committee members also noted that if not properly designed and implemented, the use of TCOC incentives, could potentially lead to a reduction in services that would improve patient-centeredness of care.

#### **IV. COMMENTS FOR CONSIDERATION BY THE SECRETARY**

Based on findings from the Committee's analysis of PB-TCOC-related components in PTAC proposals; information in the literature; listening session presentations from Committee members, previous submitters, and SMEs; panel discussions with additional SMEs on issues related to PB-TCOC models; and stakeholder responses to a Request for Input (RFI), this section summarizes PTAC's comments regarding optimizing PB-TCOC models in the context of APMs and PFPMs. PTAC's comments are organized in nine topics:

- Topic 1: Desired Vision and Culture for Population-Based Total Cost of Care Models;
- Topic 2: Definitions of Total Cost of Care;
- Topic 3: Care Delivery Features;
- Topic 4: Enablers to Support Care Delivery Features;
- Topic 5: Desired Payment Features;
- Topic 6: Enablers to Support Desired Payment Features;
- Topic 7: Model Design Considerations;
- Topic 8: Desired Performance Measurement Features; and
- Topic 9: Policy Levers.

For each topic, relevant issues are highlighted, followed by a summary of PTAC's comments. Additionally, the Committee has identified areas where additional research is needed and

potential next steps related to each topic. [Appendix 4](#) includes a complete list of the Committee's comments.

#### **IV.A Topic 1: Desired Vision and Culture For Population-Based Total Cost Of Care Models**

There has been mixed evidence on the ability of previous population-based models to achieve improvements in outcomes and quality. Therefore, it is important it is important to consider the desired vision and culture for future PB-TCOC models before identifying the desired care delivery and payment model features of these models,. Committee members identified six concepts relating to the desired vision and culture for PB-TCOC models:

- A culture of accountability;
- High-touch, proactive care;
- Eliminating health care disparities;
- Care coordination for underserved populations;
- Evidence-based practices, risk stratification, and data-driven care; and
- Dissemination and uptake of best practices.

PTAC's comments regarding the desired vision and culture for PB-TCOC models are listed in Exhibit IV.1.

**A culture of accountability.** Operationalizing care transformation via PB-TCOC models will require the health care system to adopt a culture of accountability for clinical, quality, equity, and spending outcomes. Fundamental to a culture of accountability is team-based care and effective coordination between primary care providers (PCPs), specialists, and other providers embedded into the care team. The potential for health systems and other care delivery organizations to monitor accountability, however, is tied to the availability of actionable data. Actionable data refers to data that are timely, easily interpretable by providers, and that can be used to identify inefficiencies and link these inefficiencies to specific points in the care delivery process.

In addition to actionable data, establishing a culture of accountability, as one subject matter expert (SME) suggested, is also linked to patient attribution and specialty provider engagement. Provider buy-in to a shift in culture towards increased accountability will depend, at least in part, on the perceived appropriateness and fairness of attribution methodologies (e.g., prospective versus retrospective attribution) and opportunities for flexibility in payment arrangements. This is particularly true when seeking to engage specialists and providers operating in rural settings where there may be less competition for referrals.

**High touch, proactive care.** To help reduce a given population's risk of developing undesired health outcomes, stakeholders recommend a care delivery system characterized by high touch, proactive care. Adopting a high touch, proactive approach requires practitioners to build

positive relationships with patients that are both culturally appropriate and inviting of transparent communication. One SME indicated that care coordinators can help facilitate communication with patients via proactive patient outreach and by helping patients access educational resources. A more proactive approach—whether that means more care visits and preventive screenings, increased dialogue with patients, or both—offers providers the opportunity to identify problems early and limit the number of higher cost, late-stage interventions. For example, one expert noted that more engaged, proactive primary care relationships have been associated with reductions in emergency department (ED) and inpatient utilization as well as lower TCOC.

**Eliminating health care disparities.** Reducing racial and socioeconomic disparities in health outcomes should continue to guide efforts to implement PB-TCOC models. This includes increasing access to care and empowering patients to play a more active role in their care journey. As noted by Committee members and SMEs, potential methods for realizing this vision include integrating primary care and behavioral health; improving provider relationships with their communities and the social service organizations operating in these communities; and, where appropriate, mandating their participation in PB-TCOC models to ensure coverage of underserved populations.

**Care coordination for underserved populations.** Successful implementation of PB-TCOC models requires enhanced care coordination for vulnerable populations. Care coordination becomes particularly important when episodic or condition-based models are nested in a broader PB-TCOC models. The potential for care coordination-related challenges also increases when treating high-risk patients whose care often necessitates a larger care team. Through interdisciplinary, team-based care, however, providers can more effectively identify the most appropriate and cost-effective interventions and ensure appropriate follow up is conducted. Care coordination and an emphasis on team-based care can also serve as a method for holding team members accountable.

**Evidence-based practices, risk stratification, and data-driven care.** Several Committee members and SMEs emphasized the importance of following evidence-based diagnostic and treatment protocols. Evidence-based practices are data-driven and informed by risk stratification, both of which help guide practitioners when electing a particular intervention or care path. Evidence-based practices, however, may be associated with increased spending due to the nature of a given treatment or patient population. It is therefore important that payment model stakeholders recognize that clinicians do not necessarily make care decisions with the goal of maximizing cost control.

**Dissemination and uptake of best practices.** When effective practices are identified through research, evaluation, and participant experiences, it is crucial that they be widely disseminated and adopted where appropriate. Future efforts should address resource- and knowledge-related gaps that currently inhibit the diffusion and or uptake of best practices, especially when a failure to do so risks intensifying health-related disparities. One SME highlighted the

importance of effective data sharing and provider engagement as methods for encouraging changes in provider behavior and providers' willingness to support development of best practices.

#### **Exhibit IV.1: PTAC Comments**

##### ***Topic 1: Desired Vision and Culture for Population-Based Total Cost of Care Models***

###### **Summary of Key Findings:**

- Stakeholders have expressed concerns about the effectiveness of previous population-based models in achieving improvements in outcomes and quality, and reducing TCOC.
- However, effective approaches for improving outcomes and quality while taking on financial risk for managing the care of patient populations with multiple chronic conditions have been identified in both the research literature and by innovative providers.

**Comment 1A:** *It is important to foster a culture of accountability for clinical, quality, equity, and spending outcomes in PB-TCOC models.*

*This culture of accountability should support high-touch proactive care that:*

- *Prevents or mitigates populations' risk of developing undesired health outcomes;*
- *Ensures optimal outcomes; Eliminates racial and socioeconomic disparities; and*
- *Fosters continual care coordination focused on all patients including underserved communities.*

*This culture of accountability should also foster:*

- *The availability and use of actionable data; evidence-based diagnostic treatment protocols;*
- *Effective stratification of patients based on risk, data driven care delivery decisions; and dissemination and uptake of best practices; and*
- *Alignment and reduced complexity of payment models.*

#### **IV.B Topic 2: Definitions of TCOC in PB-TCOC Models**

Committee members considered issues related to definitions of TCOC and which services should be included in TCOC calculations for PB-TCOC models:

- Defining TCOC;
- Aligning definitions of services included in TCOC; and
- Issues regarding drug-related expenses.

PTAC's comments regarding definitions of TCOC for PB-TCOC models are listed in Exhibit IV.2.

**Defining TCOC.** Developing a shared vision for the design and implementation of PB-TCOC models first requires practitioners and policy makers to establish a common definition for TCOC and the various services that such models ought to cover. The Committee currently defines a PB-TCOC model as 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. Under this system, providers would receive payments for all Medicare Part A and Part B expenditures on a per beneficiary basis.

**Aligning Definitions for Services included under TCOC.** Further work is also needed to align definitions for which other services and costs to include in PB-TCOC models. Future studies are also needed to determine whether it is appropriate to develop a common definition for TCOC across population-based models or identify times when variation in definitions across models may be beneficial. Questions surrounding the feasibility of definitional alignment will be particularly important when addressing model overlap and situations where definitions may need to vary as a function of patient population, provider type, and or other contextual factors. Future research should target these more granular details associated with model design and implementation. These findings will also inform the type of wraparound services than can be covered and available to patients under PB-TCOC models (e.g., transportation services) and the necessary resources to support these activities. Finally, beyond costs associated with direct services, some stakeholders have asked whether costs associated with infrastructure needed for effective participation in PB-TCOC models should be incorporated in the definition of TCOC.

**Issues related to drug-related expenditures.** Although the Committee and many SMEs share a broad vision for the design and operationalization of PB-TCOC models, several questions remain about best practices on a more granular, context-specific level. One key question is whether Medicare Part D expenditures should be included in TCOC calculations, or whether their exclusion leads to unintended consequences related to shifting therapies between Part B and Part D options. It is therefore important that stakeholders work to identify and evaluate process measures designed to incent pharmaceutical stewardship overall. These measures would allow assessment of whether therapies are selected based on overall value-based care principles, rather than around financial incentives. Testing PB-TCOC models that include Part D will also help stakeholders assess unintended consequences tied to drug coverage such as cost shifting between Part B and Part D pharmacy spending. As some stakeholders noted, determining how to effectively incorporate pharmaceutical costs in TCOC calculations may ultimately be important for encouraging specialist integration in TCOC models.

## Exhibit IV.2: PTAC Comments

### *Topic 2: Definitions of Total Cost of Care*

#### **Summary of Key Findings:**

- In the context of Medicare APMs, TCOC typically includes Medicare Part A and Part B expenditures; and is calculated on a per-beneficiary basis for a specified time period. However, there are differences in how TCOC is currently defined in various APMs, and for payers and patient populations.
- Some stakeholders have expressed concerns about providers' ability to affect the utilization of some of the services that are typically included in TCOC.
- Stakeholders have also indicated that the definition of TCOC can affect service utilization and encourage cost-shifting. Some stakeholders have suggested that a patient-centered definition of TCOC should ideally measure all aspects of the cost of patient care – including all services paid for by Medicare, beneficiary out-of-pocket payments, informal care, etc.
- Some stakeholders have also asked if the definition of TCOC should also include additional costs such as costs associated with infrastructure needed for effective participation in PB-TCOC models.
- The process of developing a more standardized definition of TCOC is likely to be complex.

**Comment 2A.** *Further work is needed to determine if it is appropriate to develop a common definition for TCOC across population-based models or identify times when variation in definitions across models may be beneficial (e.g., as a function of patient population, provider type, and or other contextual factors). Questions about the feasibility of definitional alignment will be particularly important when addressing model overlap and efforts to improve multi payer alignment.*

**Comment 2B.** *In the short term, it is important to work towards aligning the services that are included in the definition of TCOC in cases where there is overlap across models. This will help to clarify and harmonize incentives among providers participating in multiple models. At the same time, it is also important to consider situations where it may be appropriate to vary the definition of covered services that are included in TCOC for certain models.*

**Comment 2C.** *It is important to acknowledge that excluding certain expenditures from the TCOC that providers are accountable for can have unintended consequences related to utilization (including substitution and cost-shifting, such as between Part B and Part D therapies). In order to address this issue, some organizations have developed performance measures related to the stewardship of services that are not included in the definition of TCOC (such as pharmaceutical stewardship). Consideration should also be given to testing the impact of including additional services in the definition of TCOC for PB-TCOC models.*

**Comment 2D.** *In the medium to longer term, it will be beneficial to explore the feasibility of developing a standardized definition of the services that are included in TCOC, and the way that TCOC is calculated across payers.*

### **IV.C Topic 3: Desired Care Delivery Features**

Committee members identified four main features of the ideal care delivery system for PB-TCOC models:

- Multidisciplinary team-based, patient-centered care;
- Meeting patients where they are;
- Balanced use of, and coordination between, primary care and specialty care;
- Targeted population-based interventions to prevent or mitigate populations' risk of developing adverse health outcomes; and
- Identification of health-related social needs and connection to appropriate resources.

PTAC's comments regarding desired care delivery features are listed in Exhibit IV.3.

**Multidisciplinary team-based, patient-centered care.** One consistent theme that emerged from the public meetings was the importance of high-touch, team-based, patient-centered care. Stakeholders' viewpoints differed as to whether the provider with the most patient contact should be a PCP or specialist, depending on the patient's needs. However, the Committee supported the idea of building PB-TCOC models around primary care as a foundational model. PCPs should then be supported by multidisciplinary care teams that include specialists, nurses, pharmacists, social workers, and community health workers (CHWs) as appropriate to address patients' needs. One Committee member suggested there are practical ways to assign accountability for different activities to different professionals incrementally depending on their expertise and patient needs. For example, social workers and CHWs can work one-on-one with patients to understand their needs and expectations, help them navigate insurance and pharmacy issues, schedule follow-up appointments and labs, connect patients to resources to address HRSNs, and support doctors to provide better care.

**Meeting patients where they are.** Panelists noted, and Committee members agreed, that meeting patients where they are is ideal for engaging them in PB-TCOC models. Multidisciplinary care management teams can be embedded in a way that complements care in the clinical setting, or care managers and other members of the care team can conduct outreach in community settings. One Committee member noted that building in care delivery approaches that effectively and appropriately reach individuals, educate them, and extend necessary resources can help build patient-provider relationships.

**Balanced use of, and coordination between, primary care and specialty care.** Most panelists and Committee members agreed that primary care should be the focal point of PB-TCOC models, but acknowledged the need for effective coordination with specialists. Coordination between PCPs and specialists is critical to reduce fragmentation in care and effectively manage care, especially for patients with multiple chronic conditions. Depending on patient needs, patients with certain chronic conditions may receive most of their care and rely on coordination of care from specific specialists such as gastroenterologists and nephrologists as opposed to PCPs. Committee members referred to data showing that patients attributed to ACOs often receive half or more of their care, including specialty care, outside the ACO, which limits providers' ability to control costs and suggests the need for effective referrals and information sharing between PCPs and specialists.

