

Physician-Focused Payment Model Technical Advisory Committee

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

Subject Matter Expert (SME) Roundtable Panel Discussion: To assist in grounding the Committee's theme-based discussion, this portion of the theme-based discussion will examine the following areas.

- A. Payment considerations and financial Incentives related to population-based total cost of care (TCOC) Models
- B. Options for structuring the payment methodology for population-based TCOC models
- C. Payment mechanisms to improve coordination and alignment between primary care and specialty care

PTAC believes these topics are important for developing population-based TCOC models. At the beginning of the roundtable panel discussion, the facilitator will briefly introduce each panelist, noting that full bios are available on the [ASPE PTAC website](#) (to be posted before the public meeting).

The facilitator will then ask the italicized questions below and will invite the panelists to answer the questions. For most questions, the facilitator will begin by inviting two SMEs to provide their particular expertise and perspectives for each topic. Other panelists will have an opportunity to provide their perspectives on a given topic, time permitting. Panelists will also have an opportunity to respond to follow-up questions from Committee members.

NOTE: In the interest of ensuring balance across different perspectives and questions, the facilitator will encourage all panelists to keep each response to a few minutes.

A. Payment considerations and financial incentives related to population-based TCOC models

Question 1: In your experience, what works best to incentivize the kinds of care delivery transformation that impact outcomes, quality, and cost – such as proactive, team-based, patient-centered care? Can you describe existing models that work well?

- a) What are the relative costs and savings associated with incentivizing care delivery strategies that focus on reducing TCOC for high-cost beneficiaries with multiple chronic conditions?
- b) What specific strategies can effectively incentivize a focus on improving primary care and prevention for lower cost beneficiaries (e.g., those with rising risk, etc.)?
- c) How effective are the current performance metrics in population-based models for incentivizing improvements in value-based care? Are the right things being measured? Where can adjustments be made to improve provider accountability?
- d) What types of incentives can best encourage process of care improvements? What process of care measures should be considered for performance-based payments (e.g., the number of touches per year, the ratio of primary care to specialty care touches, patient retention)?

- e) What are some of the strategies for increasing physician-level accountability for improving outcomes? How can accountability be increased for the various types of providers that may be involved in a patient's care?
- f) Are there areas where waivers or other changes could help to improve providers' ability to be accountable for patients' care?
- g) What are potential incentives for encouraging the development of models that better integrate specialty care (including behavioral health, care for patients with serious illness, and care for beneficiaries with complex needs) with primary care to create a seamless, coordinated experience that increases value and quality?

B. Options for structuring the payment methodology for population-based TCOC models

Question 2: What are the best options for structuring the payment methodology for population-based TCOC models? What are some interim steps and strategies that can help providers successfully transition to increased financial risk?

- a) Are payment methodologies that are built on a fee-for-service (FFS) architecture or payment methodologies that include full or partial capitation more effective for encouraging accountability for primary care and specialty care coordination; improving outcomes; reducing excess utilization (hospitalizations, emergency department [ED] visits, imaging, etc.); encouraging care delivery innovations (such as high touch, proactive, team-based primary care and efforts to address health-related social needs and social determinants of health); or encouraging infrastructure investments that can help to facilitate long term care delivery transformation? To what extent may the answer vary depending on the type of service, the type of provider, or geographic location?
- b) If capitation-based payment methodologies are the goal, what are the most important interim steps for increasing the number of providers who are involved in value-based payment models? How can various types of providers' ability to transition to increased financial risk be increased? Are there potential unintended consequences related to encouraging providers to transition to increased financial risk?
- c) What are some pros and cons associated with developing payment methodologies that include incentives involving nesting or carve-outs for certain conditions? Are there some conditions that might be best suited for nesting within a broader population-based model?
- d) What financial supports and payment methodologies could help to incentivize and sustain participation of safety net providers and help to manage risk? What is the cost associated with providing infrastructure supports to providers with less experience participating in value-based care (related to care delivery teams, electronic health records, training, etc.)?
- e) What are some of the most important opportunities for improving multi payer alignment, reducing administrative burden, and reducing complexity?

C. Payment mechanisms to improve coordination and alignment between primary care and specialty care

Question 3: What are the best financial incentives to encourage better coordination and alignment between primary care and specialty care? We would like to understand how best to engage specialists.

- a) What are best practices for incentivizing a flexible framework regarding requirements for primary care and specialty integration in population-based TCOC models without being too prescriptive? What options for tailoring population-based TCOC models to individual markets would be beneficial?
- b) Assuming that primary care involves responsibility for coordinating all aspects of a patient's care, what kinds of providers would be able to provide primary care within the context of a patient's care delivery team? To what extent could this vary depending on the type of patient (e.g., chronic conditions, disease progression, etc.), organization, etc.?
 - i) What specific kinds of functional activities are included in serving as the "quarterback" who is responsible for managing all of a patient's care?
 - ii) Would certain kinds of specialists potentially be able to take basic responsibility for managing all of a patient's care, or is that role more appropriate for a primary care provider?
- c) What are some of the best approaches for incentivizing specialist engagement and participation in and coordination with population-based models such as accountable care organizations?
- d) Are there any strategies to support collective responsibility / shared responsibility / varying levels of cascading responsibility for managing the care of certain patients (e.g., high-cost patients with multiple chronic conditions)? How would this be structured from a care delivery perspective and from a financial perspective, depending on the type of organization (e.g., integrated delivery system vs. physician group vs. independent physician practices, etc.)?
- e) What would be the potential impact of incentives related to mandatory versus voluntary participation, and reducing out-of-network spending?

D. Conclusion

Question 4: Are there any final insights you would like to share about population-based TCOC models and their potential for optimizing outcomes for patients and transforming value-based care?