Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation

Request for Input (RFI) Responses

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public on information that could describe current perspectives on reducing barriers to participation in population-based total cost of care (PB-TCOC) models and supporting primary and specialty care transformation.

Prior to PTAC's March 3-4, 2025 public meeting on this topic, PTAC received two responses from the following stakeholders listed below:

1. American Association of Orthopaedic Surgeons (AAOS)
2. American Academy of Physical Medicine and Rehabilitation (AAPM&R)

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

AAOS
American Association of Orthopaedic Surgeons

February 7, 2025

Physician-Focused Payment Model Technical Advisory Committee
Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Physician-Focused Payment Model Technical Advisory Committee (PTAC) Request for Input on Reducing Barriers to Participation in Population-Based Total Cost of Care Models and Supporting Primary and Specialty Care Transformation

Submitted via email to PTAC@HHS.gov.

To the Physician-Focused Payment Model Technical Advisory Committee:

On behalf of over 39,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we are pleased to share feedback on the Request for Input on Reducing Barriers to Participation in Population-Based Total Cost of Care Models and Supporting Primary and Specialty Care Transformation. AAOS is supportive of PTAC's initiatives to improve the quality of population-based total cost of care models (PB-TCOC) and ensure that orthopaedic surgeons are leading interdisciplinary, patient-centered musculoskeletal care teams in partnership with Accountable Care Organizations (ACOs).

What kinds of organizations (e.g., physician-led ACOs, hospital-led ACOs, integrated delivery systems, etc.) are likely to be able to provide the kind of multidisciplinary, team-based, person-centered that will be needed for effective PB-TCOC models?

Although ACOs have demonstrated much success in enhancing the quality of care, while sharing savings and lowering costs, considerable obstacles remain. In many health systems, the management of musculoskeletal conditions is primarily centered around non-operative care, often handled by primary care providers (PCP). Insufficient support systems and training in managing musculoskeletal conditions for PCPs can result in challenges such as unnecessary imaging studies, non-value-added interventions, and delays in providing appropriate care to patients. Until patients can access musculoskeletal experts to discuss available evidence-based treatments, they are unlikely to benefit from their potential benefits and improved health. **For this reason, AAOS is proposing a mechanism for interaction between primary care providers and musculoskeletal specialist teams.**

At the specialty level, procedure-based bundled episode payment models, such as those involving total joint replacement surgery for osteoarthritis (OA) of the hip or knee, have been met with limited

success. While procedure-based bundled episode payment models have shown some success in cost reduction, they have not consistently achieved substantial improvements in clinical outcomes or addressed the broader goals of providing timely, equitable, and comprehensive specialized care. Achieving true value in specialized care for conditions like OA requires a more comprehensive and patient-centered approach that encompasses procedural appropriateness, holistic care, and considerations for diverse populations.

AAOS has previously stated that ACOs have the option to sub-capitate or share risk downstream with specialty practitioners, aiming to align incentives and promote cost reduction, quality improvement, and patient-centered outcomes. If the ACO chooses to keep all the risk, then they will be referring out into the normal fee-for-service (FFS) market for musculoskeletal subspecialty care and will have to choose between rationing care for their patients or working with partners who are on a different incentive system, which will make it difficult to reduce costs. Since ACOs are being held accountable for musculoskeletal outcomes under condition-based payments, they will need to establish systems to effectively manage these conditions.

To effectively improve care transition management to support physicians that operate with ACOs and population based-payments models, AAOS encourages PCPs to partner with teams of specialty physicians who have expertise in musculoskeletal care, with the support of CMS, to overcome the limitations of minimal training and ensure that patients receive optimal care for their musculoskeletal conditions. This collaboration fosters incentive alignment, promotes knowledge exchange, and improves patient access and experience by considering the patient's condition, alongside their preferences, values, and needs (also characterized as “Comprehensive Condition-Based Care”). AAOS believes that a payment model that incentivizes high-value care is going to be more effective than forcing ACOs to try and identify who is already providing high-value care in their community. This payment model could be a subcapitation within a broader ACO, or it could be a single capitated payment outside an ACO.