Coordination between PCPs and specialists will require a cultural shift among specialists to recognize collective accountability. Stakeholders suggested that PB-TCOC models adopt "cascading accountability" that recognizes the different roles PCPs and specialists might play across the continuum of care and supports patients holistically. One Committee member noted the importance of moving beyond a "compartmentalized understanding" of responsibilities for primary care versus specialty care providers. Another Committee member highlighted the need to understand how specialists impact the patterns of care but also stated that the focus should be on the provider that is best suited to coordinate care, more than determining which provider last touched the patient. Other Committee members emphasized that there was still a lot to learn about how to engage and incentivize specialist participation in PB-TCOC models. One Committee member described the challenge of engaging specialists and PCPs in areas where there is no ACO or associated infrastructure to support value-based care.

Coordination between PCPs and specialists can be facilitated through tighter provider networks. One PTAC member noted that some ACOs have established specialist networks, adopting an approach from MA. However, Committee members observed that in areas with lower uptake of APMs, there are fewer specialists willing to take on accountability and shared risk. Local context can impact the ability of PCPs to direct patients to specialists within an ACO or PB-TCOC model. For example, a very large urban center may have an abundant supply of specialists willing to participate in a PB-TCOC model. In these cases it may be straightforward to develop a high quality, lower cost specialist network, whereas rural and less urban areas have a limited supply of specialists to incorporate into networks. One Committee member emphasized that in some rural regions, it is difficult to access even primary care, let alone specialty care. On the other hand, in some rural and less urban communities, PCP referrals are a large part of a specialist's incoming patient stream and there is an incentive to maintain strong relationships. Related to this point, however, one Committee member cautioned that the ability for PCPs to leverage such relationships may vary.

**Targeted population-based interventions to prevent or mitigate populations' risk of developing adverse health outcomes.** Several stakeholders discussed how population-based interventions can prevent or mitigate adverse health outcomes, particularly for patients with complex health needs. Certain unwanted and unexpected outcomes can be prevented, even while the overarching process of aging cannot be prevented.

Complex patients require a more robust care team and coordination resources above the needs of the general population. Addressing the needs of patients with the most complex health status provides the best opportunity for short-term improvements in outcomes. One stakeholder noted that robust care management for high-needs patients is likely a major contributor to the strong patient experience outcomes reported by evaluations of ACOs. Another stakeholder discussed how care coordinator outreach can be targeted to those who would most benefit from education to self-manage their health needs.

While addressing high-need populations has the greatest opportunity to lower costs in the short-term, it is also important for TCOC models to address the needs of low-risk patients for prevention. Identifying issues before they become acute can reduce downstream costs. One stakeholder described the ideal cancer care journey including pathways to diagnoses and timely initial treatment. Because patient health status changes over time, monitoring the entire population is necessary to identify those who currently have the greatest needs.

For complex patient populations, improving hospice and palliative care could improve outcomes in TCOC models. A stakeholder from the Long Term Care Accountable Care Organization, which serves a complex and frail population, offers its providers resources around palliative care, hospice care, and advanced care planning. Another stakeholder noted that certain CMMI models, including ACO REACH and Kidney Care Choices, are directly addressing concurrent care (i.e., palliative and curative care).

Given the considerations outlined above, stratifying patients so that models can be flexible in how they delivery care to patients based on their level of clinical and spending risk, particularly during care transitions, may improve patient outcomes. Stratifying patients for different approaches to care delivery could also encourage providers to care for those with complex needs and support providers efforts to do so. This could include a mechanism to help provider systems fund services that address the social determinants of health.

**Identification of health-related social needs and connection to appropriate resources.** Stakeholders discussed the importance of screening and referrals for health-related social needs (HRSNs) to improve population health outcomes. Several stakeholders described that, although the benefits of screening and referrals for HRSN are widely understood, reimbursement for addressing these needs is fragmented and limited. New models should increase investment in screening and referrals to help standardize the process. Stakeholders

discussed how CHWs may be able to deliver these services efficiently. Current alternative payment models typically include Medicare Parts A and B spending; CMMI may wish to include screening and referrals for HRSN as an additional service in new models.

Screening for HRSNs can identify patients at greater risk for experiencing negative health outcomes. One provider organization described its successful integration of data on HRSNs in its electronic medical record. This allows providers to monitor if referrals were made and services to address HSRNs were provided. Another stakeholder suggested that, to address the challenge of data sharing between providers and community-based organizations (CBOs), CBOs could be incorporated into new models with shared accountability for data sharing. Another stakeholder noted that HRSN screening could provide the impetus for provider organizations to collect better data on how social determinants of health (SDOH) impact their patients. Wider adoption of tools available from vendors for screening and referrals for services to address HSRNs may reduce the burden on providers. While physicians have limited time to screen for and address HSRNs, a robust care management team (e.g., one that includes CHWs) can allow a practice to screen for social needs while reserving physician time for clinical needs.

Because some providers are in the early stages of adopting the practice of screening for HRSNs, there is an immediate need to reduce burden on providers and CBOs that is required to encourage widespread adoption. In the near term, standardizing existing efforts to screen for HSRNs may include developing and deploying a consistent set of questions and definitions would reduce the time and effort to screen, ease data sharing across organizations, and improve opportunities for valid evaluation.

The availability of social service resources varies by community. In some communities, social service providers may not have adequate capacity to act on referrals. In addition, there may be cultural differences between health care and CBOs that add complexity to collaborations. It may take time for the return on investment from screening and referrals to emerge. Despite these challenges, the potential of referrals for HRSNs to prevent costly conditions from developing warrants increasing investments.

Longer term, new models should incorporate partnerships to ameliorate HRSNs, in addition to screening and referrals. Successful models integrate medical and social services, while recognizing that it is important for the health care system to maintain a strong focus on clinical quality. Stakeholders discussed promising examples of strong partnership between providers and CBOs. For example, one stakeholder discussed using community liaisons to build relationships with social services and community resources (in this case affordable housing and food banks) to support patients beyond the clinical setting. Another stakeholder discussed that his organization's experience with referral and follow-up informs the community benefit it offers to partner organizations. Some states such as North Carolina are experimenting with providing Medicaid funds to address HRSNs (e.g., housing and transportation).

### **Exhibit IV.3: PTAC Comments and Areas Where More Information is Needed**

#### *Topic 3: Care Delivery Features*

##### **Summary of Key Findings:**

- Stakeholders emphasized the importance of multidisciplinary, team-based care that is built around primary care and includes high-touch interventions (particularly for high-risk patients with multiple chronic conditions) in order to facilitate the provision of high-value care.
- Patient-centered care should include identifying the patient’s primary care team; improving patient engagement; building patient trust; and reducing complexity by co-locating care delivery sites, synchronizing prescriptions, and providing accessible patient education. Special attention should be given to managing care transitions across settings.
- Stakeholders also discussed exploring approaches to integrate specialists in patient-centered, multi-disciplinary care delivery teams; and enhance care delivery teams with behavioral health providers, pharmacists, community-health workers, and other service providers.
- Additionally, some stakeholders discussed the importance of managing the types of care team encounters with patients or “touches” (e.g., primary care versus specialty care). However, several stakeholders noted that while specialty integration is critical because it is the largest component of spending for person-centered health care, specialty integration into value-based care is not widespread.

**Comment 3A.** *Encourage high-touch multidisciplinary team-based, patient-centered care that is built around primary care. Strengthen investments in primary care with enhanced care delivery teams that include behavioral health providers, pharmacists, CHWs, and other providers as appropriate. Explore approaches for integrating specialty care in patient-centered, multidisciplinary care delivery teams.*

**Comment 3B.** *Balance the use of primary care and specialty care; and manage the roles and use of primary care providers (PCPs) and specialty care providers in coordinating care for patients with certain acute and chronic conditions, and during certain disease stages. Involve PCPs and specialty care providers in developing patient-centered models with cascading or collective responsibility for population care management.*

**Comment 3C.** *Leverage data on the number and types of care team encounters (such as the ratio of primary care to specialty care “touches”) to encourage team-based care.*

**Comment 3D.** *Proactive patient engagement for patients with complex conditions can help provide appropriate resources to address their needs, reduce gaps in care, and mitigate risk of adverse outcomes. To facilitate targeted interventions, it is important to consider stratifying*

*patients by clinical risk and potential for higher service delivery spending to tailor care coordination to their needs and manage transitions effectively.*

**Comment 3E.** *It is important to consider the benefits of balancing immediate spending-reduction goals with the need to increase investment in primary and preventive care that can help reduce TCOC in the medium and long term, both for high-risk patients and for patients with “rising” risk or low risk.*

**Comment 3F.** *Emphasize screening and referral for health-related social needs (HSRNs) and use existing data on social needs to help identify and establish outreach to patients most likely to be adversely affected by social determinants of health (SDOH). In the short-term it is important to consider developing standardized screening questions for assessing HSRNs across models to minimize provider burden and enable evaluation. Over time, efforts could also include exploring incentives for building and sustaining partnerships with CBOs; and assigning accountability for addressing HSRNs to the appropriate entities.*

**Areas Where Additional Information Is Needed:**

- Best practices for integrating different kinds of specialty care in multidisciplinary care delivery teams (e.g., cognitive specialties, procedural specialties, and other specialty care providers as appropriate)
- Best practices for managing transitions when patients are primarily being treated by primary care providers versus specialists during different disease stages of acute and chronic conditions
- Patterns of specialty care utilization and spending in general and for specific conditions and patients
- How to engage and incentivize specialist participation
- How to improve specialty integration in value-based care
- Best practices for standardizing screening questions for assessing HSRNs
- How to reach a “tipping point” in which a sufficient percentage of a provider’s patient panel is covered by a value-based payment model to incentivize participation. In Medicare, this would specifically refer to FFS beneficiaries that are eligible to participate in APMs.

**IV.D Topic 4: Enablers To Support Desired Care Delivery Features**

Committee members identified five main enablers to support the ideal care delivery system in PB-TCOC models:

- Real-time access to actionable data and information on best practices;
- Infrastructure investments; and

- Multi-payer alignment on performance measures to incentivize improvements in quality, outcomes, and patient experience.

PTAC's comments regarding enablers to support desired care delivery features are listed in Exhibit IV.4.

**Real-time access to actionable data and information on best practices.** Many stakeholders emphasized that access to real-time patient data (including clinical data and claims) from all sources of care is essential for provider success in TCOC models. Real time data on patient health care utilization gives providers the information they need to be able to take on risk, since providers cannot influence patient outcomes if they lack information, for example, on the hospital or emergency room care their patients receive. Access to data is critical for enabling providers to adopt best practices, for example, around medication management, palliative care, and advanced care planning. Models must provide the tools, resources, and infrastructure to enable providers to access real-time data, and to facilitate data sharing between providers and risk-bearing entities. Stakeholders discussed how access to data is essential to improving coordination between specialists and primary care physicians. Given the critical nature of shared clinical data, one stakeholder suggested adopting the term "health information utility" and emphasized the importance of "pushing" this information out to providers in a consistent way rather than relying on provider to provider sharing.

Beyond provider's access to information from claims data or medical records, it is necessary for providers to have sophisticated analytic capacities to be successful in TCOC models. For example, through "case finding", providers can proactively form longitudinal relationships with patients at risk for having substantial medical needs in the future. However, these capacities require significant financial investments. One stakeholder discussed the example of how kidney disease outcomes can be improved through data in TCOC models: lab data can be used to identify patients with kidney disease, while effective treatments can be tracked using administrative or claims data.

Stakeholders noted that it is more difficult for smaller organizations than larger organizations to develop and sustain the capacity for using data analytics to improve patient care. However, stakeholders noted that businesses have emerged to facilitate the participation of smaller provider organizations (e.g., PCPs or others) in ACOs. These businesses can help providers access important IT and data analytic tools. Other challenges to the widespread adoption of successful, useable data sharing include lack of interoperability across provider systems (which can be due to provider use of proprietary systems but can be a challenge even when providers use the same vendor) and lack of consistent funding for collecting and sharing relevant data. Integrated health systems have an advantage in that they can provide access to data among a range of their providers, but most patients, especially those receiving care outside of an integrated health system, see providers from multiple entities.

Stakeholders discussed that providers must have access to relevant information in a way that is timely and feasible. For example, rather than requiring providers to log-in to a system to receive updates on care their patients received at other providers, health information exchange systems can automatically send updates to on a given patient's care to multiple entities, such as their ambulatory care providers, care manager, skilled nursing facility, or home health agency. Real-time data access gives providers greater opportunity to influence patient outcomes relative to data they received on a delay. In particular, claims-based quality measures are subject to a 2-3 year data lag, which limits the ability of providers to adjust care based on what they learn from these data. One stakeholder emphasized that accountable entities need to be able to reward network providers in a timely manner and that timely reconciliations of shared savings could be helpful for engaging providers in models, including specialist participation in clinical episode models.

It is important to note, however, that delays in data may improve accuracy and completeness compared to data provided in real time.

**Infrastructure Investments.** Many stakeholders discussed the need for upfront investments in provider infrastructure to reduce barriers to participation in PB-TCOC models. Infrastructure investments in staff and information technology were identified as being particularly important for enabling value-based care. There are significant startup costs associated with participating in value-based care, such as building data analytic capacity, hiring care managers, and educating providers. Panelists noted existing payment mechanisms are not sufficient to cover the upfront cost that PCPs or other providers will incur to build the necessary infrastructure.

Upfront payments are especially important to increase the PB-TCOC participation among smaller and rural practices. As one panelist explained, large health or hospital systems may access capital reserves to support an upfront investment. However, smaller entities, especially those operating through cash accounting, will not have access to the necessary capital. One panelist emphasized that upfront payments would help limit barriers to entry.

**Multi-payer alignment on performance measures to incentivize improvements in quality, outcomes and patient experience.** SMEs and Committee members stressed the importance of encouraging multi-payer alignment across PB-TCOC models. When value-based care programs are not aligned, it can be complex and counterproductive for providers who provide care to patients across multiple payers. It is important to align payment approaches so that clinicians and organizations can focus on care transformation without the complexity of multiple payment structures, regulations, and performance metrics.

