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

Request for Input (RFI)

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) is hosting theme-based discussions to inform the Committee on topics that are important for physician-focused payment models (PFPMs). Given the increased emphasis on developing larger population-based Alternative Payment Models (APMs) that encourage accountable care relationships, PTAC has conducted a series of theme-based discussions that examined key definitions, issues and opportunities related to developing and implementing population-based total cost of care (PB-TCOC) models with accountability for quality and TCOC.[1] Subsequent theme-based discussions have addressed topics related to improving care delivery and integration of specialty care, improving management of care transitions, increasing participation of rural patients and providers, developing and implementing performance measures, and addressing needs of patients with complex chronic conditions and serious illnesses for PB-TCOC models.

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

PTAC's two-day September 2024 public meeting focused on identifying the pathway toward maximizing participation in PB-TCOC models. During the public meeting, Committee members heard from various subject matter experts, including stakeholders who have previously submitted proposals to PTAC that included value-based care components. Specific topics that were addressed included:

- Stakeholder perspectives on developing a pathway toward having all Medicare beneficiaries with Parts A and B in care relationships with accountability for quality, outcomes, and TCOC;
- Envisioning future PB-TCOC models, the needs of different kinds of participating PB-TCOC organizations, and necessary components for success;
- Organizational structure, payment, and financial incentives for supporting accountable care relationships;
- Developing a balanced portfolio of performance measures for PB-TCOC models; and
- Addressing challenges regarding data, attribution, benchmarking, and risk adjustment.

[1] Please see the Appendix for PTAC's definition of PB-TCOC models.

Stakeholders also had an opportunity to provide public comments. Findings from this theme-based discussion will be included in a report to the Secretary of Health and Human Services (HHS).

Background:

The Center for Medicare and Medicaid Innovation (CMMI) has set the goal of having all Medicare fee-for-service (FFS) beneficiaries with Parts A and B coverage in a care relationship with accountability for quality and TCOC by 2030.[2]

Additionally, the Secretary of Health and Human Services (HHS) has established 10 criteria[3] for proposed PFPMs that PTAC uses to evaluate submitted proposals, including "Quality and Cost." The goal of this criterion is to ensure that each proposed model will "improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost" (Criterion 2).

Among the 35 proposals that were submitted to PTAC between 2016 and 2020, including 28 proposals that PTAC has deliberated and voted on during public meetings, nearly all of the proposals address the proposed model's potential impact on costs, to some degree. Committee members found that 20 of these proposals met Criterion 2 (Quality and Cost), including five proposals that were determined to meet all 10 of the criteria established by the Secretary for PFPMs. Additionally, at least nine other proposals discussed the use of TCOC measures in their payment methodology and performance reporting.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides an environmental scan for every proposal reviewed by PTAC so that Committee members understand the clinical and economic circumstances within which a proposed model would be implemented, as well as related resource information that can inform their evaluation of each proposal. To assist PTAC in preparing for the September 2024 theme-based discussion, an environmental scan was developed with background ion the goal of having all Medicare beneficiaries with Parts A and B in accountable care relationships by 2030; information on

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[2] Center for Medicare and Medicaid Innovation. *Innovation Center Strategy Refresh*; 2021:32. https://innovation.cms.gov/strategic-direction-whitepaper

[3] The 10 criteria are scope, quality and cost, payment methodology, value over volume, flexibility, ability to be evaluated, integration and care coordination, patient choice, patient safety, and health information technology.

challenges and technical issues related to maximizing participation in PB-TCOC models; and summarizes relevant features in previously submitted PTAC proposals..

Beginning in 2021, PTAC has conducted a series of theme-based discussions to examine topics relevant to PFPMs, with a focus on issues related to accountable care and PB-TCOC models. Within this context, PTAC is has developed the following working definitions:

Accountable Care Relationship

- *A relationship between a provider and a patient (or group of patients) that establishes that provider as accountable for quality and total cost of care (TCOC) including the possibility of financial loss/risk for an individual patient or group of patients for a defined period (e.g., 365 days).*

- *Would typically include accountability for quality and TCOC for all of a patient's covered health care services.*

Population-Based Total Cost of Care (PB-TCOC) Model

- *Alternative Payment Model (APM) in which participating entities assume* ***accountability for quality and TCOC*** *and receive payments for* ***all covered health care costs***[4] *for a broadly defined population with varying health care needs during the course of a year (365 days).*

- *Within this context, a PB-TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be "nested" within a PB-TCOC model.*

See the Appendix for additional definitions around PB-TCOC models. These definitions will likely continue to evolve as the Committee collects additional information from stakeholders.

Additionally, based upon the information that the Committee has acquired over the course of its series of theme-based discussions relating to developing and implementing PB-TCOC models, PTAC has identified the following key questions for identifying pathways toward having all Medicare beneficiaries in accountable care relationships:

[4] For this purpose, all covered health care costs does not include pharmacy-related costs (Medicare Part D).

