

## Population-Based Total Cost of Care (TCOC) Models Request for Input (RFI)

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) is hosting a series of theme-based discussions throughout 2022 to inform the Committee on topics important to physician-focused payment models (PFPMs). Given the increased emphasis on developing larger population-based Alternative Payment Models (APMs) that encourage accountable care relationships, PTAC will examine key issues and options related to the development and implementation of population-based total cost of care (TCOC) models.<sup>1</sup>

This series of theme-based discussions is designed to give Committee members information about current perspectives on the role that population-based TCOC models can play in optimizing health care delivery and value-based transformation in the context of APMs and PFPMs specifically. PTAC will hear from the public and subject matter experts, including stakeholders who have previously submitted proposals to PTAC that included elements related to population-based models and TCOC. Findings from these theme-based discussions will be included in a report to the Secretary of Health and Human Services (HHS).

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 population-based TCOC models and episode-based or condition-specific models. PTAC anticipates covering additional care delivery and payment issues during the upcoming June and September public meetings.

- The **June 2022** public meeting will include a theme-based discussion on assessing best practices in care delivery for population-based TCOC models. Key topics to be addressed include options for incentivizing care delivery improvements that have the potential to reduce TCOC; lessons learned from integrated delivery systems and risk-bearing entities; best practices for incorporating specialty innovations into larger, population-based models; identification of appropriate performance metrics for population-based TCOC models; issues related to evaluating and measuring the success of these models; and related implications for health equity.
- The **September 2022** public meeting will include a theme-based discussion on payment considerations and financial incentives related to population-based TCOC models. Key topics will include options for financially structuring population-based TCOC models to incentivize care delivery improvements and provider participation; options for encounter-based versus capitated provider payment arrangements; methodologies for developing TCOC benchmarks; approaches for risk adjustment; and related implications for health equity.

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<sup>1</sup> Appendix 1 outlines PTAC's definition of a population-based TCOC model.

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### Background:

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.<sup>2</sup> Additionally, the Secretary of HHS established “Quality and Cost” as one of the 10 criteria for proposed PFPMs that PTAC uses to evaluate submitted proposals. 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).<sup>3</sup> Within this context, PTAC has assessed previous submitters’ use of TCOC measures in various PFPM proposals that targeted specific patient populations and episodes of care.

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.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides an environmental scan for every proposal reviewed by PTAC to provide background information to inform the Committee’s evaluation of each proposal. To help PTAC prepare for the 2022 theme-based discussions related to population-based TCOC models, a brief environmental scan was developed with background information on definitional issues; relevant features of existing programs and selected Center for Medicare and Medicaid Innovation (CMMI) models; use of components related to population-based TCOC models in selected previously submitted PTAC proposals; metrics for evaluating relevant interventions; and findings from research related to models and programs that seek to reduce TCOC.

Additionally, the March 2022 theme-based discussion included: (1) a listening session with a Committee member; (2) listening sessions with subject matter experts and a stakeholder who previously submitted a PFPM proposal to PTAC; and (3) a panel discussion with a diverse group of subject matter experts. Stakeholders also had an opportunity to make public comments.

During the March 2022 theme-based discussion, PTAC used the following working definition of how TCOC should be defined in the context of population-based 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*

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

<sup>3</sup> Physician-Focused Payment Model Technical Advisory Committee. *Physician-Focused Payment Models: PTAC Proposal Submission Instructions*. Revised as of April 2, 2021.

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*Models, TCOC typically includes Medicare Part A and Part B expenditures, and is calculated on a per-beneficiary basis for a specified time period.*

Additionally, PTAC used the following working definition of a population-based TCOC model as a guide for focusing the discussion during the March 2022 public meeting:

*A population-based TCOC model refers to a population-based 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.*

These definitions will likely evolve as the Committee collects additional information from stakeholders. Appendix 1 includes examples of how TCOC is defined in some current models.