One Committee member emphasized the need for multi-payer alignment on data and quality measures and where there's an opportunity to decrease administrative costs and improve efficiency. One panelist stated that success in multi-payer alignment will require a shared vision across payers. They noted that differentiation to allow for competition should coexist with alignment in some areas such as quality measurement, risk adjustment, and patient attribution methodologies.

Committee members also discussed the importance of multi-payer arrangements because of the challenge of changing practice patterns only on a limited scale, noting one payer, one program at a time approaches may not include enough patient or revenue volume to change practice. One SME explained that multi-payer alignment is essential to the "increase the critical mass" of participation in value-based care models and decrease the burden of adopting such models.

Committee membersSeveral states like Oregon and Vermont are already creating or on the path to creating integrated all-payer models. Some members suggested that all-payer models are achievable at a state level, indicating that state level alignment may ideally inform the development of other similar all-payer models to create the scale providers need to engage in the value-based payment effort. One panelist noted that multi-payer models will require establishing community-level governance and convenings to help commercial payers work with a large federal agency.

#### **Exhibit IV.4: PTAC Comments**

##### ***Topic 4: Enablers to Support Care Delivery Features***

##### **Summary of Key Findings:**

- Many stakeholders emphasized that access to real-time patient data (including clinical and claims data) from all sources of care is essential for provider success in TCOC models.
- It is important to consider the tradeoffs that sometime exist between providing timely data and providing data that are accurate and complete – recognizing that quality and timeliness are important to make data actionable, while data quality and completeness are important to establish valid benchmarks and risk adjustment which are important for managing and tracking performance on spending and quality.
- Stakeholders also discussed the importance of access to information and measures on best practices; forums for the sharing of best practices; infrastructure investments in staff and information technology to enable value-based care; and alignment on performance measures to incentivize improvements in quality, outcomes, and patient experience.

**Comment 4A.** *Recognizing that data access affects providers' ability to participate in PB-TCOC models, it is important to align approaches to exchange data in a way that ensures the information shared is actionable. This may mean considering how to give accountable entities real-time access to centralized, multi-sourced data systems (including data from CMS and other providers and payers) using a "data utility" approach rather than relying on provider to provider data sharing. It is also important to consider assessing and enhancing approaches used by providers to access and share data, with a focus on data standards.*

**Comment 4B.** *Encourage the development of forums for disseminating detailed information about how successful providers have been able to improve quality while reducing spending and taking on financial risk. Additionally fostering collaboration between researchers and successful PB-TCOC model participants can help to identify and promulgate best practices for caring for patients with complex needs through the use of different research and evaluation methods including randomized trials. It may also be feasible to work with medical societies to design studies to test performance outcomes associated with the use of their published guidelines and clinical pathways.*

**Comment 4C.** *There is an opportunity to analyze the relationship between specific care delivery approaches and performance outcomes by incentivizing or requiring accountable entities to regularly submit and update structured information about the care delivery strategies that they are using, and including this information in the evaluations of PB-TCOC models.*

**Comment 4D.** *Infrastructure investments in staff and information technology are important for facilitating participation in value-based care. It is important to ensure the availability of sufficient upfront resources and infrastructure to promote care delivery changes. There is a potential to provide resources to support primary care providers who are not currently participating in value-based care (e.g., embedded care teams providing 24-hour support). However, there is a need for sustainable funding to incentivize and support development of the necessary health data-sharing infrastructure to facilitate centralized data analytics over an extended period of time.*

**Comment 4E.** *Given that the typical health care organization currently monitors hundreds of inpatient and outpatient performance metrics, identifying and encouraging alignment on key performance metrics that drive desired care delivery improvements is particularly important. Aligning the key performance metrics that are related to the care of a substantial share of a provider's full panel of patients would help to reduce burden while facilitating the monitoring of outcomes. Improving alignment of performance metrics is particularly important for specialists.*

#### **Areas Where Additional Information Is Needed**

- Resources needed to support participation of more safety net providers in value-based care.

#### **IV.E Topic 5: Desired Payment Features**

Committee members identified four desired payment features in PB-TCOC models:

- Provider accountability in PB-TCOC models;
- Determining accountable entities;
- Glide paths for increasing financial risk over time;
- Comprehensive participation strategy;;
- Contemporaneous value-based payments; and
- Provider and beneficiary incentives.

PTAC's comments regarding enablers to support desired care delivery features are listed in Exhibit IV.5.

**Provider accountability in PB-TCOC models.** PB-TCOC models require clear assignment of accountability across organizations and providers to identify which entity is accountable for different components of care. While there was not consensus among stakeholders, many noted the desirability of incorporating incentives (financial and non-financial) at the provider level as well as at the level of the accountable entity. Stakeholders discussed several criteria for assigning accountability, including focusing on providers who provide the most care to a patient (usually PCPs), targeting areas of waste in the health care system, and only holding providers accountable for services directly under their control.

Several SMEs and Committee members agreed that primary care is the natural setting for centering accountability in PB-TCOC models, with the understanding that PCPs should provide high-value referrals to specialists in their network. However, one SME noted that there is friction regarding how much specialty care should be under the purview of PCPs. One SME and one Committee member observed that for some chronic conditions, such as kidney disease and digestive disorders, a specialist is best suited to assume accountability. As discussed under Topic 3 "Desired Payment Features", cascading accountability structures may facilitate the integration of specialty providers into PB-TCOC models and encourage coordination between specialists and PCPs.

There are several challenges in assigning accountability in PB-TCOC models. First, patients will likely see providers that are not affiliated with value-based care models. Committee members discussed data that suggest patients attributed to many ACOs receive roughly 50 percent of their care outside the ACO, which limits the ability of participating providers to manage spending to achieve the goals of value-based care. Second, providers in value-based payment models need to see their patients regularly to influence care delivery and spending. One SME indicated that medical groups are not successful in Medicare TCOC models if they do not see 95

percent or more of their patient population at least once per year, independent of the population's risk level, which one Committee member echoed. Third, in some geographic areas there are fewer specialists for referrals who would be willing to take on accountability and shared risk. Finally, ACO providers have incentives to lower spending on care that they do not provide. For example, accountable entities that are physician-led will try to reduce spending in inpatient settings, whereas accountable entities that are hospital-led will try to reduce outpatient spending. Population-health TCOC will need to include incentives to foster shared accountability among participating practitioners and facilities.

**Determining accountable entities.** In PB-TCOC models, it is important to designate an entity that assumes accountability and financial risk for its aligned patients. Some SMEs suggested that accountability should be placed at the organizational level. They noted that ACOs and hospitals have more resources and infrastructure to assume risk compared to individual providers. One SME pointed out that there are very few primary care practices that have a critical mass of patients, let alone individual physicians, to assume significant risk on their own. Individual providers or small group practices may not have margins to take on significant downside risk. One SME explained that the purposes of contracting with organizations is to pool risk and to encourage organizations to do what clinicians cannot, such as organizing care practices, making joint decisions about capacity, and managing the workforce, noting that devolving risk from the group to the clinician level defeats that purpose. They further observed that sharing risk with clinicians based on their collective performance does not affect clinician incentives because “free-riders” would emerge.

However, another Committee member found that the idea of organizational accountability conflicts with the idea that the provider should prosper under value-based models and noted that profits in ACOs are often not distributed to providers but rather go toward ACOs' infrastructure. Another Committee member agreed, noting that when financial incentives are paid to the organization, the provider does not realize the potential benefits of the model.

**Glide paths for increasing financial risk over time.** Stakeholders widely agreed on the need for a phased approach allowing providers and organizations to gradually assume more downside risk. Payment models could be structured on a glide path toward greater risk and greater reward over time to encourage providers to begin to participate and take on more risk over time. One SME noted that it is particularly challenging for smaller organizations to take on the infrastructure investments needed to succeed in PB-TCOC models and suggested that models offer a track with lower-risk options for smaller practices to encourage participation. One Committee member explained that the purpose of PB-TCOC models is not to be punitive to people who are in FFS, but to enlarge the incentives to moving to value-based care, understanding that not all of them can do it right away.

**Comprehensive participation strategy.** There are a range of incentives that can affect provider choices regarding participating in a PB-TCOC model. SMEs described a continuum of strategies for moving away from the current payment environment, ranging from strongly incentivizing participation to making participation mandatory. Stakeholders agreed that PB-TCOC models should at least be heavily incentivized, and several discussed the potential desirability of a gradual shift to mandatory participation for some providers.

There are several potential advantages related to mandatory participation. First, mandatory participation would encourage providers that have not engaged with value-based payment to join PB-TCOC models, thereby helping to increase the proportion of providers' revenues that are in value-based arrangements and the incentives for engaging in broader value-based transformation. One SME noted that APMs cannot succeed without including enough of the right kinds of provider participants, which might require mandatory participation. A Committee member observed that mandatory participation may be needed if PB-TCOC models cannot create sufficient incentives to engage specialists, particularly in underserved and rural markets. Second, mandatory participation will enable more rigorous evaluation of PB-TCOC models by alleviating the selection effect present in voluntary models. Organizations that tend to join PB-TCOC models have the motivation and ability to improve quality and efficiency, thus limiting the generalizability of findings to other organizations and providers. One Committee member suggested that the time has come for mandatory participation, especially in order to facilitate valid evaluation. Third, accountable entities facing losses in voluntary models are likely to exit, limiting the impact of the models. Mandatory participation would bring in and retain lower-performing organizations and providers that are in most need of improving care delivery and spending.

There are also potential challenges associated with mandating participation in PB-TCOC models. Most notably, not all providers are positioned to succeed in PB-TCOC models. Stakeholders suggested approaches to navigating these challenges. One SME supported an approach to encouraging participation in which incentives are considered on a spectrum, with different levels of incentives or requirements depending on the type of provider. For instance, large organizations can be heavily incentivized or required to incorporate two-sided risk, and small organizations can participate in less-heavily incentivized programs similar to MSSP Classic. Stakeholders also noted that the move to mandatory participation can happen incrementally, starting with voluntary models, then introducing more downsides of non-participation in these models, and eventually moving toward mandatory models over time.

**Contemporaneous value-based payments.** Stakeholders discussed the benefits of shifting model design to allow for more timely payments for model participants. While shared savings payments in most ACO models are issued retrospectively, there are other models that provide concurrent payments to accountable entities and providers. For example, capitated models

provide upfront payments. In the new Primary Care First model, which began in 2021, population-based payments are provided to primary care practices quarterly.

Stakeholders discussed many benefits of timely value-based payments. One stakeholder observed that when data on financial performance is delayed, it limits model participants' ability to accurately forecast or benchmark expenditures. Other stakeholders discussed that lagged payments reduce the interest of providers in participating; one expert noted that physicians are more interested in identifying future opportunities to improve care and reduce costs than in focusing on the past by retrospectively assessing claims. As discussed in comment 4D, upfront payments also support providers (particularly smaller providers) in making the necessary infrastructure investments to succeed in TCOC models.

Outcomes-based measures using claims data are often on a two- or three-year lag. Given that usable data claims data is often available after six months, it may be feasible to shorten the time period for payment in ACO models. One stakeholder suggested increasing the extent to which incentives are tied to process measures as surrogates for desired outcomes, given the time required for improving health outcomes or showing health gains after an intervention. A potential example process measure is the ratio of primary care interactions to specialty care interactions for specific patients, with the benchmark ratio taking into account a patient's condition. Stakeholders also discussed that electronic medical record data may be easier to use in real-time relative to claims.

Stakeholders noted that upfront payment for high-value services outside the traditional scope of FFS health care can make such services feasible, given that some provider organizations will not be able to fund these services up front when the potential for shared savings payments is too far in the future. For example, the North Carolina Healthy Opportunities Pilots have a fee schedule that provides direct payment for specific social services.

**Provider and beneficiary incentives.** In current TCOC models, individual providers or provider groups often receive a portion of the accountable entity's shared savings, but physicians often continue to receive FFS payments as their primary payment mechanism. This can amount to relatively weak incentives at the individual provider level. Experts have previously suggested that providers may be more responsive to individual incentives compared to incentives based on the performance of a large group where success can easily be driven by care managed by other providers. During public meetings, stakeholders agreed that incentives applied to accountable entities may not influence providers when provider payments continue to be predominantly FFS. For example, one Committee member discussed that having accountable entities take on risk will not transform care unless that risk is shared by both primary and specialty care providers. One SME mentioned Medicare Advantage (MA) plans as one example of a type of accountable entity where incentives do not necessarily convey down to the provider level.

Several stakeholders also discussed challenges of including direct financial incentives to providers for individual performance and discussed benefits of setting financial incentives at the provider organization level. One SME suggested that highly customized payments to a large group of individual providers can be too complex to be feasible. Similarly, stakeholders discussed the complexity of attributing patient outcomes to one provider and of incorporating both primary and specialty care providers into such arrangements.

One SME stated that measuring outcomes at the organizational level supports innovative collaboration across providers. Another explained that incentives at the practice level work well in the case where there are care management teams embedded in primary care practices. Some SMEs indicated that instead of direct financial incentives, traditional management approaches can be effective at changing how individual physicians provide care to aligned with value-based models. This includes improving patient care infrastructure (e.g., improved electronic medical records), having frequent conversations about organization's goals related to value based care and whether those goals are being achieved, tracking key performance indicators, and goal setting and performance discussions for employed providers.

In current TCOC models, payment arrangements include bonus payments when costs are below a threshold. Existing payments based on such a threshold alone may have the most impact on costs if baseline costs are near the threshold. Furthermore, cost thresholds do not provide incentives to improve quality. Therefore, threshold-based payments could be complemented by additional incentives related to cost and quality.