- *Categorizing Medicare beneficiaries by the extent to which they are currently in care relationships with accountability for quality and/or TCOC.*
- *Characterizing geographic areas by the extent to which their providers are participating in value-based care.*
- *Identifying model characteristics associated with success.*
- *Developing approaches, models, target timeframes, and intermediary steps for increasing involvement in accountable care relationships for various categories of Medicare beneficiaries (e.g., by dual eligible status, age).*
- *Identifying and addressing gaps and challenges.*

PTAC Areas of Interest:

PTAC is particularly interested in perspectives on developing pathways toward maximizing participation in PB-TCOC models. Particular topics of interest include identifying successful components of models to envision future PB-TCOC models; discussing organizational structure, payment, and financial incentives for supporting accountable care relationships; developing a balanced portfolio of performance measures; and addressing challenges regarding data, attribution, benchmarking, and risk adjustment in PB-TCOC models.

PTAC seeks to build upon the insights of stakeholders and use those insights and considerations to further inform the Committee's review of proposals and recommendations that the Committee may provide to the Secretary relating to this topic. Therefore, PTAC requests stakeholders' input on the questions listed below.

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

Questions to the Public:

1) What should be the vision for developing PB-TCOC models that can help to ensure that every Medicare beneficiary with Parts A and B is in a care relationship with accountability for quality and total cost of care (TCOC)?
    a) What should be the goals and characteristics of an accountable care relationship?
    b) Which kinds of models are best able to support accountable care relationships?

c) Is it realistic to be able to have all beneficiaries with Parts A and B in accountable care relationships with two-sided risk by 2030 (such as beneficiaries in rural areas)?

2) What are the necessary components for PB-TCOC models to be successful in achieving the goal of having all Medicare beneficiaries with Parts A and be in accountable care relationships?

   a) What should be the key steps and milestones for developing pathways toward having all beneficiaries with Parts A and B in accountable care relationships by 2030?

   b) Is there a need to develop multiple pathways for different types of PB-TCOC organizations and if so, how should these multiple pathways be developed?

   c) Are there current models that have successfully developed multiple pathways (e.g., one-sided risk, two-sided risk) for different types of organizations, and has this approach led to increased participation?

3) What are the characteristics of beneficiaries who are not currently in accountable care relationships? What approaches can help to increase their involvement in accountable care relationships?

   a) How does alignment with ACOs and other types of APMs affect beneficiaries' access to care, quality of care, health outcomes and out-of-pocket costs?

   b) To what extent are Medicare beneficiaries aware if they are aligned with a physician that is in an APM?

   c) What kinds of features might be developed to incentivize Medicare beneficiaries to align with providers who are in APMs?

4) Why have some providers not been signing up to participate in PB-TCOC models? Why have some providers chosen to cease participating in PB-TCOC models? What can be done to address barriers to participation?

   a) What are the most important factors affecting providers' decisions to participate in PB-TCOC models (e.g., based on size, specialty, level of clinical integration, rural status, geographic region)?

   b) What impact does physicians' employment status have on their participation in PB-TCOC models? What are the most important factors affecting hospitals or corporate entities' decisions to participate in PB-TCOC models?

   c) Why have some providers chosen to cease participating in PB-TCOC models?

5) What gaps still exist within the current portfolio of value-based payment models, and what features need to be implemented in future models to close those gaps?
6) What are the most effective payment approaches for promoting accountable care relationships in PB-TCOC models?
    a) Should payment models differ based on the types of organizations (e.g., integrated delivery system versus independent physician-led)?
    b) What financial incentives are needed to encourage providers to participate in models that include two-sided risk?
    c) Are different approaches needed for structuring organization-level vs. provider-level financial incentives? How should physician-level financial incentives be structured?
7) What considerations may be needed to develop appropriate payment models to promote accountable care relationships for different specialties, conditions, or settings?
    a) Can nested models and episodes of care be used to develop more effective payment models? How should these models be structured?
8) How should PB-TCOC models integrate performance measures that are specific to specialty, condition, or setting with population-based performance measures?
    a) What is the appropriate level (e.g., organization, practice) to measure population-based, specialty, condition, or setting-specific outcomes in PB-TCOC models?
    b) What unique implementation challenges exist with implementing specialty, condition, or setting-specific measures in PB-TCOC models?
9) What are best practices for establishing benchmarks for use in PB-TCOC models?
10) What are the most appropriate risk-adjustment methods to use for PB-TCOC models?
    a) How should the optimal risk-adjustment approaches differ for different types of organizations and/or performance measures?
11) What should the relationship look like between PB-TCOC models and other Medicare value-based payment programs (e.g., Medicare Advantage (MA), Medicare Shared Savings Program, setting-specific programs)?
12) Has the existence of CMS' 2030 goal of increasing enrollment of FFS beneficiaries in PB-TCOC models changed or interacted with how other payers are implementing (or considering implementing) accountable care relationships? If so, how?
13) What opportunities exist to address data interoperability challenges? What steps can be taken to ensure data interoperability across programs and settings?

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Request for Input (RFI)

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

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

Appendix: Working Definitions Related to Population-Based Total Cost of Care (PB-TCOC) Models

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

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

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

> *Alternative Payment Model (APM) in which participating entities assume accountability for quality and TCOC and receive payments for all covered health care costs for a broadly defined population with varying health care needs during the course of a year (365 days).*

Within this context, a PB-TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be "nested" within a PB-TCOC model. Additionally, PTAC is using the following working definition of TCOC:

> *Total cost of care is a composite measure of the cost of all covered medical services delivered to an individual or group. In the context of Medicare Alternative Payment Models, TCOC typically includes Medicare Part A and Part B expenditures, and is calculated on a per-beneficiary basis for a specified time period.*

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

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

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