Some institutions have already implemented this model. One such place is the Musculoskeletal Institute at Dell Medical School in Austin, Texas. They have assembled a team primarily focused on the treatment of different musculoskeletal conditions. The team varies according to the condition that they are treating. By way of example, the treatment for knee pain includes an orthopaedic surgeon, associate providers (Physician Assistant/Nurse Practitioner), physical therapist, dietitian, and the support of a social worker to help with socioeconomic issues and care coordination. This team has been functioning under a condition-based payment for Lower Extremity Pain with their county health system for the past 4 years and delivers the full spectrum of treatment options including education, weight loss, physical therapy, medications, injections, durable medical equipment (DME), and surgery. When patients do require surgery, they are being discharged faster than the national average,

going home with a self-care routine more frequently than the national average, and avoiding readmissions better than the national average.

By implementing this team-based model, the Musculoskeletal Institute at Dell Medical School exemplifies the potential benefits of interdisciplinary collaboration and condition-based payment systems in improving the quality, coordination, and outcomes of musculoskeletal care. Such models have the potential to enhance patient experiences, optimize resource utilization, and promote a patient-centered approach to musculoskeletal health.

What are some specific potential pathways toward maximizing participation of different kinds of organizations in PB-TCOC models?

AAOS recognizes that the future of healthcare is based on emphasizing the reorganization of expert teams and implementing the shift towards value-based care. This Comprehensive Condition-Based Care model aligns with the principles of improving outcomes, decreasing costs, and empowering patients and physicians to collaborate for better health. This model envisions a healthcare system that is proactive, patient-centered, and driven by collaboration and evidence-based practices. It emphasizes prevention, effective care through delivery of high-value services, and aligning incentives to optimize outcomes and control costs. By embracing this vision, healthcare organizations can transform healthcare delivery and improve the overall health and well-being of populations.

The crucial elements for success in delivering high-quality care across practice types is the ability to organize teams with aligned incentives, establish data infrastructure, and manage costs to achieve a patient-centered approach, improve care coordination, and enhance overall value. AAOS believes that implementing these elements requires collaboration and engagement from all stakeholders, including healthcare providers, administrators, payers, and patients.

We recommend that the model include incentives to support potential participants, particularly those in private practice, who are eager to participate yet lack the resources to build the infrastructure required to participate in this type of model. Currently, many musculoskeletal practices exist that could take on a condition-based payment structure with minimal investment and adjustment. Often created by the expansion of Orthopaedic surgery groups, there are many examples of teams that already include Rheumatology, Physical Medicine and Rehabilitation, Primary Care, Physical Therapy, Podiatry, and Prosthetics/Orthotics. Such groups will be poised to take on pilot programs and prove the concept in conjunction with CMS. While internal organization may be required for many, new capital investment and hiring could be minimized.

We also recommend that for all participants, new models should begin with no risk and allow progression to risk-bearing as experience is accumulated. Special emphasis must be given to rural

locales where large geographic areas must be covered to gain efficiency. This will require more effective use of telemedicine from physician-to-physician, and not just from physician to patient. Due to low patient volume, participants may see large swings in performance which make risk bearing difficult.

CMS should create upside incentives for interested participants that would reward innovation and high-value patient care. We believe the program should be voluntary on a nationwide basis for any set of surgeons, facilities, and providers who seek to collaborate in innovative ways to bring higher quality, better coordinated, and lower cost care for musculoskeletal conditions and who have or are willing to build the infrastructure necessary to carry out an episode of care approach to payment and delivery. A key component of this is ensuring that any payment structure used is one that accounts for inflation and other changes that have a direct impact on the financial viability of physician practices. Physicians want to provide high-quality, lower-cost care to patients, but they must feel confident that the economics of the model will also allow their practice to succeed.