To improve outcomes, incentives faced by providers and provider organizations should be aligned with beneficiaries' own financial incentives. Stakeholders noted that cost-sharing can prevent Medicare beneficiaries from receiving high-value services, such as advanced care planning. One SME discussed the wide range of financial incentives that MA plans can use to encourage patients to use more high-value services and fewer low-value services. These include reduced or eliminated cost sharing for primary care and generic drugs, financial rewards (e.g., gift cards) for flu shots or for engaging in disease management, and supplemental benefits for specific conditions (e.g., transportation to dialysis). The SME further noted that the evidence is not yet strong enough for actuaries to project that non-traditional services will save costs. Another SME noted that the ACO REACH model may provide enhanced benefits and beneficiary-facing incentives, such as telehealth visits, home care after leaving the hospital, and help with copays. A Committee member noted that ACO REACH is waiving copays for care management fees, and that this could be considered for other models. However, one SME noted that in FFS Medicare there are patient cost sharing reduction initiatives that can be dampened by supplemental coverage (which may already provide benefits for a broad range of services).

## Exhibit IV.5: PTAC Comments

### Topic 5: Desired Payment Features

#### Summary of Key Findings:

- Stakeholders emphasized that PB-TCOC models require clear assignment of accountability across organizations and providers to identify which entity is accountable for different components of a patient's care.
- Centering accountability with PCPs is appropriate for managing the care of most patients, but accountability models should also address coordination with specialty care providers to facilitate team-based care. However, the general consensus was that accountability for TCOC should be placed at the organizational level rather than at the provider level.
- There are a range of incentives that can affect provider choices regarding participating in a PB-TCOC model. Increasing the volume of patients in value-based care arrangements will likely have a beneficial impact on provider participation and engagement.
- Providers may also be motivated by opportunities to receive "real-time" rewards for performance improvement, as well as non-financial incentives (such as smaller patient panels and increased autonomy).
- Stakeholders widely agreed on the need for a phased approach that incentivizes voluntary participation in PB-TCOC models, and allows providers and organizations to gradually assume more downside risk.
- Additionally, several stakeholders noted that in certain cases, mandatory models could help to increase participation, address issues related to patient and provider selection, and help to expedite care delivery transformation.

**Comment 5A.** *Continue developing payment models that assign accountability for quality and spending to a single entity that would be responsible for actuarial risk, and have flexibility in determining how to manage accountability and incentives for participating PCPs and specialists*

**Comment 5B.** *Develop a comprehensive participation strategy that includes models with multiple tracks and phase-in periods for taking on two-sided risk, which can also encourage provider participation in PB-TCOC models. This participation strategy should also include a balance providing incentives for voluntary participation with the potential for requiring mandatory participation in certain cases.*

**Comment 5C.** *Increase the use of prospective payment models that can provide participating organizations with certainty about finances and flexibility to implement care delivery changes.*

**Comment 5D.** *Encourage mandatory, time-certain models to ensure adequate provider participation and patient alignment. In order to move all Medicare beneficiaries into value-based payment models by 2030, it is important to require providers that treat Medicare patients to take on financial risk.*

**Comment 5E.** *Consider options for facilitating more timely payments to accountable entities that are participating in payment models to provide increased flexibility to effectively set incentives for and provide payment to participating providers. Individual providers are more responsive to incentives that are linked with their own performance rather than performance across an accountable entity. Some organizations that have been successful in taking on financial risk make quarterly performance-based payments to providers based on their own upside risk. The majority of usable FFS claims data are usually available within six months, which could make it feasible to provide performance-based payments earlier in FFS-based shared savings models.*

**Comment 5F.** *For beneficiary directed incentives, consider changes to cost-sharing to align incentives in PB-TCOC models. For example, it may be beneficial to reduce or eliminate copays for high-value services.*

**Areas Where Additional Information Is Needed:**

- Appropriate criteria for assigning accountability
- Duration of accountability period
- Structuring shared accountability between primary care providers and specialists for certain episodes, conditions, or disease stages
- Minimum threshold of the number of patients for inclusion in a PB-TCOC model
- How mandatory models may need to be adapted for non-Medicare providers

#### **IV.F Topic 6: Enablers To Support Desired Payment Features**

Committee members identified three enablers to support desired payment features in PB-TCOC models:

- Determining and implementing an ideal mix of FFS-based and capitated models; and
- Rewarding both improvement and absolute levels of performance.

**Determining and implementing an ideal mix of FFS-based and capitated models.** CMMI has established a vision for 2030 in which every traditional Medicare beneficiary is in a care relationship with accountability for quality and total cost of care. This vision marks a transition

away from traditional FFS payment that does not emphasize accountability as much as PB-TCOC models. This vision for greater accountability may involve a variety of payment approaches that incorporate FFS and capitated payments to different degrees. As CMMI pursues its vision, it is important to determine whether the emphasis is on models similar to ACOs that are often built on a FFS architecture with retrospective shared savings and/or losses—or on prospective capitated payment approaches.

In the discussions during the public meetings, experts and PTAC noted strengths and weaknesses of FFS and capitated payment approaches. One expert noted that a challenge of the FFS system is that it does not encourage flexibility because providers are paid for the “inputs”—health care services such as hospital days, imaging procedures, lab tests, and drugs—instead of the “output” of overall health. On the other hand, another expert pointed out some advantages of a FFS payment approach such as distributing payments to providers in accordance with service delivery, monitoring performance at the level of the billing provider, facilitating patient choice by allowing them to see any Medicare certified provider, and having a de facto mechanism for risk adjustment (i.e., higher need patients use more services so providers are paid more to treat them). In the current FFS context, however, it is difficult to pay less for low-value services or to offset higher payment for high-value services by paying less for other services. Improvements could be made to FFS payments that would help transition the health care system and build provider infrastructure to support PB-TCOC approaches. PTAC noted that an understanding of the strengths of FFS payment can help inform the design of PB-TCOC models.

Prospective capitated payment approaches also have strengths. Committee members noted that capitation provides increased incentives to engage in care transformation, offers up-front payments, gives accountable entities flexibility to develop innovative care delivery models, allows for the creation of new provider networks, and can help align financial incentives for providers with value. An increased impetus to coordinate care under capitated arrangements may come with greater flexibility for innovation than is currently available under FFS, such as use of synchronous or asynchronous virtual and digital care approaches. This can encourage innovation that creates more meaningful interactions between patients and providers. One drawback of a capitated approach is that it could potentially limit beneficiary choice of providers, depending on how the accountable entity structures affiliations and communicates options for providers to beneficiaries.

In light of these strengths and weaknesses, PTAC noted that payment methodologies that are based on capitation are more likely to elicit value-based care delivery and payment features for PB-TCOC models, though there have been some successful shared savings models that use FFS payment mechanisms.

In the current environment, advanced primary care models and episode-based payment models can help transition providers to value-based arrangements with accountability for quality and total cost of care in alignment with the CMMI 2030 vision. Looking to a future in which PB-TCOC models are used more widely, it is unclear whether these advanced primary care models and episode-based models will continue to exist separately or be absorbed into larger, more comprehensive models.

PTACs comments on determining ideal mix of FFS-based and capitated models are listed in Exhibit IV.6.

***Rewarding both improvement and absolute levels of performance.*** Incentives play a key role in the development and implementation of PB-TCOC models. During the September PCDT presentation, provider and beneficiary incentives were specifically highlighted as a desired payment feature for PB-TCOC models. The September PCDT further noted the importance of rewarding participation, progress, and absolute levels of performance rather than only focusing on performance relative to past experience.

During the June PCDT presentation, it was noted that consistent implementation of more straightforward incentives may help encourage participation in models. In addition to encouraging participation in models, incentives offer an opportunity to spur innovation in care delivery so long as the incentive is designed to do so. One example raised was an incentive focused specifically on substituting low-cost high, value care to patients in time to avoid much higher cost care that may otherwise be needed later. While much of the discussion focused on financial incentives, one Committee member noted the importance of non-financial factors that are important to providers as well.

During both the June and September meetings there were discussions of the role of incentives in encouraging higher quality care through clinical coordination and integration between primary care, specialty care, and subspecialty care. Findings from the meeting suggest that, not only do incentives need to exist, but they should be timely in order to be effective. Without a clear timeline for realizing potential upside or downside consequences, it may be difficult for some providers to participate based on their geography, patient mix, or patient volume. The point on timeliness of incentives was echoed by experts across meetings. One expert noted that incentives can also support provider alignment by tying incentives to TCOC outcomes.

Another expert noted how challenging it is to align incentives with high quality of care because measuring high quality care itself is difficult. By strengthening incentives, the system could see greater overall savings suggested one expert. One member noted the complexity of devising and implementing incentives to have a meaningful impact on care delivery. Participants noted that, to do this, incentives need to be more appealing than FFS. Experts varied in terms of their assessment of whether incentives should be set at the accountable entity level or the provider

level, with some noting that setting incentives at the entity level and giving entities flexibility to structure downstream incentives to their providers may be beneficial.

## **Exhibit IV.6: PTAC Comments**

### *Topic 6: Enablers to Support Desired Payment Features*

#### **Summary of Key Findings:**

- Several stakeholders emphasized the importance of multi-payer alignment of data and payment approaches so that providers and organizations can focus on care transformation while minimizing the complexity associated with multiple payment structures and performance metrics.
- Multi-payer arrangements are also important for ensuring enough patient or revenue volume to facilitate changing practice patterns. However, one stakeholder indicated that sufficient differentiation to allow for competition should coexist with alignment in some areas such as quality measurement, risk adjustment and patient attribution methodologies. Several states are currently engaged in developing all-payer models.
- There is an immediate opportunity to reduce administrative burden by increasing alignment of performance metrics and HRSN or/ SDOH screening tools. Effective incentives can be set to reward absolute levels of performance with respect to clinical, quality, equity, and spending outcomes as well as improvements on these metrics.
- Rewarding provider-level improvement on performance metrics can help to support providers that have less experience with value-based care.

**Comment 6A.** *Multi-payer alignment allows for increased risk-sharing with respect to both number of providers in risk-sharing arrangements and degree of risk. Multi-payer alignment also improves care as it allows provider entities to implement care pathways across their full range of patients and decreases fragmented care. In addition to encouraging the engagement of multiple payers, alignment of payment features, performance measures and model design components will be important for decreasing administrative waste and improving provider engagement. There is an immediate opportunity to reduce administrative burden by increasing alignment of performance metrics and HRSN or/ SDOH screening tools.*

**Comment 6B.** *Consider including performance-based incentives that reward absolute improvements in a given provider's performance with respect to quality, equity and spending outcomes, in addition to incentives that reward absolute performance relative to external benchmarks. Rewarding improvements in provider-level performance can help to encourage ongoing care delivery innovations among various types of providers, including those with more experience and less experience with value-based care.*

**Comment 6C.** *It is important to focus on improving health data utility to prevent providers from focusing on the metric rather than patient care. Some quality measures are not effective*

*or are cumbersome to measure. Data of high utility that flows up to the state level is essential for expanding value-based care.*

#### **IV.G Topic 7: Model Design Considerations**

Committee members identified eight important model design considerations in PB-TCOC models:

- Participation incentives and organizational requirements;
- Upfront resources and infrastructure to support desired care delivery transformation;
- Attribution, benchmarking, and risk adjustment;
- Selection and use of performance measures;
- Incentivizing clinical coordination and integration between primary and specialty care;
- Overlap between PB-TCOC and other models;
- Incentives for screening and referral for health-related social needs; and
- Encouragement of multi-payer alignment on model design components.

PTAC's comments regarding model design considerations are listed in Exhibits IV.7.

**Participation incentives and organizational requirements.** One element in the design of a PB-TCOC model is the inclusion of incentives to encourage providers and organizations to participate. While broad participation is desirable, PB-TCOC models must also include requirements to ensure that accountable entities are qualified and capable to assume their role. In response to discussions and presentations during the public meetings, Committee members noted that participation incentives should be focused at the level of the individual provider to actively engage providers in the transformation of care delivery. Even with participation incentives targeted to individual providers, financial accountability for TCOC targeted at the entity or organization level is appropriate, especially to encourage participation from individual clinicians or smaller groups of clinicians that may not be ready to take on full risk.

PTAC also noted the potential to improve the clarity of provider and population alignment so that clinicians have a better sense of the patients for whom they are primarily responsible under the model. Retrospective, utilization-based alignment uses historical claims to align patients to providers for payment and accountability purposes, so clinicians do not know in real time who constitutes their attributed patient panel. This adds to uncertainty for providers and can be a disincentive for participation. Shifting away from retrospective alignment toward a more prospective approach could improve clarity with respect to which patients are part of the model and attributed to any given provider.

Regarding requirements for participation, it is important to determine the minimum size for participation as an accountable entity in a PB-TCOC model. An accountable entity in a PB-TCOC model requires a sufficient volume of patients (perhaps 4,000 patients) to support the investments in a patient-centered care team. Smaller organizations may find it challenging to make or sustain these investments, while larger organizations can spread the costs across more patients. In addition, entities with smaller patient panels may be more vulnerable to outlier cases in their patient panels that could affect performance and spending in a year.

**Upfront resources and infrastructure to support desired care delivery transformation.** The transformation of care delivery requires upfront resources and infrastructure to support those changes. Examples of these upfront investments include upgrading data and technology systems, hiring and training additional staff, and implementing process changes to improve care delivery. Within a PB-TCOC model that includes shared savings, a risk-free monthly care management payment for the providers accountable for managing care could support care delivery transformation. Providers could use this flexible payment to tailor investments to best meet the needs of their patients within the local health care and community context. The monthly care management payment could be adjusted based on beneficiary risk tiers, such that providers would receive higher care management payments for patients with greater health needs including social service-related needs.

In addition to care management payments delivered in a fee for service shared-savings PB-TCOC model, partially- or fully-capitated PB-TCOC models can also support the upfront investments required to achieve care delivery transformation. These models provide accountable entities the flexibility to use a portion of the capitated payment to on investments that enhance care, such as data infrastructure or social needs screenings and referrals. Increasing the number of these partially- and fully capitated PB-TCOC models can further support care delivery transformation.

**Attribution, benchmarking, and risk adjustment.** When developing PB-TCOC models, attribution, benchmarking, and risk adjustment are key model design features to consider. Not only does each of these features contribute to model viability on its own, but the interactions between these features also affect which entities will participate and be successful (e.g., by achieving shared savings) in APMs. Subject matter experts emphasized the need to consider how attribution, benchmarking, and risk adjustment will work together to achieve desired care delivery goals when designing PB-TCOC models. However, lack of data availability and technical infrastructure needed to ensure reliability and validity across these three features may hinder model development and implementation, and stakeholders noted that certain models may better address one or two design features and relative to others.