### **PTAC Interests:**

Within the broader context of population-based TCOC models, PTAC is particularly interested in issues related to model design and implementation. PTAC considers the following issues to be particularly important related to further defining population-based TCOC models in the context of APMs and PFPs:

- Identifying the accountable entity, the duration of the accountability period;
- Minimum threshold of the number of patients that could be included;
- Determining which services should be included in order to best address patient needs;
- Addressing issues related to model overlap, including the relationship between larger population-based models and episode-based or condition-specific models;
- Identifying best practices for coordinating primary care and specialty care, incentivizing care delivery improvements, and meeting the needs of severely ill patients;
- Increasing provider participation and enhancing provider readiness to participate, including options for transitioning to increased participation in models with increasing levels of risk;
- Determining the structure of the payment model (e.g., fee-for-service [FFS]-based with two-sided risk, capitation);
- Incentivizing physicians through innovative physician payment models, particularly for independent physician practices and safety-net providers;
- Encouraging multi-payer alignment;
- Addressing issues related to financial incentives, attribution, benchmarking, and risk adjustment;

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- Determining how to evaluate and measure the success of these models; and
- Addressing issues related to diversity and health equity.

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. PTAC also seeks additional information on stakeholders’ experiences related to population-based TCOC models. Therefore, PTAC requests stakeholder input on the questions listed below.

The questions address issues that were discussed during the March public meeting, as well as additional care delivery and payment issues that PTAC anticipates addressing during the upcoming June and September public meetings. To assist stakeholders in understanding how the various questions relate to each of the Committee’s public meetings on population-based TCOC models, a single asterisk (\*) is used to identify questions that are particularly relevant for the issues that were discussed during the March public meeting, a double asterisk (\*\*\*) is used to identify questions that are particularly relevant for the issues that will be discussed during the June public meeting, and a triple asterisk (\*\*\*) is used to identify questions that are particularly relevant for the issues that will be discussed during the September public meeting.

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

### Questions to the Public:

1. The Center for Medicare and Medicaid Innovation (CMMI)’s *Strategy Refresh* includes a goal that all Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and TCOC by 2030.<sup>4</sup> What should these future population-based TCOC models look like? \*
2. What type(s) of entity/entities or provider(s) should be accountable for TCOC in population-based TCOC models? Could the accountable entities look like current Accountable Care Organizations (ACOs) or Medicare Advantage (MA) plans? Could the accountable entities be delivery systems taking on risk, a combination of delivery organizations and payers, or fully integrated systems? \*
  - a. Does the ability to manage TCOC vary by certain factors (e.g., type of provider, specialty, condition)?

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<sup>4</sup> CMS Innovation Center Strategy Refresh. Centers for Medicare & Medicaid Services (CMS). <https://innovation.cms.gov/strategic-direction>. Published October 20, 2021. Accessed January 3, 2022.

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3. Based on your experience, what are some approaches and best practices for integrating and improving coordination between primary care and specialty care providers within population-based TCOC models? \*\*
  - a. Has provider participation in population-based TCOC models affected innovation with respect to the integration of primary care and specialty care?
  - b. What are some incentives that can help to improve care coordination and provider accountability for TCOC?
4. What are some options for evaluating and increasing provider readiness to participate in population-based TCOC models? \*
  - a. Are there differences in provider readiness by specialty or other factors?
  - b. To what extent can provider participation in models with some upside and downside risk help to increase provider readiness to participate in population-based TCOC models? If so, what are some options for improving provider readiness to take on risk?
  - c. What are some of the provider-level barriers to participating in population-based TCOC models (including barriers for specialists)?
5. Based on your experience, what kinds of care delivery strategies (e.g., patient-centered medical homes, telehealth, and care coordination; addressing social determinants of health, addressing behavioral health needs, and focusing on seriously ill patients) have been particularly effective for improving quality and reducing TCOC? Why have these strategies been effective? What have been some challenges and opportunities related to these approaches? \*\*
  - a. What are options for incorporating these strategies when developing care delivery models for future population-based TCOC models?
  - b. What are some best practices for improving the affordability of care for beneficiaries (e.g., copayments, prescription drugs) within population-based models?
6. Based on your experience, what payment strategies have been particularly effective for supporting efforts to improve quality and reduce TCOC (e.g., shifting risk downstream to providers)? Why have these strategies been effective? What have been some challenges and opportunities related to these approaches? \*\*\*
  - a. What are the pros and cons of using payment methodologies that rely on a fee-for-service (FFS) architecture with upside and downside risk versus payment methodologies that involve global budgets or capitated payments?