Thank you for your time and attention to the thoughts of the American Association of Orthopaedic Surgeons (AAOS). AAOS looks forward to working closely with the PTAC on further improving alternative payment models. Should you have questions on any of the above comments, please do not hesitate to contact Lori Shoaf, JD, MA, AAOS Office of Government Relations at shoaf@aaos.org.

Sincerely,

Paul Tornetta III, MD, PhD, FAAOS
AAOS President

cc: Annunziato Amendola, MD, FAAOS, First Vice-President, AAOS
Wilford K. Gibson, MD, FAAOS, Second Vice-President, AAOS
Thomas E. Arend, Jr., Esq., CAE, CEO, AAOS
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February 11, 2025

Terry Mills, Jr., MD, MMM
Soujanya R. Pulluru, MD
Co-Chairs
Physician-Focused Payment Model Technical Advisory Committee
Office of the Assistance Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation – Request for Input

Dear Co-Chairs Mills and Pulluru:

On behalf of the more than 9,000 physiatrists of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), we appreciate the opportunity to submit comments to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in response to the above-referenced Request for Input (RFI). AAPM&R is the national medical specialty organization representing physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

AAPM&R appreciates PTAC's ongoing emphasis on driving accountable care through population-based total cost of care (PB-TCOC) models, including its interest in increasing specialty engagement and supporting specialty care transformation. AAPM&R has long recognized the importance of value-based care and the significant role that PM&R physicians can play in improving cost and quality outcomes. To that end, AAPM&R developed the attached Principles for Alternative Payment Models (APMs), which outline key elements that we believe are necessary to ensure that APMs support outcomes of the highest priority to patients, families, and caregivers. ***We encourage PTAC to consider AAPM&R's principles when developing recommendations to expand the reach of PB-TCOC models, as well as to increase the engagement of specialists in contributing to their success.***

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PM&R physicians are especially positioned to support the goals of PB-TCOC models given their pivotal role in managing patients' post-acute care (PAC) needs, as well as across the care continuum. They are uniquely trained to help oversee a patient's care trajectory, navigate patients through their recovery, and help patients achieve independence as quickly as possible. Physiatrists not only identify the rehabilitation potential of a patient, but also ensure the patient is triaged to the most appropriate setting of care to receive the most medically appropriate level of service. Furthermore, research shows that early physiatry involvement can lead to numerous benefits, including shorter length of acute inpatient stays and better functional outcomes.[1,2] Prioritizing PM&R participation in PB-TCOC models can therefore support the models' cost and quality goals, and we address opportunities to do so in our comments below.

Financial Incentives to Support Specialty Engagement

AAPM&R believes that APMs must strive to deliver high-quality, high-value care. Importantly, accountability for quality of care must include patient-reported outcome measures that are focused on function and quality of life. When compared to traditional quality measures, these measures can be far more indicative of patients' wellbeing and future health and health care utilization, as well as more reflective of patients' needs and long-term goals. Tools such as the Patient-Reported Outcomes Measurement Information System (PROMIS) Global-10 Survey (PROMIS-10) – which is a well-validated tool for collecting patient-reported data that can be used across settings and conditions – are readily available to incorporate into models' quality accountability frameworks.

Furthermore, we believe that model participation should evaluate performance on patient-reported outcome measures over a sufficiently long follow-up period. Particularly for functional outcome measures, longitudinally tracking patients for at least three months to one year is necessary to determine whether patients' care results in long-lasting improvements in functional status.

Finally, we believe that models should hold participants accountable for furnishing high-quality care through payment incentives tied to such patient-reported

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[1] Wagner AK, Fabio T, Zafonte RD, Goldberg G, Marion DW, Peitzman AB. Physical medicine and rehabilitation consultation: relationships with acute functional outcome, length of stay, and discharge planning after traumatic brain injury. *Am J Phys Med Rehabil.* 2003;82(7):526-536.