Each of these payment model design features also has its own opportunities and challenges.

**Attribution.** Stakeholders described challenges with attribution at the entity-level, with entities not necessarily knowing which patients are enrolled. Subsequently, entities may not be able to successfully target attributed patients with innovative care delivery features under APMs.

Attribution requirements may also lead to some patients receiving effective care management via a participating entity but the entity not getting credit for improving coordination for those patients because of the attribution rules. Subject matter experts noted one common approach to attribution is requiring a qualifying primary care physician visit, which overlooks the reality that some primary care is provided non-physicians, including nurse practitioners and physician assistants. Attribution through specialty care may be warranted for patients with certain chronic conditions, but is also particularly challenging due to organizational complexity, limited health information technology (HIT) interoperability, prevailing FFS incentives, and a lack of data and measures to evaluate specialist performance.

Additionally, as APMs increase in scope and number, model overlap will lead to challenges with attribution, with wide-ranging effects. Depending on which APMs are involved in an enrollee's care, synergies in care delivery may be possible, or model participants may be penalized for events outside of their control.

Prospective and/or voluntary approaches to attribution may reduce some of these issues while promoting patient choice.

**Benchmarking.** Benchmarks may be used in APMs to assess entity performance on spending and/or quality to determine whether entities receive shared savings or incur shared losses, as well as the magnitude of the financial reward or penalty, thereby incentivizing change through payment-based mechanisms. Benchmarks based on entities' historical spending may provide a viable on-ramp for providers to participate in APMs.

However, appropriate benchmarking may be limited by data availability. Entities may serve populations with substantially higher needs (e.g., related to HRSNs) that may be challenging to identify without additional data collection. As a result, benchmarks may not be set in a way that allows entities to achieve or sustain savings. As a result, entities may prefer traditional FFS payment to APM alternatives.

Subject matter experts noted that models, where benchmarks are set based on an entity's ability to continue to achieve improvements even after they have demonstrated improvements in prior cycles make it harder for participating entities to achieve success. This is the biggest challenge to using benchmarks as financial incentives. Ratcheting may limit participant ability to provide innovative care delivery by decreasing funding and flexibility if they are not able to show enough cycle over cycle improvement; thus, ratcheting may discourage participation and reduce model viability.

However, there are several opportunities to maintain financial incentives. Administrative benchmarks that are externally set can reduce ratchet effects. Setting benchmarks based on projected spending rather than observed spending may also limit ratchet effects. Additionally, financial and quality performance benchmarks may need to account for different entity-level factors related to the type of organization and the population served. These factors may affect an entity's ability to meet benchmarks.

**Risk adjustment.** Risk adjustment in APMs is necessary to ensure reasonable comparisons across entities, which may serve diverse patient populations with different patterns of utilization within and across categories of patient risk. Risk adjustment also helps ensure that entities are not penalized in models for serving a higher-risk pool. Robust risk adjustment methodologies should account for patient demographics, clinical characteristics, and HRSNs.

There are several challenges to effective risk adjustment in APMs. Stakeholders noted that existing measures may not sufficiently account for SDOH or HRSNs, which affects measured performance for entities that serve disadvantaged enrollees. There may also be trade-offs between predictive accuracy of risk adjustment approaches and other objectives, such as equity. For example, to improve care delivery for historically underserved populations, models may want to provide higher payments to entities that serve these populations relative to their counterparts. Additionally, reliability and validity of risk adjustment may be limited by available data. This is true where data may be outdated or lacking key information, as well as where there are differences in discretionary coding or coding intensity. These challenges hinder fairness and accuracy of performance-based payments in APMs.

**Incentivizing clinical coordination and integration between primary and specialty care.**

Successful implementation of PB-TCOC models requires clinical coordination and integration between primary and specialty care. When designing PB-TCOC models, it is therefore important to develop appropriate incentives for encouraging participants to engage in coordinated, team-based care. Subject matter experts stressed that as participation in PB-TCOC models becomes more attractive, it will become less convenient for providers to default to FFS arrangements, the latter of which often fail to reward clinical coordination and integrated care.

Subject matter experts highlighted several methods for incentivizing clinical coordination and integration between primary and specialty care. For example, one expert suggested implementing patient-specific base payments to specialists embedded in the patient care team who are responsible for care management activities. These patient-specific base payments would supplement any FFS-based payments (including payment bundles) associated with a given procedure or episode. Some MA plans already offer specialists the opportunity to receive monthly or annual population-based payments intended to support specialist engagement in care management activities. Strategies for engaging specialists should also establish incentives

to encourage teleconsultations; this is particularly important for supporting providers in rural settings. Although the appropriate incentive structure for a given model will depend on organizational structure and provider type, it is important for each approach to ensure adequate compensation for all activities associated with care coordination and integration.

**Overlap between PB-TCOC and other models.** In addition to ensuring appropriate compensation for services provided, subject matter experts also emphasized the need to avoid overcomplication when designing incentive structures and coordinating model overlap. Nesting payment for bundles of care rather than using carve-outs may be a more effective approach for reducing complexities when integrating episodic and PB-TCOC models. However, when multiple providers are involved in managing a patient's care, it can be difficult to determine the exact services included in a particular nested bundle. Model overlap also introduces the potential for participants to be doubly penalized or rewarded; future models will need to develop methods to safeguard against such unintended redundancies.

Moving forward, it will be beneficial to test these nested arrangements for a limited number of episodic or condition-based payment models to develop a deeper understanding of how various model inputs and context influence provider behavior and shape patient outcomes. Implicit in this approach is an understanding that there does not exist a one-size-fits-all method for incentivizing coordinated, team-based care and addressing model overlap. For example, one subject matter expert proposed that hospital-based ACOs mandate the adoption of bundled payments nested within the broader PB-TCOC model. Conversely, this subject matter expert noted that other ACOs, such as smaller, provider-based ACOs, may benefit from a more moderate glide path and are not appropriate for these kinds of mandates.

**Incentivizing health-related social needs screenings and referrals.** Unmet health-related social needs increase health care costs and exacerbate disparities in patient outcomes. PB-TCOC models should therefore incentivize HSRN screenings and referral to services that address HSRNs. Several subject matter experts highlighted ongoing efforts to promote the capture of HSRN data, including, for example, refining approaches for measuring screening and referral activities as well as linking screening and referral activities to performance metrics. Additionally, models could offer providers supplemental payments intended to cover costs associated with HSRN screening and referral activities. Data gathered via screenings can also be applied to risk adjustment algorithms, which, by appropriately accounting for patient social risk, could serve as a backdoor method for incentivizing screening and referral activities as well as general participation in risk-based APMs among providers that see patients with HSRNs.

**Encouraging multi-payer alignment.** Multi-payer alignment is fundamental to effective implementation of PB-TCOC models. This is particularly true when nesting episodic or bundle-based models within broader PB-TCOC models. Many of the patients covered under these

models are dually eligible Medicaid beneficiaries and or receive services covered by other governmental or commercial payers.

Multi-payer alignment serves to reduce administrative burden, limit the collection of redundant or conflicting data, and standardize quality measures across payers. To realize these benefits, however, future models will need to include features for addressing the aggregation and sharing of data across payers. Although multi-payer alignment may not necessitate a single model for all payers, future models should identify aspects of model design where alignment is most essential. Subject matter experts highlighted current efforts to encourage multi-payer alignment as well as real-world examples of when multi-payer alignment has been successfully implemented. Examples included region-specific successes associated with the Comprehensive Primary Care Plus (CPC+) model as well as collaborations in California to align payers across the state, including Medicaid payers and payers that reimburse social service providers.

#### **Exhibit IV.7: PTAC Comments**

##### *Category 7: Model Design Considerations*

##### **Summary of Key Findings:**

- An accountable entity in a PB-TCOC model requires a sufficient volume of patients to support the investments in a patient-centered care team.
- It is important to consider how attribution, benchmarking, and risk adjustment will work together to achieve desired care delivery goals when designing PB-TCOC models.
- Each of these payment model design features also has its own opportunities and challenges. For example, retroactive, utilization-based attribution creates uncertainty about attribution of beneficiaries to accountable entities and providers, which can potentially be exacerbated by model overlap.
- Shifting toward a more prospective approach could improve clarity regarding which patients are part of the model and attributed to any given provider.
- Current benchmarking approaches can create a “ratcheting” effect in which participants’ positive performance in one cycle reduces their future opportunities for additional financial rewards in future cycles.
- Current risk adjustment approaches do not always capture the risk associated with a given population appropriately.
- Stakeholders highlighted several approaches for incentivizing clinical coordination and integration between primary and specialty care, including: providing payments to specialists who are embedded in the patient care team to support engagement in

care management activities, encouraging specialty teleconsultations, and addressing model overlap by nesting payment for specialty bundles of care in PB-TCOC models.

- Different approaches to nesting bundled payments will be needed in order to address differences in organizational incentives among different types of ACOs. Given that unmet health-related social needs (HRSN) can increase health care spending and exacerbate disparities in patient outcomes, it is important for PB-TCOC models to incentivize participants to provide screenings and referrals to address HSRNs.

**Comment 7A.** *Placing financial accountability for TCOC at the entity or organization level is appropriate to manage risks for individual clinicians or smaller groups of clinicians, but there should also be incentives focused at the level of the provider. Shifting away from retrospective alignment toward a more prospective approach could improve clarity regarding which patients are part of the model and attributed to any given provider, and facilitate improved care coordination.*

**Comment 7B.** *Providing upfront resources to support desired care delivery transformation can help to increase participation in PB-TCOC models, particularly in cases where risk is based on retrospective rewards for savings. One option would involve providing a monthly care management payment to the accountable provider(s) that could be adjusted based on beneficiary characteristics or tiered risk. It is necessary for monthly payments not to exceed savings from the model. Additionally, increasing the number of PB-TCOC models that include full or partial capitation would provide flexibility to use a portion of prospective capitated payments to support care delivery transformation.*

**Comment 7C.** *In the near term, it is important to address the benefits of addressing issues related to attribution, benchmarking, and risk adjustment in order to encourage participation in PB-TCOC models.*

- *Options for reducing uncertainty about attribution of beneficiaries to accountable entities and accountable providers include encouraging claims-based prospective attribution in which beneficiaries are linked to accountable providers before the beginning of a model performance period and voluntary attribution by the beneficiary.*
- *Options for sustaining financial incentives for participation in PB-TCOC models could potentially include the use of administrative benchmarks that are externally set; maintained over a period of time; and based on projected spending growth and desired participation rather than observed spending growth. It may be beneficial to adjust administratively-set benchmarks based on different factors, including organization type.*
- *Options for addressing the problems with current risk adjustment processes include limiting the ability for accountable entities to drop high-risk beneficiaries, adjusting for*

*growth in risk scores, and allowing upward adjustment of risk scores for beneficiaries who have more needs.*

**Comment 7D.** *Successful implementation of PB-TCOC models requires clinical coordination between primary and specialty care, and developing incentives for engaging in coordinated, team-based care. There are fewer complexities related to nesting specialty episodes in PB-TCOC models than with carve-outs (in which certain costs are excluded from the PB-TCOC model). Approaches that involve nesting a limited number of episode or condition-specific bundled payment models within a broader PB-TCOC model have shown promise.*

**Comment 7E.** *In cases where there is overlap between separate PB-TCOC models and other models it is important to adopt performance measures that avoid double-counting savings and maintain incentives for participants in these models to collaborate.*

**Comment 7F.** *It is important for PB-TCOC models to incentivize participants to provide screenings and referrals to address HSRNs. This could include providing incentives based on performance metrics for HSRN screening and referral. It would be important for these activities to have dedicated payments that would not be subject to reduction based on cost of care.*

**Areas Where Additional Information Is Needed:**

- Minimum size for an accountable entity to participate in a PB-TCOC model
- Determining how to construct an episode of care when nesting a condition-specific or episode-based model in a PB-TCOC model
- Determining which condition-specific or episode-based models would be appropriate for nesting within a population-based model
- Best approach for setting appropriate accountability periods for providers in nested models

#### **IV.H Topic 8: Desired Performance Measure Features**

Committee members identified four desired performance measure features in PB-TCOC models:

- Emphasis on accountability for clinical, quality, equity, and spending outcomes; and
- Selection and use of performance measures.

PTAC's comments regarding model design considerations are listed in Exhibit IV.8.

**Emphasis on accountability for clinical, quality, equity, and spending outcomes.** Identifying meaningful outcomes for performance measurement, as well as thresholds for achievement or improvement, in clinical, quality, equity, and spending domains is a key consideration in PB-

TCOC model design. However, current data and data systems are not sufficient to measure outcomes in these domains, and information on access to care, coordination of care, and equity necessary to measure these domains or include them in robust risk adjustment methodologies is especially lacking.

In particular, SMEs highlighted the importance of expanding equity measurement, noting that specific equity concerns (e.g., unmet HRSNs) should be integrated in model payment feature design. Factors related to equity to consider in PB-TCOC model design include multi-payer alignment; removing structural barriers for underserved populations; team care incorporating clinical team members as well as social workers and community health workers; aligning payment incentives with community infrastructure, potentially allowing higher spending for target populations; and creating complementary reforms for specialty care nested in PB-TCOC models aimed at engaging specialists.

Approaches to assigning accountability for performance measurement outcomes warrant additional consideration as a design feature of PB-TCOC models. Accountability is a product of existing cultures, systems, and organizations, and determining which provider(s) are accountable for outcomes can be challenging due to differences across data systems, including data submission portals and reporting tools. Increasing interoperability between data systems may improve data sharing across providers and, as a result, promote shared accountability. Stakeholders recommended incentivizing data exchanges to promote joint accountability (e.g., between a primary and specialty care provider) for patient-focused outcomes.