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7. What are some options for addressing model overlap and incorporating episode-based payments within population-based TCOC models? \*
  - a. How might these options vary by differing factors (e.g., ACO ownership type, condition, specialty, type of episode)?
  - b. What are potential issues related to nesting, carve-outs, and other potential approaches?
8. What specific issues should be considered when applying population-based TCOC models to diverse patient populations and care settings? \*
  - a. Are there potential unintended consequences associated with implementing population-based models (for patients, primary care providers, specialty providers, and others)?
  - b. Are there potential issues related to health equity regarding the implementation of population-based TCOC models?
  - c. What are the options for increasing the participation of underrepresented and underserved populations in value-based models, including population-based TCOC models?
  - d. What are the potential implications for safety-net providers and providers who serve historically underserved populations to participate in population-based TCOC models? What are options for identifying these providers and improving their readiness to participate in these models?
9. Based on your experience, what are the best performance metrics for evaluating population-based TCOC models, and their impact on the quality and cost of care? \*\*
  - a. What are options for balancing efforts to advance the development and use of patient-centered quality measurements (e.g., patient-reported outcome measures) with the burden associated with collecting the relevant data?
10. Based on your experience, what are different methodologies for developing benchmarks used to determine payment under population-based TCOC models? What are the pros and cons of these approaches? How can approaches for developing benchmarks be improved? \*\*\*
11. Based on your experience, what are different methodologies for risk adjusting measures used to determine payment under population-based TCOC models? What are the pros and cons of these approaches from a beneficiary, physician, or program perspective? Are there any unintended consequences of applying risk adjustment methodologies?  
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12. Are there opportunities to improve multi-payer alignment and increase multi-payer participation in population-based TCOC models? What are the most important model design components related to increasing multi-payer alignment (e.g., clinical tools, outcome measures, payment)? \*
13. What types of services should be included in calculating TCOC in the context of APMs, PFPs, and population-based TCOC models? To what extent do definitions of TCOC differ across specialties, models, payers, and other factors? \*
  - a. Should there be a single definition of TCOC in future population-based TCOC models? Are there considerations regarding why the definition of TCOC should potentially be allowed to differ by certain factors (e.g., payer type)?
  - b. Are there additional services that should be included in calculations of TCOC for future population-based TCOC models (e.g., prescription drugs, specialty drugs, or non-medical services)? What, if any, issues may exist related to including these additional services in TCOC?
  - c. Are there current measure specifications that work well? Why or why not?
14. Are there any other important questions that should be considered related to the development of population-based TCOC models and PFPs?

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

*Note: Any comments that are not focused on the topic of APMs and PFPs for population-based TCOC initiatives 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.*

## Population-Based Total Cost of Care (TCOC) Models Request for Input (RFI)

### Appendix 1: Working Definitions Being Used to Frame the March 2022 Theme-Based Discussion on Population-Based Total Cost of Care (TCOC) Models

#### Total Cost of Care

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. TCOC may be calculated differently depending on the model or model track, and can be adjusted for other factors. For example:

- In the **Maryland TCOC Model**, “Total cost of care means the **aggregate Medicare FFS costs for all items and services, or a specific subset thereof**, delivered to Medicare FFS beneficiaries.”<sup>5</sup> The aggregate Medicare FFS costs include Medicare Part A and Part B expenditures only. When determining the annual Medicare savings, any Outcomes-Based Credits are also included in the per-beneficiary TCOC calculation.
- In the **Global and Professional Direct Contracting (GPDC) Model**, “The Performance Year Benchmark [a target Per Beneficiary Per Month (PBPM) dollar amount] represents the average Medicare beneficiary total cost of care [TCOC] for aligned beneficiaries and **refers to the target expenditure amount [calculated using the Parts A and B expenditures for aligned beneficiaries during a baseline period]** that will be compared to Medicare expenditures for items and services furnished to aligned beneficiaries (Direct Contracting beneficiaries) during a performance year [to determine the Direct Contracting Entity (DCE)’s savings or losses].”<sup>6</sup>

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<sup>5</sup> Maryland Health Services Cost Review Commission. Maryland Total Cost of Care Model State Agreement. Published online 2018. <https://hscrc.maryland.gov/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf>

<sup>6</sup> Center for Medicare and Medicaid Innovation. Direct Contracting Model: Global and Professional Options Request for Applications, 11/25/2019. Published online 2019. <https://innovation.cms.gov/files/x/dc-rfa.pdf>.