Questions to Guide Listening Session #1 for the March 2023 Theme-Based Meeting: Improving Care Delivery and Integrating Specialty Care in Population-Based Models

Topic: Implementing Nesting in Population-Based Total Cost of Care (PB-TCOC)[1] Models

Thursday, March 2, 2:40 p.m. – 4:10 p.m. EST

Listening Session Subject Matter Experts (SMEs):

- ***Mark McClellan, MD, PhD*****,** Robert J. Margolis Professor of Business, Medicine, and Policy, and Founding Director, Duke-Margolis Center for Health Policy, Duke University
- ***François De Brantes, MBA, MS***, Senior Partner, High Value Care Incentives Advisory Group
- ***Rozalina G. McCoy, MD, MS*****,** Associated Professor of Medicine, Mayo Clinic
- ***Lili Brillstein, MPH***, Chief Executive Officer, BCollaborative

Committee Discussion and Q&A Session
To assist in grounding the Committee's discussion, the questions for the presenters will focus on the following areas.

A. Approaches for nesting specialty episodes in PB-TCOC models

B. Attribution in PB-TCOC Models

C. Financial considerations for nested episodes

D. Approaches for structuring risk

After each SME provides an 8-10-minute presentation, Committee members will ask the presenters questions.

The questions below are sample questions that Committee members may ask.

1. What are the best approaches for designing episode-based care models that can be nested in population-based total cost of care models, and how do they vary by specialty or condition?

[1] 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 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.* This definition will likely evolve as the Committee collects additional information from stakeholders.

a) What are some of the challenges related to implementing nested episodes? Are there specific types of specialty episodes that would be more appropriate for nesting within a PB-TCOC model than others?

b) How might approaches for nesting specialty-focused episodes differ depending on the type of specialty episode (for example, chronic outpatient episodes, acute episodes, and procedure-based episodes)? What are some best practices for defining chronic outpatient episodes for nesting within a PB-TCOC model?

c) What are effective strategies for integrating episode-based specialty care payment within ACO and PB-TCOC models? How can models encourage ongoing specialist participation, and what are some incentives to encourage retention of providers within the model?

d) How should risk be shared between the payer, ACOs, the provider, and beneficiaries for nested episodes? Who should be responsible for managing the patient's care at various stages during the care journey, particularly for patients who have multiple chronic conditions?

2. What are the most appropriate approaches for attributing patients to primary care and specialty care providers in population-based total cost of care models? How should attribution be done for chronic outpatient episodes, and in cases where multiple specialists are involved in caring for a given patient?

   a) Which of these attribution models would be most appropriate for PB-TCOC models with nested specialty episodes?

   b) Is there preference for prospective or retrospective attribution? Should retrospective attribution include considerations for any adopted, respecified, or de novo measures?

   c) What are the impacts of patient attribution across overlapping models due to patient's multiple chronic conditions? How should PB-TCOC models determine provider accountability in these scenarios?

3. What are financial and other incentives that can encourage specialist participation in population-based total cost of care models with nested episodes?

   a) How can PB-TCOC models incentivize specialist participation in nested specialty-focused episodes?

   b) What financial incentives may be more appropriate for different kinds of specialties and conditions? What incentives may be more appropriate for different kinds of specialty providers (e.g., independent, hospital-affiliated, etc.)? What incentives may be more appropriate for different kinds of ACOs?

   c) What are the potential benefits and challenges associated with mandatory versus voluntary participation of specialists in different kinds of PB-TCOC models?

   d) To what extent could the potential benefits of mandatory versus voluntary participation vary depending on the type of organization, such as hospital-based or physician-based ACOs?

   e) What would be the potential impact of requiring mandatory participation in a limited number of nested specialty episodes in hospital-based ACOs?

f) How can PB-TCOC models potentially shift from voluntary to mandatory participation in nested specialty episodes as they progress?

4. What are the most effective approaches for structuring entity-level and provider-level risk in population-based total cost of care models?

   a) What policies or resources should APMs include to support shared risk between primary and specialty care providers?

   b) How can APMs best encourage participation from providers who serve clinically complex patient populations in order to cover a broader range of conditions?

   c) How can APMs best encourage a broad range of participants to assume higher levels of risk or full risk?