Outcomes-based measures using claims data are often on a two- or three-year lag. One stakeholder suggested increasing the extent to which incentives are tied to process measures as surrogates for desired outcomes, given the time required for improving health outcomes or showing health gains after an intervention. A potential example process measure is the ratio of primary care interactions to specialty care interactions for specific patients, with the benchmark ratio taking into account a patient's condition.

Although data collection for claims-based measures is lower burden, clinically relevant data necessary to measure or adjust for access, care coordination, and equity are not available through claims data. These domains will be captured in electronic health records (EHRs); therefore, developing and implementing electronic clinical quality measures (eCQMs) will be a crucial next step to target these measures for performance improvement.

Technological advancements in performance measurement will also promote shared accountability between primary and specialty care providers. However, HIT systems may vary within and across providers, hindering care coordination. SMEs noted that incentivizing

transparent data exchange and promoting HIT/EHR interoperability may be a key design feature to consider in PB-TCOC models.

Several barriers to provider accountability and, especially, shared accountability are described above. Advancing shared accountability may require culture change: for example, experts recommended refocusing payment model design features that incentivize individual providers to improve quality and reduce costs on organizations. Performance measures to help ACOs identify high quality, cost-efficient practices for collaboration would assist these organizations in assuming shared accountability.

Shared accountability (e.g., between primary and specialty care providers) would also advance patient-centered care. However, the lack of performance measures for specialty care providers hinders progress towards shared accountability. Although some quality measures are developed for use in specific populations, condition-specific measures may have limited utility due to sample size limitations, and stakeholders noted that providers may not respond to performance measures if they do not view them as reliable and valid.

To encourage accountability, experts recommended that incentives be tied to key performance measure domains, such as equity. Equity measures that may promote provider accountability include measures of team-based care and multidisciplinary care management. Patient outcomes may differ when considering care team composition, and model participant outcome rates may vary substantially when comparing individual provider and practice- or organization-level performance.

**Selection and use of performance measures.** Performance metrics are not only used in APMs to assess model participant performance, but also to help entities identify practices with which to partner (e.g., letting them know which potential partners have been successful in achieving higher quality while reducing costs). Existing performance metrics often focus on processes (e.g., what providers do to improve health by meeting standards of care) and outcomes, which may include utilization, spending, clinical, and patient-reported outcomes of care. Subject matter experts identified cost, quality, and equity as key measurement areas for APMs and noted the importance of monitoring utilization to prevent both underutilization and overutilization of care.

Stakeholders noted that APMs, overall, focus on preventive care metrics to improve population health and reduce avoidable or low-value care as a way to increase value. They identified some concerns with the existing performance metric landscape and how performance metrics are used in APMs and offered recommendations to improve on existing measurement systems.

One challenge of existing performance metrics is that they are not created for specific populations; as a result, they may not be a meaningful assessment of health care quality for a

given population. Subject matter experts stated that isolating and measuring performance for care delivered to specific populations may help address this concern and recommended developing performance metrics that better capture quality of specialty care. At the same time, they emphasized that patient panels to which performance metrics are applied must be sufficiently large to allow for meaningful measurement and comparison.

Performance metric reliability and validity, especially relating to data availability, are also a key concern. Stakeholders noted that, to attract APM participants and encourage model engagement, metrics must be meaningful, reliable, and valid. Greater consistency in performance metrics across APMs may help encourage model participation and engagement.

Model participant views on the usefulness of APM performance metrics are colored by their perception of the underlying data quality, especially for spending and clinical outcomes. Model overlap may also affect the usefulness of performance metrics. As APMs expand in scope and number, model overlap leads to increasing difficulties in attributing performance metric impact to a particular APM.

Additionally, subject matter experts described concerns with the current body of performance metric evidence, noting that it is largely limited to claims-based metrics. Claims-based metrics are lagged, due to data submission windows and runout periods, meaning that performance metric rates may not be available to entities until two to three years after the end of the measurement period. This delayed feedback prevents entities from making “real-time” care delivery improvements in response to performance metrics. Experts stated that near real-time metrics, such as those used in the Veterans Health Administration, are the future of performance measurement and can better address these concerns and others, including those related to HRSNs and equity. SMEs and Committee members also discussed the importance of including process measures that can serve as proxies for desired care delivery features and outcomes; as well as the efficient collection of patient-reported outcome data.

#### **Exhibit IV.8: PTAC Comments**

##### ***Topic 8: Desired Performance Measurement Features***

##### **Summary of Key Findings:**

- Identifying meaningful outcomes for performance measurement, as well as thresholds for achievement or improvement, in clinical, quality, equity, and spending domains is a key consideration in PB-TCOC model design.
- However, current data are not sufficient to measure certain metrics related to access to care, coordination of care, and equity. In addition to using existing performance

metrics, PB-TCOC models can benefit from monitoring process measures related to desired care delivery features that have an impact on quality and spending.

**Comment 8A.** *The selection and use of performance measures is an important design considerations for PB-TCOC models. Stakeholders have expressed concerns that the current body of performance metric evidence is largely limited to claims-based metrics. Current approaches to performance measurement also do not adequately measure access, care coordination, or equity. There is also a need for additional outcome measures. In the future, it will be important to set appropriate thresholds for quality performance, and incorporate equity measures, which have not traditionally been included in PB-TCOC models.*

**Comment 8B.** *It will be necessary to develop the necessary infrastructure to support quality accountability and measurement that can better support PB-TCOC models. For example, in the long term, there will be a need to link digitally enabled clinical guidelines and clinical decision support with performance measures that are in a digital format, and to promote interoperability among EHRs and other databases to facilitate measurement and reporting.*

**Comment 8C.** *Even if not used as formal performance metrics for determining payment, it may be useful for PB-TCOC models to monitor additional process metrics that capture certain processes that are related to desired care delivery features and outcomes, and incremental improvements in quality and spending. Data on the amount of time spent with patients and the number of overnight calls could be proxies for providing high touch primary care, and data on the number of primary care and overall encounters or “touches” could be a surrogate marker for patient engagement. Additionally, data on pharmaceutical stewardship could be a proxy for the provision of high-value care.*

**Comment 8D.** *It is also important for PB-TCOC models to monitor performance measures related to utilization and access to prevent underutilization of care (such as number of visits, wait times, and changes in beneficiary out-of-pocket spending).*

**Comment 8E:** *It is important to develop include specific metrics relevant to specialty care in PB-TCOC models that include specialists. Most quality metrics are primary care based and not focused on the needs of the patient with multiple chronic medical conditions managed by specialists*

**Comment 8F:** *It is important to consider measurement burden if adding measures in PB-TCOC models by ensuring that new measures add value and low-quality measures are eliminated.*

**Areas Where Additional Information Is Needed:**

- Determining what additional data and performance measures are needed in order to encourage accountability and support the success of potential participants in future PB-TCOC models.

## IV.I Topic 9: Policy Levers

Committee members discussed several policy levers that could be useful for supporting the improvement and expansion of PB-TCOC models:

- Encouraging sufficient motivation for joining PB-TCOC models;
- Addressing Medicare payment policy;
- Addressing the number of PB-TCOC models being tested;

PTAC's comments regarding policy levers are listed in Exhibit IV.9.

**Encouraging sufficient motivation for joining PB-TCOC models.** While CMMI has shared and reiterated its vision to have every Medicare beneficiary in a value-based payment model by 2030, panelists and Committee members noted that the sense of inevitability of value-based care has been lost in recent years. Committee members agreed that it is important to project the urgency of transitioning to PB-TCOC models. If organizations understand the eventuality of value-based care, they can foster the culture change and invest in the infrastructure to support PB-TCOC models.

Stakeholders discussed maintaining or adding payment incentives to keep providers engaged or bring in new providers to PB-TCOC models. First, several panelists and Committee members expressed that the five percent bonus for participating in a Medicare Advanced Alternative Payment Models, which is set to expire in 2024, should be maintained to facilitate recruitment of additional providers. One SME predicted that if the program is not extended by Congress, many providers will not continue to participate in PB-TCOC models. Other SMEs suggested enhanced primary care payments such as global capitated payments for patients aligned to PB-TCOC models. Higher payments to PCPs can also offset the administrative burden of care coordination.

**Addressing Issues in Medicare payment policy.** One question that generated a great amount of discussion at the September meeting was the role of traditional FFS Medicare in PB-TCOC models and whether models should still be designed for the FFS environment. There was widespread agreement on the importance of making traditional FFS less attractive than PB-TCOC models. However, some stakeholders believed FFS could be reformed while others advocated for moving away from FFS.

Stakeholders that supported working within the FFS system recognized the need to reform payment policies based on relative value units (RVUs), which reward volume over value, and differential payments for site of care, which may drive procedures into acute and expensive settings. One SME suggested that fee schedules and codes could be adjusted to allow providers to profit from improving efficiency while curbing the overall spending growth rate. Other SMEs saw opportunity to facilitate flexibility within the FFS payment structure to adjust incentives

and make compensation attractive to and supportive of providers. A Committee member noted that if nothing else, FFS can serve as a marker against how to measure the performance of PB-TCOC models.

Stakeholders that preferred moving away from FFS discussed both incentives for participating in PB-TCOC models and disincentives for remaining in FFS. They noted the need to balance “carrots” and “sticks” to drive provider change. They also recognized that providers would need viable alternatives if being shifted away from FFS. Committee members and SMEs understood that not all organizations can make the transition to PB-TCOC models right away and mentioned the idea of glide paths. They also cautioned that incentives and disincentives be structured a way that does not penalize FFS providers serving populations with greater clinical and social needs. Finally, stakeholders noted the challenge of making FFS less appealing to specialists that profit in the FFS environment and for whom small percentages of revenue are from PB-TCOC models.

In addition to FFS Medicare, stakeholders discussed the need to reform the MA program to be financially beneficial to CMS. SMEs noted that the four percent higher payments to MA plans over FFS negates the savings MA plans may achieve from efficiency in care delivery. They also noted that overpayments can lead some organizations looking to recruit patients and providers away from traditional FFS. One SME explained that the MA program is currently larger than intended and must be redesigned with new benchmarks to gain efficiencies and improve value. A Committee member raised the question of whether MA is considered a PB-TCOC model and if that should be the ultimate goal if shifting away from FFS.

**Addressing the number of PB-TCOC models being tested.** Consistent with CMMI’s vision to have a consolidated portfolio of APMs, stakeholders cited several advantages to offering a limited range of harmonized PB-TCOC models. First, SMEs noted the importance of being able to test models, and how multiple models in the same market complicates evaluation. As APMs are becoming ubiquitous in many markets, it is difficult to select a comparative group that is not exposed to some form of PB-TCOC model. Additionally, a select set of PB-TCOC models will make it easier to encourage multi-payer and multi-state participation.

Stakeholders discussed the advantage of having a limited number of PB-TCOC models and how it will reduce complexity for providers and patients. For providers, it will be easier to track patients across different payers and models, and to engage specialists. It will also reduce providers administrative burden to only have to focus on requirements for one model. For patients, standardization and parity across PB-TCOC models can improve beneficiaries’ understanding and reassure them that they are getting the same benefits regardless of the PB-TCOC model with which they are aligned. One SME noted that the average beneficiary has 39 MA plans to choose from and that the variation between models makes it almost impossible to

properly educate them. Committee members pointed out the need to educate patients about the APMs and convey what participation in the model means for them.

#### **Exhibit IV.9: PTAC Comments**

##### *Category 9: Policy Levers*

##### **Summary of Key Findings:**

- Various stakeholders have emphasized the importance of making it more desirable for providers to participate in value-based care and PB-TCOC models than to remain in FFS. Stakeholders have also identified differences in the features that are available in different kinds of population-based models, which can affect provider decisions to participate in these models.
- For example, some stakeholders noted that the rapid growth of Medicare Advantage enrollment can reduce the number of beneficiaries who are available to participate in other population-based models, reduce the number of providers who are available to care for beneficiaries in other population-based models, and create selection issues in various markets.
- Stakeholders also discussed the importance of accountable entities having flexibility to develop innovative approaches for managing quality and spending.

**Comment 9A:** *Increasing the financial incentives and flexibility associated with participation in PB-TCOC models can encourage provider participation in these models, while making it less desirable for providers to remain in FFS.*

**Comment 9B:** *It will be important to determine how much flexibility should be allowed for accountable entities in future PB-TCOC models, the desired level of variation, and areas where less variation would be desired (such as access to providers).*

## APPENDIX 1. COMMITTEE MEMBERS AND TERMS

**Lauran Hardin**, MSN, FAAN, *Co-Chair*

**Angelo Sinopoli**, MD, *Co-Chair*

### Term Expired October 2022

**Paul N. Casale**, MD, MPH  
*New York-Presbyterian, Weill Cornell Medicine and  
Columbia University*  
New York, NY

**Bruce Steinwald**, MBA  
*Independent Consultant*  
Washington, DC

### Term Expires October 2023

**Jay S. Feldstein**, DO<sup>iii</sup>  
*Philadelphia College of Osteopathic Medicine*  
Philadelphia, PA

**Walter Lin**, MD, MBA  
*Generation Clinical Partners*  
St. Louis, MO

**Lauran Hardin**, MSN, FAAN<sup>iii</sup>  
*National Healthcare & Housing Advisors, LLC*  
Laguna Hills, CA

**Terry L. Mills Jr.**, MD, MMM  
*CommunityCare*  
Tulsa, OK

**Joshua M. Liao**, MD, MSc  
*University of Washington School of Medicine*  
Seattle, WA

### Term Expires October 2024

**Lawrence R. Kosinski**, MD, MBA  
*SonarMD, Inc.*  
Chicago, IL

**Angelo Sinopoli**, MD  
*UpStream*  
Greensboro, NC

**Soujanya R. Pulluru**, MD<sup>iii</sup>  
*Walmart, Inc.*  
Bentonville, AR

**Jennifer L. Wiler**, MD, MBA  
*UCHealth and University of  
Colorado School of Medicine*  
Aurora, CO

### Term Expires October 2025

**Lindsay K. Botsford**, MD, MBA  
*One Medical*  
Houston, TX

**James Walton**, DO, MBA  
*JWalton, LLC*  
Dallas, TX

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<sup>iii</sup> Jay Feldstein, DO was not in attendance at the March 7, 2022 public meeting. <sup>ii</sup> Soujanya Pulluru, MD was not in attendance at the June 8, 2022 public meeting. <sup>iii</sup> Lauran Hardin, MSN, FAAN was not in attendance at the September 20, 2022 public meeting.

