**Developing and Implementing Performance Measures for Population-Based 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] improving care delivery and integration of specialty care in population-based models, improving management of care transitions in population-based models, and encouraging rural participation in 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 March 2024 public meeting focused on developing and implementing performance measures for PB-TCOC models. Specific topics discussed included defining performance measurement objectives for PB-TCOC models; selecting and balancing between the number and types of performance measures for PB-TCOC models; best practices for linking performance measures with payment and financial incentives in PB-TCOC models; addressing challenges related to implementing performance measures; and incorporating health equity and the patient experience into performance measures. 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 HHS has established "Quality and Cost" (Criterion Two) and "Value over Volume" (Criterion Four) as two of the 10 criteria for proposed PFPMs that PTAC uses to evaluate submitted proposals. The goal

[1] Please see the Appendix for PTAC's definition of PB-TCOC models.
[2] Center for Medicare and Medicaid Innovation. *Innovation Center Strategy Refresh*; 2021:32. https://innovation.cms.gov/strategic-direction-whitepaper

of the Quality and Cost 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". The goal of the Value over Volume criterion is to "provide incentives to practitioners to deliver high-quality health care."

Within this context, PTAC has assessed previous submitters' planned use of performance measures in the implementation and evaluation of their proposed PFPMs. Nearly all of the 35 proposals that were submitted to PTAC between 2016 and 2020 included information about proposed performance measures to some degree. Additionally, the Committee found that at least 16 of the proposed models met both Criterion 2 (Quality and Cost) and Criterion 4 (Value over Volume).

PTAC has developed the following working definition of "performance measures" as they relate to PB-TCOC models:

> *Performance measures **assess and monitor all aspects of participants' performance in models** including quality (e.g., process and structure), outcomes, cost, and utilization.*

PTAC has developed the following working definition of the following types of performance measures as they are used in PB-TCOC models:

> Quality Measures assess the safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness of models. Quality measures may capture structures, processes, and patient experiences with health care.
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> Outcome Measures focus on the health status of a patient resulting from health care.
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> Cost Measures quantify the cost of healthcare services provided. Cost measures can measure total cost of care or specific costs.
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> Utilization Measures address the frequency of health care services provided.

**PTAC Areas of Interest**

PTAC is particularly interested in innovative approaches for addressing the challenges related to developing and implementing performance measures for PB-TCOC models. Topics of interest include, but are not limited to, perspectives on the goals of performance measurement in PB-TCOC models, identifying desired performance measures for PB-TCOC models, gaps between current measures used in APMs and desired performance measures, balancing between different kinds of performance measures and data sources, linking performance measures with

payment in PB-TCOC models, how to capture patient/caregiver experience, and technical issues related to performance measurement.

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 developing and implementing performance measures in population-based models. 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 main goals of performance measurement for PB-TCOC organizations (for example, to drive change through financial incentives, to ensure quality of care, to provide actionable information for providers, or to inform beneficiary choices)?
    a) How should the goals of performance measurement and the measures for PB-TCOC models differ from the approaches used for other types of APMs (such as primary care or condition-specific models), and fee-for-service payment systems?
2) What are the most important desired performance characteristics that should be measured at the organizational level for PB-TCOC models?
3) What types of measures should be used to monitor and incentivize PB-TCOC models' performance related to these desired performance characteristics (for example, quality measures, outcome measures, process measures)?
    a) What should be the mixture of quality, process, outcome, patient/caregiver experience, utilization and cost measures?
    b) What are some of the pros and cons associated with using various types of performance measures (for example, ease of collection, administrative burden)?
4) What data sources would be most effective for collecting data on performance measures (e.g., EHR, claims data, administrative data)? Does this vary depending on the type of performance measure?
    a) What are the pros and cons associated with the different types of data sources?
    b) What are the advantages and challenges of using digital health information technology (HIT) for gathering health-related information from individuals?

c) How should performance measures be designed given the potential for systematic bias relating to incomplete data?