[2] Needham DM, Korupolu R, Zanni JM, et al. Early physical medicine and rehabilitation for patients with acute respiratory failure: a quality improvement projected. *Arch Phys Med Rehabil.* 2010;91:536-542.

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outcome measures. Without financial responsibility for maximizing such outcomes, including related to function, the risk is too great that model participants will focus on cost savings at the risk of long-term patient well-being. We note that financial accountability for such measures will also help to drive participation of relevant specialists whose contributions support desired quality outcomes associated with such measures.

Facilitation of Data-Sharing Between Primary Care and Specialty Providers
As we note in AAPM&R's APM Principles, we believe APMs must be data driven, and that interoperability is necessary to ensure appropriate communication, relationships, and quality measurements of care through day-to-day operations and to support transitions of care. However, we highlight the challenges that providers working in PAC settings face, given relatively low levels of certified electronic health record (EHR) technology (CEHRT) adoption among PAC providers. This is largely due to the high costs associated with operationalizing CEHRT and the fact that PAC providers were not eligible for the billions of dollars in federal incentives offered under the EHR Incentive Programs for the adoption and use of CEHRT. As a result, EHR adoption in PAC settings is uneven, with providers using a variety of often inadequate and non-standardized systems, and often resorting to self-developed templates to make their EHRs more user-friendly. This disparity creates barriers to seamless sharing of data between primary care and specialty care providers, who often rely on the EHRs of the PAC facilities in which they furnish care. Federal investments similar to those offered under the EHR Incentive Programs are therefore needed to enable PAC providers to adopt CEHRT and allow for seamless exchange of data between providers across settings.

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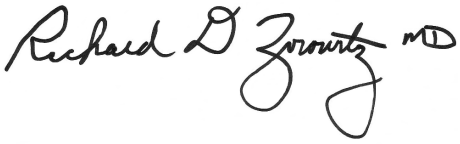
Thank you for your consideration of our comments. If you have any questions or would like more information, please contact Carolyn Millett at cmillet@aapmr.org or (847) 737-6024.

Sincerely,



Richard Zorowitz, MD, FAAPMR
Chair, AAPM&R Innovative Payment and Practice Models Committee

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Principles of Alternative Payment Models

Introduction

As healthcare continues its shift away from fee-for-service (FFS) reimbursement and towards alternative payment models (APMs) that focus on value-based care, there is an increasing need to ensure that models are designed to support outcomes of highest priority to patients, families, and caregivers. This document outlines key elements necessary to achieve such a goal. AAPM&R urges other stakeholders and policy makers to consider these principles when developing, recommending, implementing, and evaluating APMs.

A Physiatrist

A physiatrist is a licensed physician (M.D. or D.O.) who has completed a Physical Medicine & Rehabilitation (PM&R) residency accredited by the ACGME, the AOA, or the Royal College of Physicians and Surgeons of Canada and meets the training and experience requirements for examination by the American Board of PM&R or the American Osteopathic Board of PM&R. Physiatrists, also known as PM&R physicians, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disabilities, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

Principles of Alternative Payment Models

1. **Collaboration and Coordination** – An alternative payment model must prioritize and incentivize collaborative and coordinated care.
    a. Collaborative and coordinated care should include medical specialties, nursing, behavioral health, and allied health professionals as necessary across the care continuum, including inpatient and outpatient settings.
    b. Coordination of care must ensure continuity and attention as patients transition from one care setting to another or to the home.

2. **Patient-Centered Care** – An alternative payment model must emphasize patient-centered care and prioritize the needs of the patient to optimize health outcomes.
    a. To optimize health outcomes, care must be accessible and affordable for patients including those with chronic injury, illness, and activity limitations.
    b. Recognizing and accounting for social determinants of health must be a priority in all points of care.
    c. Improvement in patient function and quality of life must be the foundation for a successful model.
    d. Patient-centered care must take into account patient priorities, including circumstances related to availability of caregivers and other assistance.