**APPENDIX 2. CHARACTERISTICS OF SELECTED PTAC PROPOSALS IDENTIFIED AS BEING RELEVANT TO POPULATION-BASED TOTAL COST OF CARE (PB-TCOC) MODELS, DECEMBER 2016 – DECEMBER 2020**

Submitter and Proposal	Patient Population, Clinical Focus, Providers, Setting, and Payment Mechanism	TCOC-Related Objectives	TCOC-Related Performance Measures	TCOC-Related Payment Elements
<p><b>1. American Academy of Family Physicians (AAFP)</b></p> <p><i>Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM)</i></p>	<p><b>Patient Population:</b> Medicare beneficiaries</p> <p><b>Clinical Focus:</b> Primary care</p> <p><b>Providers:</b> Primary care providers (PCPs)</p> <p><b>Setting:</b> Primary care practices</p> <p><b>Payment Mechanism:</b> Per beneficiary per month (PBPM)</p>	<p>Reduce TCOC by increasing percentage of total spending allocated to primary care</p>	<p>Core Quality Measure Collaborative measures; hospital utilization; ED utilization</p>	<p>Prospective, risk-adjusted PBPM payment for primary care; prospectively awarded performance-based incentive payments</p>
<p><b>2. American Academy of Hospice and Palliative Medicine (AAHPM)</b></p> <p><i>Patient and Caregiver Support for Serious Illness (PACSSI)</i></p>	<p><b>Patient Population:</b> Beneficiaries with serious / advanced illness</p> <p><b>Clinical Focus:</b> Palliative care</p> <p><b>Providers:</b> Palliative care teams (PCTs)</p> <p><b>Setting:</b> Inpatient, outpatient, other</p> <p><b>Payment Mechanism:</b> PBPM</p>	<p>Reduce per capita end-of-life costs by providing coordinated palliative care and support services</p>	<p>Patient-reported outcomes for experience of care, completion of care processes, utilization of health care services</p>	<p>Up-front base PBPM payments with performance-based incentives/penalties or shared savings/losses linked to TCOC</p>
<p><b>3. American College of Surgeons (ACS)</b></p> <p><i>ACS–Brandeis Advanced Alternative Payment Model</i></p>	<p><b>Patient Population:</b> Beneficiaries having at least one of over 100 conditions or procedures</p> <p><b>Clinical Focus:</b> Cross-clinical</p>	<p>Reduce TCOC for a specific episode</p>	<p>Total savings (number of episodes x [expected cost – actual cost])</p>	<p>Retrospective incentive payments based on difference between observed and expected spending</p>

Submitter and Proposal	Patient Population, Clinical Focus, Providers, Setting, and Payment Mechanism	TCOC-Related Objectives	TCOC-Related Performance Measures	TCOC-Related Payment Elements
	<p><b>Providers:</b> Single / multi-specialty practices; groups of small provider practices</p> <p><b>Setting:</b> Inpatient, outpatient, ambulatory</p> <p><b>Payment Mechanism:</b> Episode-based</p>			
<p><b>4. American Society of Clinical Oncology (ASCO)</b></p> <p><i>Patient-Centered Oncology Payment Model (PCOP)</i></p>	<p><b>Patient Population:</b> Cancer patients</p> <p><b>Clinical Focus:</b> Cancer care</p> <p><b>Providers:</b> : Practices/physicians providing hematology / oncology services; partners</p> <p><b>Setting:</b> : Oncology practices</p> <p><b>Payment Mechanism:</b> Episode-based</p>	<p>Reduce TCOC by decreasing costs associated with drugs, monitoring activities, and emergency / acute / post-acute care</p>	<p>Unplanned hospital admissions, emergency and observation care visits, supportive and maintenance drug costs</p>	<p>Prospective care management payments; bundled payments for value of specified services (Track 2 only)</p>
<p><b>5. Avera Health (Avera)</b></p> <p><i>Intensive Care Management in Skilled Nursing Facility Alternative Payment Model (ICM SNF APM)</i></p>	<p><b>Patient Population:</b> Beneficiaries who reside in skilled nursing facilities (SNFs)</p> <p><b>Clinical Focus:</b> Primary care in skilled nursing facilities (SNFs) and nursing facilities (NFs)</p> <p><b>Providers:</b> Geriatrician Care Teams</p> <p><b>Setting:</b> SNFs and nursing facilities (NFs)</p> <p><b>Payment Mechanism:</b> PBPM</p>	<p>Reduce TCOC through prevention of avoidable escalation of illness for residents living in SNFs</p>	<p>Monitoring 11 scored metrics for determining losses / savings, and 13 additional quality metrics</p>	<p>Prospective payments dependent on quality and financial performance (one-time payment for new admissions and PBPM payments)</p>

Submitter and Proposal	Patient Population, Clinical Focus, Providers, Setting, and Payment Mechanism	TCOC-Related Objectives	TCOC-Related Performance Measures	TCOC-Related Payment Elements
<p><b>6. Coalition to Transform Advanced Care (C-TAC)</b></p> <p><i>Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model</i></p>	<p><b>Patient Population:</b> Beneficiaries with advanced illness, focusing on last 12 months of life</p> <p><b>Clinical Focus:</b> Serious illness and palliative care</p> <p><b>Providers:</b> : ACM care team (registered nurse, licensed social worker, provider with board certified care expertise); other ancillary collaborator organizations</p> <p><b>Setting:</b> All sites of care during treatment for advanced illness, including the home</p> <p><b>Payment Mechanism:</b> PBPM</p>	<p>Reduce TCOC for enrollees in their last 12 months of life using palliative care teams (PCTs)</p>	<p>Measures for developing bonus payments and additional quality measures for monitoring program</p>	<p>Wage-adjusted PMPM payments for the last 12 months of life and quality bonus payments or shared losses based on TCOC</p>
<p><b>7. New York City Department of Health and Mental Hygiene (NYC DOHMH)</b></p> <p><i>Multi-provider, bundled episode of care payment model for treatment of chronic hepatitis C virus (HCV)</i></p>	<p><b>Patient Population:</b> Beneficiaries with hepatitis C infection</p> <p><b>Clinical Focus:</b> Hepatitis C virus (HCV)</p> <p><b>Providers:</b> PCPs (trained by hepatologists / gastroenterologists); specialists; nurse practitioners; physician assistants; and nonclinician staff</p> <p><b>Setting:</b> Primary Care / hospital-based outpatient clinics</p>	<p>Lower costs by reducing expenses from preventable hospitalizations, ED visits, and complications associated with hepatitis C intervention</p>	<p>Risk-adjusted facility-based sustained virologic response (SVR) score, matched cohort study analyzing the impact of care coordination</p>	<p>Prospective bundled payment</p>

Submitter and Proposal	Patient Population, Clinical Focus, Providers, Setting, and Payment Mechanism	TCOC-Related Objectives	TCOC-Related Performance Measures	TCOC-Related Payment Elements
	<b>Payment Mechanism:</b> Bundled episode-based / monthly			
<p><b>8. Illinois Gastroenterology Group and SonarMD, LLC (IGG/SonarMD)</b></p> <p><i>Project Sonar</i></p>	<p><b>Patient Population:</b> Beneficiaries with chronic illness (Crohn’s Disease)</p> <p><b>Clinical Focus:</b> Chronic disease (Crohn’s Disease)</p> <p><b>Providers:</b> Gastroenterology practices; community-based physicians and specialists</p> <p><b>Setting:</b> Patient home</p> <p><b>Payment Mechanism:</b> PBPM</p>	<p>Incentivize proactive care to improve patient quality of life and decrease total costs (by reducing avoidable complications, ED visits, and inpatient admissions)</p>	<p>TCOC (including costs related to outpatient visits, ED visits, and infusion / injection biological costs)</p>	<p>Prospective PMPM payment with retrospective reconciliation; additional monthly payments for non-“face to face” services</p>
<p><b>9. Large Urology Group Practice Association (LUGPA)</b></p> <p><i>LUGPA Advanced Payment Model for Initial Therapy of Newly Diagnosed Patients with Organ-Confined Prostate Cancer</i></p>	<p><b>Patient Population:</b> Beneficiaries who are newly diagnosed with prostate cancer</p> <p><b>Clinical Focus:</b> Urology/oncology (prostate cancer treatment)</p> <p><b>Providers:</b> Urologists and other coordination physicians</p> <p><b>Setting:</b> Urology practices</p> <p><b>Payment Mechanism:</b> PBPM</p>	<p>Defer active intervention (AI) and avoid overutilization of services while reducing morbidity and costs</p>	<p>Proportion of beneficiaries receiving AI after an initial episode, efficiency and cost reduction, care coordination, patient-reported outcomes, cost of care</p>	<p>Prospective care management payment; retrospective performance-based payment based on difference between target and actual spending</p>
<p><b>10. University of Chicago Medicine (UChicago)</b></p>	<p><b>Patient Population:</b> Frail / complex</p>	<p>Reduce overall spending on high-cost</p>	<p>Financial and quality measures, patient and</p>	<p>PBPM care continuity fee (for physicians who</p>

Submitter and Proposal	Patient Population, Clinical Focus, Providers, Setting, and Payment Mechanism	TCOC-Related Objectives	TCOC-Related Performance Measures	TCOC-Related Payment Elements
<p><i>The Comprehensive Care Physician Payment Model (CCP-PM)</i></p>	<p>beneficiaries with hospitalizations</p> <p><b>Clinical Focus:</b> Frequently hospitalized patients</p> <p><b>Providers:</b> Inpatient and outpatient providers</p> <p><b>Setting:</b> Patient home and rehabilitation sites</p> <p><b>Payment Mechanism:</b> PBPM</p>	<p>patients (high-risk Medicare beneficiaries) by improving inpatient-outpatient care coordination</p>	<p>provider satisfaction, self-rated patient mental health, rehospitalization rates, TCOC (Medicare) reduction</p>	<p>meet benchmarks for providing their patients with both inpatient and outpatient care)</p>

### **APPENDIX 3. ADDITIONAL RESOURCES RELATED TO PTAC’S THEME-BASED DISCUSSIONS ON OPTIMIZING POPULATION-BASED TOTAL COST OF CARE (PB-TCOC) MODELS**

The following is a summary of additional resources related to PTAC’s theme-based discussions on optimizing PB-TCOC models in APMs and PFPMs. These resources are publicly available on the ASPE PTAC website at these links:

#### **Environmental Scans and Reports**

[Environmental Scan on Population-Based Total Cost of Care Models in the Context of APMs and PFPMs](#)

[Supplement to the Environmental Scan on Population-Based Total Cost of Care Models](#)

[Second Supplement to the Environmental Scan Related to the Development of Population-Based Total Cost of Care Models](#)

[Population-Based Total Cost of Care Models March 2022 Summary Report \(Forthcoming\)](#)

[Population-Based Total Cost of Care Models June 2022 Summary Report \(Forthcoming\)](#)

[Population-Based Total Cost of Care Models September 2022 Summary Report \(Forthcoming\)](#)

#### **Request for Input (RFI)**

[Request for Input on PTAC’s Review of Population-Based Total Cost of Care Models](#)

*Topics included in the RFI:*

- Structure of future population-based TCOC models
- Types of entities or providers participating in population-based TCOC models
- Best practices for integrating and improving coordination between primary care and specialty care
- Options for evaluating and increasing provider participation
- Successful delivery and payment strategies
- Issues related to nesting and carve-outs
- Unintended consequences
- Performance measurement
- Unanswered questions

#### **Public Comments on PTAC’s Review of Population-Based Total Cost of Care Models**

[Respondents as of August 8, 2022 \(listed in the order in which their responses were received\)](#):

- Coalition to Transform Advanced Care
- Medical Group Management Association
- Stellar Health
- National Association of Chain Drug Stores

- American Physical Therapy Association
- National Association of ACOs
- American Society for Radiation Oncology
- Advocates for Community Health
- Academy of Nutrition and Dietetics

## **Materials from the Public Meetings**

### ***Materials from the Public Meeting on March 7, 2022***

[Presentation: Population-Based Total Cost of Care Models March Preliminary Comments Development Team Findings](#)

[Presentation: PTAC Member Listening Session](#)

[Presentations: Subject Matter Experts Listening Session](#)

[Panelist Biographies](#)

[Listening Session Facilitation Questions](#)

### ***Other Information Related to the Public Meeting on March 7, 2022***

[Public Meeting Minutes](#)

[Public Meeting Transcript](#)

### ***Materials from the Public Meeting on March 8, 2022***

[Presentation: Population-Based Total Cost of Care Models March Preliminary Comments Development Team Findings](#)

[Presentations: Subject Matter Experts Listening Session](#)

[Panelist Biographies](#)

[Panelist Questions](#)

[Listening Session Facilitation Questions](#)

### ***Other Information Related to the Public Meeting on March 8, 2022***

[Public Meeting Minutes](#)

[Public Meeting Transcript](#)

### ***Materials from the Public Meeting on June 7, 2022***

[Presentation: Population-Based Total Cost of Care Models June Preliminary Comments Development Team Findings](#)

[Presentation: PTAC Member Listening Session](#)

[Presentations: Subject Matter Experts Listening Sessions](#)

[Panelist Biographies](#)

[Listening Session Facilitation Questions](#)

***Other Information Related to the Public Meeting on June 7, 2022***

[Public Meeting Minutes](#)

[Public Meeting Transcript](#)

***Materials from the Public Meeting on June 8, 2022***

[Presentations: Subject Matter Experts Listening Session](#)

[Panelist Biographies](#)

[Panelist Questions](#)

[Listening Session Facilitation Questions](#)

***Other Information Related to the Public Meeting on June 8, 2022***

[Public Meeting Minutes](#)

[Public Meeting Transcript](#)

***Materials from the Public Meeting on September 19, 2022***

[Presentation: Population-Based Total Cost of Care Models September Preliminary Comments Development Team Findings](#)

[Presentations: Subject Matter Experts Listening Sessions](#)

[Panelist Biographies](#)

[Panelist Questions](#)

[Listening Session Discussion Guide](#)

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## APPENDIX 4. SUMMARY OF PTAC COMMENTS ON POPULATION-BASED TOTAL COST OF CARE (PB-TCOC) MODELS

The Committee’s comments have been summarized in the following broad topic areas:

- Topic 1: Desired Vision and Culture for Population-Based Total Cost of Care Models;
- Topic 2: Definitions of Total Cost of Care;
- Topic 3: Care Delivery Features;
- Topic 4: Enablers to Support Care Delivery Features;
- Topic 5: Desired Payment Features;
- Topic 6: Enablers to Support Desired Payment Features;
- Topic 7: Model Design Considerations;
- Topic 8: Desired Performance Measurement Features; and
- Topic 9: Policy Levers.

