April 15, 2022

Paul N. Casale, MD, MPH
Chairman
Physician-Focused Payment Model Technical Advisory Committee (PTAC)
200 Independence Avenue, SW
Washington, DC 20201

**RE: Population-Based Total Cost of Care (TCOC) Models Request for Input (RFI)**

Dear Dr. Casale:

On behalf of the Medical Group Management Association (MGMA), I am pleased to submit comments to the Physician-focused Payment Model (PFPM) Technical Advisory Committee (PTAC) in response to the "Population-Based Total Cost of Care (TCOC) Models" request for input following the March 2022 public meeting. MGMA appreciates the opportunity to provide input and feedback to support PTAC's continuing theme-based discussions regarding TCOC models.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties.

With the introduction of the Center for Medicare and Medicaid Innovation (the "Innovation Center") and the Physician-focused Payment Model Technical Advisory Committee (PTAC), the healthcare system made significant strides in developing new models, spurred innovation, and created a new spectrum of innovation in healthcare.

The journey to value-based care is best described as a continuum; while fee-for-service (FFS) is the foundation for payment across healthcare, value-based care provides practices with new opportunities and flexibilities to implement novel clinical care pathways within alternative payment mechanisms. MGMA believes that this continuum must be preserved and that each individual practice will have a unique experience in value-based care. As such, MGMA supports the opportunity for practices to engage in TCOC models as they see fit but believes alternative options within value-based care are critical to ensure every practice can participate under a value arrangement that is meaningful, clinically relevant, and supports the financial goals of the practice.

Below, please find MGMA's responses to selected questions from PTAC's published RFI.

**PTAC RFI: Population-Based Total Cost of Care Models**

**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? Does the ability to manage TCOC vary by certain factors (e.g., type of provider, specialty, condition)?**

The types of entities that could be accountable for the TCOC within a population-based model could look similar to an accountable care organization (ACO). Such organizations have been successful in managing care within other Innovation Center models and have successfully generated savings. An ACO arrangement supports team-based coordinated care by centralizing data and providing necessary tools to ensure participating providers have the tools necessary to succeed within a two-sided risk model.

As PTAC looks ahead to continue developing recommendations related to TCOC models, MGMA recommends that the Committee critically consider how practices, both small independent practices and larger health systems, can participate in TCOC models. All practices have a role to play in supporting the value-based care continuum and furnish care to diverse patient populations.

**4. What are some options for evaluating and increasing provider readiness to participate in population-based TCOC models?**

Each practice's journey exploring value-based payment models is a unique experience, however, there are certain criteria that significantly help practices prepare to participate in TCOC models. TCOC models require providers to assume a certain level of risk for their assigned patient population; not every practice is appropriately prepared to take on such risk, and not every practice has the goal to take on such high levels of risk.

Currently, under the Innovation Center, there are several different types of models practices can participate under that focus on a specific clinical condition or specialty. These targeted models provide clinicians with the opportunity to explore value-based payment arrangements in the context of their clinical specialty and provide critical experience to prepare for participation in a TCOC model. This experience within the value-based care continuum serves as an important steppingstone for practices prior to participation in a TCOC model.

To increase provider readiness to participate in a population-based TCOC model, it is critical for practices to have the tools to fully understand their patient populations. Successful practices within a TCOC arrangement will have the infrastructures in place to continuously evaluate their patient populations, identify who they are providing care to, determine the most appropriate care coordination services for each patient, and determine where opportunities exist to improve care and eliminate duplicative or lower-value unnecessary care.

In addition to understanding a practice's given patient population, it is equally as critical for a practice to be financially resilient to achieve success within a TCOC model. Participation in any model, even with prior experience participating in an alternative payment model (APM), requires significant financial

investment. Within value-based care there are unavoidable uncertainties in the cost of care and, more often than not, there are delays in the return on investment for care coordination, preventive services, and clinical improvement activities that drive value-based payment arrangements. A practice's ability to manage variable costs will significantly support success within a TCOC model.

**a. Are there differences in provider readiness by specialty or other factors?**

As previously mentioned, there have been different opportunities to participate in APMs based on many different factors, including availability of model types focused on clinically relevant conditions and financial stability for practices. Additionally, the COVID-19 pandemic has stymied some of the expected growth that could have progressed within APMs over the past several years. As PTAC looks ahead at the next phase of APMs and TCOC models, it is important to consider the impact the pandemic has had on practices including financial strain, staffing concerns, and overall readiness to take on new risk within a model.

**c. What are some of the provider-level barriers to participating in population-based TCOC models (including barriers for specialists)?**

63% of medical group practices indicated they are interested in participating in an APM, however 80% of those interested stated that there isn't a clinically relevant APM available to participate in.[1] MGMA believes that every provider should have the opportunity to participate in value-based payment arrangements, however, every practice has not yet been afforded this opportunity. Without having had previous experience participating in a payment model, practices of certain specialties will likely struggle within a TCOC model that assumes a higher level of risk.

Additionally, population-based TCOC models require significant coordination within the risk bearing entity and participating providers. Primary care providers may have greater insight into patient care coordination and utilization over specialists focusing on a particular patient condition. For successful participation in TCOC models, organizations will require additional communication channels and coordination to ensure practices across specialties have aligned incentives under a population-based TCOC model.

**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?**

As PTAC and the Innovation Center continue to develop a greater variety of model participation options for different specialty participation across the risk spectrum, there are several factors that must be considered. Nesting episode models within larger TCOC models may create competing incentives for participating providers. For example, if an episode-based model is carved-out of a TCOC model, the TCOC entity may want to direct certain patients to specific specialty providers that could be participants within the entity. If, however, an episode is nested within a TCOC model, it will be important to consider how the nested models operate in such a way that provides specialists with the opportunity to

[1] Medical Group Management Association (MGMA) Annual Regulatory Burden Report. October 2021. https://www.mgma.com/getattachment/22ca835f-b90e-4b54-ad93-9c77dfed3bcb/MGMA-Annual-Regulatory-Burden-Report-October-2021.pdf.aspx?lang=en-US&ext=.pdf

participate across multiple TCOC entities. This will provide specialty practices with the opportunity to leverage care improvement activities within one TCOC entity, across multiple partnerships and a greater number of patients.

In a shared savings arrangement, it is necessary to determine which entity savings would go to for care provided under an episode-based payment model. There are multiple different mechanisms that could be created to incentivize a TCOC entity to refer patients to the most effective, high-quality, low-cost episode-based provider. Such incentives could include incentives for quality of care achieved or split savings for a specified patient encounter. With any of the proposed options to support specialist participation within a TCOC model, it is critical to ensure that any episode-based model carve-out or nesting explicitly define the episode with distinct diagnoses or treatments defining the onset of an episode and a defined timeframe to determine the end of the episode.

MGMA appreciates the opportunity to provide these comments to the Committee and we look forward to our continued engagement in future PTAC public meetings to discuss TCOC models. If you have any additional questions, please do not hesitate to contact Kelsey Haag, Associate Direct of Government Affairs at khaag@mgma.org or (202) 887-0798.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs
Medical Group Management Association