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3. **High-Value Care** – An alternative payment model must prioritize the delivery of high-quality, high-value care.
    a. Physicians should coordinate care across the care continuum to best serve the patient.
    b. Care provided must be based on the best available evidence.
    c. Accountability for quality of care must include patient reported outcome measures focused on function and quality of life. Process and utilization metrics alone are not sufficient to assess patient outcomes.
    d. Models should reward high-quality care through payment incentives.
    e. Cost evaluation in models for demonstrating value must account for cost savings across the system, not just in certain silos of care.

4. **Accountability –** An alternative payment model must hold model participants accountable only for outcomes over which they have control.
    a. Quality and cost metrics used to determine performance must reflect the scope of services furnished by model participants.
    b. Alternative payment models must include accurate risk adjustment to ensure that model participants are not penalized for providing care to high-risk patients.

5. **Physician Engagement** – An alternative payment model must be driven through physician engagement.
    a. Alternative payment models should incorporate physicians in leadership structures to ensure that patient care needs are addressed adequately and to enable engagement from the provider community.
    b. Physician stakeholders and clinical champions must be given the opportunity to participate in development of alternative payment models.
    c. Alternative payment models must support physician autonomy in developing care plans and provide physicians flexibility to make independent clinical decisions.

6. **Incorporation of Physiatry** – An alternative payment model must consider the role of physiatrists when the model incorporates or benefits from rehabilitation care.
    a. Physiatrists must play a leading role in addressing function and optimizing quality of life, which are prime metrics in alternative payment models and patient-centered care.
    b. Physiatrists must be involved in model development to provide expertise and analysis that is unique to the PM&R specialty.

7. **Reasonable Risk** – Mandatory alternative payment models must allow for meaningful participation by providers with varying capacity to take on downside risk.
    a. To ensure flexibility, it must be recognized that some model participants may not have the population size to assume downside risk appropriately for the costs of care.
    b. Considerations must be made for model participants with a large proportion of high-risk patients that may not have the capacity to assume downside risk for the costs of care.

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8. **Availability of Resources** – An alternative payment model must ensure that participants are equipped with the resources they need to provide high-value care.
    a. Payment must be sufficient to ensure the delivery of high-quality, high-value care.
    b. Small practices must be supported to allow for model participation.
    c. Participants must be offered training and support in meeting the requirements of alternative payment models.
    d. Resources such as IT capability or provider network management should be made available to model participants as necessary.

9. **Data Driven** – An alternative payment model must be data driven.
    a. Data must be made available and accessible to all participants on a regular and timely basis.
    b. Data analysis and/or access to customized analytical assistance (e.g., clinical data registries) must be made available to model participants to support process improvement and optimization of care delivery.
    c. Alternative payment models must promote interoperability to ensure appropriate communication, relationships, and quality measurements of care through day-to-day operations and to support transitions of care.

10. **Flexibility and Efficiency** – An alternative payment model must eliminate barriers and improve efficiency to advance delivery of high-value care.
    a. Alternative payment models should encourage streamlined provider and care team communication and decision-making.
    b. Alternative payment models must support providers to optimize workflow and limit administrative burden, for example by eliminating prior authorization and unnecessary reporting requirements.
    c. Patient care must not be compromised when promoting efficiency.

Disclaimer
This AAPM&R Position Statement is intended to provide general information to physiatrists and is designed to complement advocacy efforts with payers and policymakers at the federal, state and regional levels. The statement should never be relied on as a substitute for proper assessment with respect to the specific circumstances of each case a physiatrist encounters and the needs of each patient. This AAPM&R statement has been prepared with regard to the information available at the time of its publication. Each physiatrist must have access to timely relevant information, research or other material which may have been published or become available subsequently.

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