<b>Topic 1: Desired Vision and Culture for Population-Based Total Cost of Care Models</b>	
1A	<p><i>It is important to foster a culture of accountability for clinical, quality, equity, and spending outcomes in PB-TCOC models.</i></p> <p><i>This culture of accountability should support high touch proactive care that:</i></p> <ul style="list-style-type: none"> <li>• <i>Prevents or mitigates populations’ risk of developing undesired health outcomes;</i></li> <li>• <i>Ensures optimal outcomes,</i></li> <li>• <i>Eliminates racial and socioeconomic disparities;</i></li> <li>• <i>Fosters continual care coordination focused on all patients including underserved communities.</i></li> </ul> <p><i>This culture of accountability should also foster the availability and use of:</i></p> <ul style="list-style-type: none"> <li>• <i>Actionable data;</i></li> <li>• <i>Evidence-based diagnostic treatment protocols;</i></li> <li>• <i>Effective stratification of patients based on risk,</i></li> <li>• <i>Data driven care delivery decisions;</i></li> <li>• <i>Dissemination and uptake of best practices; and alignment, and</i></li> <li>• <i>Reduced complexity of payment models.</i></li> </ul>

<b>Topic 2: Definitions of Total Cost of Care</b>	
2A	<p>Further work is needed to determine if it is appropriate to develop a common definition for TCOC across population-based models or identify times when variation in definitions across models may be beneficial (e.g., as a function of patient population, provider type, and or other contextual factors). Questions about the feasibility of definitional alignment will be particularly important when addressing model overlap and efforts to improve multi payer alignment.</p>

<b>Topic 2: Definitions of Total Cost of Care</b>	
2B	In the short term, it is important to work towards aligning the services that are included in the definition of TCOC in cases where there is overlap across models. This will help to clarify and harmonize incentives among providers participating in multiple models. At the same time, it is also important to consider situations where it may be appropriate to vary the definition of covered services that are included in TCOC for certain models.
2C	It is important to acknowledge that excluding certain expenditures from the TCOC that providers are accountable for can have unintended consequences related to utilization (including substitution and cost-shifting, such as between pharmaceuticals therapies in Part B to Part D therapies). In order to address this issue, some organizations have developed performance measures related to the stewardship of services that are not included in the definition of TCOC (such as pharmaceutical stewardship). Consideration should also be given to testing the impact of including additional services in the definition of TCOC for PB-TCOC models.
2D	In the medium to longer term, it will be beneficial to explore the feasibility of developing a standardized definition of the services that are included in TCOC, and the way that TCOC is calculated across payers.

<b>Topic 3: Care Delivery Features</b>	
3A	Encourage high-touch multidisciplinary team-based, proactive patient-centered care that is built around primary care. Strengthen investments in primary care with enhanced care delivery teams that include behavioral health providers, pharmacists, CHWs, and other providers as appropriate. Explore approaches for integrating specialty care in proactive patient-centered, multidisciplinary care delivery teams.
3B	Balance the use of primary care and specialty care; and manage the roles and use of primary care providers (PCPs) and specialty care providers in coordinating care for patients with certain acute and chronic conditions, and during certain disease stages. Involve PCPs and specialty care providers in developing patient-centered models with cascading or collective responsibility for population care management.
3C	Leverage data on the number and types of care team encounters (such as the ratio of primary care to specialty care “touches”) to encourage team-based care.
3D	Proactive patient engagement for patients with complex conditions can help provide appropriate resources to address their needs, reduce gaps in care, and mitigate risk of adverse outcomes. To facilitate targeted interventions, it is important to consider stratifying patients by clinical risk and potential for higher service delivery costs spending to tailor care coordination to their needs and manage transitions effectively.
3E	It is important to consider the benefits of balancing immediate spending-reduction goals with the need to increase investment in primary and preventive care that can help reduce TCOC in the medium and long term, both for high-risk patients and for patients with “rising” risk or low risk.
3F	Emphasize screening and referral for health-related social needs (HSRNs) and use existing data on social needs to help identify and establish outreach to patients most likely to be adversely affected by social determinants of health (SDOH). In the short-term it is important to consider developing standardized screening questions for assessing HSRNs across models to minimize provider burden and enable evaluation. Over time, efforts could also include exploring incentives for building and sustaining partnerships with CBOs; and assigning accountability for addressing HSRNs to the appropriate entities.

<b>Topic 4: Enablers to Support Care Delivery Features</b>	
4A	Recognizing that data access affects providers’ ability to participate in PB- TCOC models, it is important to align approaches to exchange data in a way that ensures the information shared is actionable. This may mean considering how to give accountable entities real-time access to centralized, multi-sourced data systems (including data from CMS and other providers and payers) using a “data utility” approach rather than relying on provider-to-provider data sharing. It is also important to consider assessing and enhancing approaches used by providers to access and share data, with a focus on data standards.
4B	Encourage the development of forums for disseminating detailed information about how successful providers have been able to improve quality while reducing costs spending and taking on financial risk. Additionally fostering collaboration between researchers and successful PB-TCOC model participants can help to identify and promulgate best practices for caring for patients with complex needs through the use of different research and evaluation methods including randomized trials. It may also be feasible to work with medical societies to design studies to test performance outcomes associated with the use of their published guidelines and clinical pathways.
4C	There is an opportunity to analyze the relationship between specific care delivery approaches and performance outcomes by incentivizing or requiring accountable entities to regularly submit and update structured information about the care delivery strategies that they are using, and including this information in the evaluations of PB-TCOC models.
4D	Infrastructure investments in staff and information technology are important for facilitating participation in value-based care. It is important to ensure the availability of sufficient upfront resources and infrastructure to promote care delivery changes. There is a potential to provide resources to support primary care providers who are not currently participating in value-based care (e.g., embedded care teams providing 24-hour support). However, there is a need for sustainable funding to incentivize and support development of the necessary health data-sharing infrastructure to facilitate centralized data analytics over an extended period of time.
4E	Given that the typical health care organization currently monitors hundreds of inpatient and outpatient performance metrics, identifying and encouraging alignment on key performance metrics that drive desired care delivery improvements is particularly important. Aligning the key performance metrics that are related to the care of a substantial share of a provider’s full panel of patients (types and definitions) would help to reduce burden while facilitating the monitoring of outcomes. Improving alignment of performance metrics is particularly important for specialists.

<b>Topic 5: Desired Payment Features</b>	
5A	Continue developing payment models that assign accountability for quality and spending to a single entity that would be responsible for actuarial risk, and have flexibility in determining how to manage accountability and incentives for participating PCPs and specialists.
5B	Develop a comprehensive participation strategy that includes models with multiple tracks and phase-in periods for taking on two-sided risk, which can also encourage provider participation in PB-TCOC models.

<b>Topic 5: Desired Payment Features</b>	
5C	This participation strategy should also include a balance providing incentives for voluntary participation with the potential for requiring mandatory participation in certain cases. Encourage mandatory, time-certain models to ensure adequate provider participation and patient alignment. In order to move all Medicare beneficiaries into value-based payment models by 2030, it is important to require providers that treat Medicare patients to take on financial risk
5D	Increase the use of prospective payment models that can provide participating organizations with certainty about finances and flexibility to implement care delivery changes.
5E	Consider options for facilitating more timely payments to accountable entities that are participating in payment models to provide increased flexibility to effectively set incentives for and provide payment to participating providers. Individual providers are more responsive to incentives that are linked with their own performance rather than performance across an accountable entity. Some organizations that have been successful in taking on financial risk make quarterly performance-based payments to providers based on their own upside risk. The majority of usable FFS claims data are usually available within six months, which could make it feasible to provide performance-based payments earlier in FFS-based shared savings models.
5F	For beneficiary directed incentives, consider changes to cost-sharing to align incentives in PB-TCOC models. For example, it may be beneficial to reduce or eliminate copays for high-value services.

<b>Topic 6: Enablers to Support Desired Payment Features</b>	
6A	Multi-payer alignment allows for increased risk-sharing with respect to both number of providers in risk-sharing arrangements and degree of risk. Multi-payer alignment also improves care since it allows provider entities to implement care pathways across their full range of patients and decreases fragmented care. In addition to encouraging the engagement of multiple payers, alignment of payment features and performance measures will be important for decreasing administrative waste and improving provider engagement. There is an immediate opportunity to reduce administrative burden by increasing alignment of performance metrics and HRSN or/ SDOH screening tools .
6B	Consider including performance-based incentives that reward absolute improvements in a given provider's performance with respect to quality, equity and spending outcomes, in addition to incentives that reward absolute performance relative to external benchmarks. Rewarding improvements in provider-level performance can help to encourage ongoing care delivery innovations among various types of providers, including those with more experience and less experience with value-based care.
6C	It is important to focus on improving health data utility to prevent providers from focusing on the metric rather than patient care. Some quality measures are not effective or are cumbersome to measure. Data of high utility that flows up to the state level is essential for expanding value-based care.

<b>Topic 7: Model Design Considerations</b>	
7A	Placing financial accountability for TCOC at the entity or organization level is appropriate to manage risks for individual clinicians or smaller groups of clinicians, but incentives should be focused at the level of the provider. Shifting away from retrospective alignment toward a more prospective approach could improve clarity regarding which patients are part of the model and attributed to any given provider, and facilitate improved care coordination.
7B	Providing upfront resources to support desired care delivery transformation can help to increase participation in PB-TCOC models, particularly in cases where risk is based on retrospective rewards for savings. One option would involve providing a monthly care management payment to the accountable provider(s), both PCPs and SCPs, that could be adjusted based on beneficiary characteristics or tiered risk. It is necessary for monthly payments not to exceed savings from the model. Additionally, increasing the number of PB-TCOC models that include full or partial capitation would provide flexibility to use a portion of prospective capitated payments to support care delivery transformation.
7C	In the near term, it is important to address the benefits of addressing issues related to attribution, benchmarking, and risk adjustment in order to encourage participation in PB-TCOC models.
7D	Successful implementation of PB-TCOC models requires clinical coordination between primary and specialty care, and development of incentives for engaging in coordinated, team-based care. There are fewer complexities related to nesting specialty episodes in PB-TCOC models than with carve-outs (in which certain costs are excluded from the PB-TCOC model). Approaches that involve nesting a limited number of episode or condition-specific bundled payment models within a broader PB-TCOC model have shown promise.
7E	In cases where there is overlap between separate PB-TCOC models and other models It is important to adopt performance measures that avoid double-counting savings and maintain incentives for participants in these models to collaborate
7F	It is important for PB-TCOC models to incentivize participants to provide screenings and referrals to address HRSNs. This could include providing incentives based on performance metrics for HSRN screening and referral. It would be important for these activities to have dedicated payments that would not be subject to reduction based on cost of care.

<b>Topic 8: Desired Performance Measurement Features</b>	
8A	The selection and use of performance measures is an important design consideration for PB-TCOC models. Stakeholders have expressed concerns that the current body of performance metric evidence is largely limited to claims-based metrics. Current approaches to performance measurement also do not adequately measure access, care coordination, or equity. There is also a need for additional outcome measures. In the future, it will be important to set appropriate thresholds for quality performance, and incorporate equity measures, which have not traditionally been included in PB-TCOC models.
8B	It will be necessary to develop the necessary infrastructure to support quality accountability and measurement that can better support PB-TCOC models. For example, in the long term, there will be a need to link digitally enabled clinical guidelines and clinical decision support with performance measures that are in a digital format, and to promote uniform field structures and interoperability among EHRs and other databases to facilitate measurement and reporting.

<b>Topic 8: Desired Performance Measurement Features</b>	
8C	Even if not used as formal performance metrics for determining payment, it may be useful for PB-TCOC models to monitor additional process metrics that capture certain processes that are related to desired care delivery features and outcomes, and incremental improvements in quality and spending. Data on the amount of time spent with patients and the number of overnight calls could be proxies for providing high touch primary care, and data on the number of primary care and overall encounters or “touches” could be a surrogate marker for patient engagement. Additionally, data on pharmaceutical stewardship could be a proxy for the provision of high-value care.
8D	It is also important for PB-TCOC models to monitor performance measures related to utilization and access to prevent underutilization of care (such as number of visits, wait times, and changes in beneficiary out-of-pocket spending).
8E	It is important to develop include specific metrics relevant to specialty care in PB-TCOC models that include specialists. Most quality metrics are primary care based and not focused on the needs of the patient with multiple chronic medical conditions managed by specialists
8F	It is important to consider measurement burden if adding measures in PB-TCOC models by ensuring that new measures add value and low-quality measures are eliminated.

<b>Topic 9: Policy Levers</b>	
9A	Increasing the financial incentives and flexibility associated with participation in PB-TCOC models can encourage provider participation in these models, while making it less desirable for providers to remain in FFS.
9B	It will be important to determine how much flexibility should be allowed for accountable entities in future PB-TCOC models, the desired level of variation, and areas where less variation would be desired (such as access to providers).