PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

+ + + + +

PUBLIC MEETING

+ + + + +

The Great Hall
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

+ + + + +

MONDAY, SEPTEMBER 19, 2022

PTAC MEMBERS PRESENT

PAUL N. CASALE, MD, MPH, Chair
LAURAN HARDIN, MSN, FAAN, Vice Chair
JAY S. FELDSTEIN, DO*
LAWRENCE R. KOSINSKI, MD, MBA
JOSHUA M. LIAO, MD, MSc
WALTER LIN, MD, MBA
TERRY L. MILLS JR., MD, MMM
SOUJANYA R. PULLURU, MD
ANGELO SINOPOLI, MD
BRUCE STEINWALD, MBA
JENNIFER L. WILER, MD, MBA

STAFF PRESENT

LISA SHATS, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
AUDREY McDOWELL, ASPE
STEVEN SHEINGOLD, PhD, ASPE

*Present via Webex

A-G-E-N-D-A

P-R-O-C-E-E-D-I-N-G-S

8:46 a.m.

* CHAIR CASALE: I'd like to bring the meeting to order.

Good morning and welcome to the meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC.

I am Paul Casale, the Chair of PTAC.

As you may know, PTAC has been looking across its portfolio to explore themes that have emerged from proposals received from the public. Last fall, as we were planning for our next theme, the CMS[1] Innovation Center released its strategy refresh for the next decade. One of the objectives is to drive accountable care with the goal of having all Medicare beneficiaries with Parts A and B in a care relationship with accountability for quality and total cost of care by 2030.

In support of that goal, PTAC launched a series of three public meetings on population-based total cost of care models earlier this year. CMS has been engaged with us throughout this series on this important topic.

1 Centers for Medicare & Medicaid Services

This morning, we are honored to have opening remarks prerecorded from Chiquita Brooks-LaSure, the Administrator of the Centers for Medicare & Medicaid Services. She oversees programs including Medicare, Medicaid, the Children's Health Insurance Program, and the healthcare.gov health insurance marketplace.

A former policy official who played a key role in guiding the Affordable Care Act through passage and implementation, Ms. Brooks-LaSure has decades of experience in the federal government, on Capitol Hill, and in the private sector.

The Administrator had wanted to join us in person, but because of scheduling reasons, she recorded her remarks in advance.

So, at this time, I will turn it over to the Administrator.

*** Chiquita Brooks-LaSure, MPP, Administrator, Centers for Medicare & Medicaid Services Remarks**

(The following remarks were prerecorded by Administrator Brooks-LaSure.)

ADMINISTRATOR BROOKS-LaSURE: I'm delighted to be able to join the Physician-Focused Payment Model Technical Advisory

Committee's September 2022 public meeting, even though I can't be there in person. And I hope to meet everyone in the Great Hall of the Humphrey Building at the next PTAC meeting in December.

Today, I want to focus the spotlight on CMS's priorities related to equity and innovation. Through all of our efforts, we're dedicated to advancing health equity, expanding access to affordable coverage and care, and improving health outcomes through all of our programs.

Medicare, in particular, is the largest single purchaser of health care in the country, considered as a transformative force in the U.S., and through it, CMS can play an enormous role in aligning equity with the systems of care and payment models.

That's why CMS is driving high-quality, person-centered care which advances equity by accelerating participation in value-based care. And our care models are rewarding better care, smarter spending, and improved outcomes.

The promise of these models became more clear during the pandemic. For example, many Accountable Care Organizations, including

ACOs participating in the Medicare Shared Savings Program and the Next Generation ACO Model, invested in care managers and community health workers who provided critical support to communities struggling to stay healthy and well.

They were also able to quickly transition to telehealth and to continue to provide needed access to care, and they provided the team-based services needed to address the full spectrum of issues arising from the pandemic. They especially showed us that better care coordination, providing care not just within the four walls of the hospital, but across a person's unique circumstances, is key to keeping people healthy.

We're currently working across CMS to enhance the movement towards this type of value-based, high-quality care, so that 100 percent of people with original Medicare will be in care relationships that are accountable for quality and total cost of care by 2030.

Now, we know that when value-based programs are not aligned, it can be confusing and counterproductive for providers who see patients that cross the spectrum of payers. It can also create unnecessary confusion for

people with Medicare who would benefit from the improvements in quality/support in managing health and special needs, and coordination across health care providers.

To help advance and enhance value-based care, in July, CMS penned a blog for Health Affairs, the Medicare Value-Based Care Strategy: Alignment, Growth, and Equity, which discussed the significant progress that's being made nationally on value-based care.