5) To what extent can current performance measures be used to monitor and incentivize PB-TCOC models' performance on desired performance characteristics?

   a) What are examples of current performance measures that are appropriate for use in PB-TCOC models?

   b) Are key performance measures missing that should be developed? If so, which ones?
   c) Could existing performance measures be modified to address these gaps?
   d) Could existing performance measures be combined to develop composite performance measures for PB-TCOC models? If so, how?

6) What strategies can be used to improve the development of measures that are meaningful to providers and beneficiaries in PB-TCOC models?

   a) What approaches can be used to measure outcomes and/or changes in how care is being provided?

   b) Which outcome measures are most related to the drivers of TCOC (for example, inpatient admissions per 1,000, emergency department visits per 1,000, preventable inpatient admissions per 1,000, complications by specialist type and/or condition)?

   c) What approaches can be used to measure care delivery improvements that are likely to have a longer-term impact on outcomes?

7) How should patient/caregiver experience and patient-reported outcomes be measured?

   a) To what extent can patient/caregiver experience measures accurately reflect the provision of patient-centered, coordinated care, relative to direct measures of those processes?

8) In which contexts does it make sense to have organization-wide vs. specialty-specific or setting-specific performance measures in PB-TCOC models?

   a) Are certain types of performance measures better suited for specific provider types? If so, which measures are best matched with which provider types?

   b) How can patient-centered measures be linked with both primary care and specialty providers, and other members of the care team?

   c) Should some of the existing process measures be transitioned to related outcome measures over time? If so, what are best practices in developing and implementing those related outcome measures?

d) What tools do organizations need in order to facilitate their ability to monitor the performance of participating providers?

9) What are best practices for linking financial incentives with performance measures, including quality of care outcomes and patient experience measures?

   a) What kinds of financial incentives have worked and what kinds have not worked (for example, pay-for-reporting, pay-for-performance)? Why were these financial incentives successful/not successful? What can we learn from each example?

   b) In which provider types and contexts are performance-based financial incentives most effective and why?

   c) What are best practices for PB-TCOC models to progress towards incentives that increase participants' financial accountability (for example, transitioning from pay-for-reporting to pay-for-performance)?

   d) Should performance measures and financial benchmarks be designed and implemented to account for health disparities and social determinants of health (SDOH)? If so, how?

   e) Has the practice of tying payment incentives to performance measures contributed to disparities in care delivery and health outcomes for Medicare beneficiaries? If so, how can these disparities be identified and addressed?

   f) Are specific attribution methods better for assessing spending, utilization, or quality using certain performance measures?
      i) If so, which performance measures or types of performance measures should be used with which attribution methods?
      ii) What are best practices for attributing patients to providers for the purposes of performance measurement?

   g) What are best practices for incorporating risk adjustment/ stratification into model implementation?
      i) How can entity-level accountability for risk in PB-TCOC models be linked with provider-level accountability for quality and costs that they are able to control (for example, nested episodes of care)?
      ii) Should performance measures be adjusted to account for social and functional status-related risk factors? If so, how?
      iii) Do risk score caps unfairly penalize certain participants? If so, how?

10) How should the approach to performance-based payment (PBP) differ by the type of entity that is being measured (for example, larger entities vs. small practices, degree of experience with value-based payment)?

   a) What approaches can be used to increase the ability of smaller practices to participate in performance-based payment and PB-TCOC models?

b) Should the approach for setting benchmarks vary based on the type of entity?

c) Should the approach to performance-based payment vary based on type of measure (for example, evidence-based process measures vs. outcome measures or patient-reported outcome measures)?

d) What role can balancing measures (for example, measures intended to reduce harm) have in PB-TCOC models?

11) What kinds of challenges exist related to implementing various types of performance measures in different kinds of provider settings (for example, information technology, data collection, data quality, administrative burden)? What approaches can be used to address these challenges?

**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 performance measurement, 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.

> *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).*
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> *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.