And in our Innovation Center strategy refresh and vision for Medicare, we also formally announced our ambitious goal of having all people with traditional Medicare in an accountable relationship with health care providers by 2030.

A key part of this strategy focuses on aligning and coordinating the care models in both original Medicare and Medicare Advantage. Our Center for Medicare is working with our Innovation Center to align accountable care initiatives and to use the Innovation Center's authority to test innovative payment and service delivery models that could be scaled into the Medicare Shared Savings Program.

Also, our Center for Clinical Standards and Quality and the Innovation Center

are working together to help clinicians, both primary care and specialists, who are part of the Quality Payment Program to continue to drive towards value-based, high-quality care.

Overall, CMS's Innovation Center strategy refresh is driving our health care delivery system towards more meaningful transformation, including focusing on equity in everything the Innovation Center does; paying for health care based on value to the patient, instead of volume of services provided; and delivering person-centered care that meets people where they are.

The Innovation Center will also be engaging with providers who have not previously participated in value-based care and ensuring that eligibility criteria and application processes do not exclude or disincentivize care for specific populations, including people in rural and underserved communities.

We're also actively engaging to leverage stakeholder engagement through listening sessions, for example, so that beneficiaries and providers better understand these care models and can provide more input on how they're implemented.

We'll also continue to build our

shared learning collaboratives, so that we can encourage innovation and transformation in care delivery by primary care and specialty care providers.

Today's PTAC public meeting is focused on full cost of care payment models. It's of particular interest to CMS and our Innovation Center, and I'm certain there will be robust discussion among PTAC members, invited experts, and public stakeholders.

And before ending, I want to acknowledge that this is the last public meeting for Chair Paul Casale and Bruce Steinwald. Please accept my congratulations. On behalf of the Secretary and CMS, thank you for your work on behalf of the American people.

And thank you to the entire PTAC for inviting me to share some thoughts, ideas, and insights this morning. I wish you a very productive meeting.

*** Welcome and Overview - Discussion on Payment Considerations and Financial Incentives Related to Population-Based Total Cost of Care (PB-TCOC) Models Day 1**

CHAIR CASALE: Our thanks to the Administrator for providing those remarks.

That's helpful context, as we kick off today's public meeting.

At our March meeting, we laid the groundwork for this series by examining key definitions, as well as the issues and opportunities when developing and implementing these models.

We focused our June agenda on care delivery model design. We discussed how care within population-based models can promote a more high-touch, patient-centered health care system. This can include investing in primary care, building multidisciplinary teams to proactively engage patients and create a culture of accountability for improved quality, cost, and outcomes. Today and tomorrow, we'll focus on which payment methodologies and model design features can best incentivize those care delivery best practices.

We've developed an agenda to explore topics including what is the broad vision for developing successful population-based total cost of care models? What are the most important payment model design features and financial incentives? How to encourage clinical integration between primary care and specialty providers? And which performance

metrics can best encourage value-based transformation? How to promote equity and address health-related personal needs? And what are the transitional steps along the journey of improving participation, provider accountability, and outcomes in population-based models?

Our materials online offer some background on these topics, and throughout this two-day meeting, we will hear from many esteemed experts on these many topics.

We've worked hard to include a variety of perspectives through the two-day meeting, including the viewpoints of previous PTAC proposal submitters who addressed relevant issues in their proposed models.

Tomorrow morning, we will begin with opening remarks from Liz Fowler, the Deputy Administrator of CMS and the Director of the Innovation Center.

After more expert presentations tomorrow, we will have a public comment period. Public comments will be limited to three minutes each. If you're not yet registered to give an oral public comment tomorrow, but would like to, please email ptacregistration@norc.org.

The discussions materials and public comments of PTAC public meetings this year will all feed into a report to the Secretary of HHS[2] on population-based total cost of care models. The agendas for today and tomorrow include time for the Committee to discuss and shape our comments for the upcoming report to the Secretary of HHS.

Lastly, I'll note that, as always, the Committee is poised and ready to receive proposals from the public on a rolling basis. We offer two proposal submission tracks for submitters to provide flexibility, depending on the level of detail available about their payment methodology. You can find information about how to submit a proposal online.

*** PTAC Member Introductions**

So, at this time, I'd like my fellow PTAC members to please introduce themselves. Please share your name and organization. If you would like, feel free to share a brief word about any experience you have with population-based payment or total cost of care models.

First, we'll go around the table, and then, I'll ask our member joining remotely

2 Health and Human Services

to introduce himself.

So, I'll start.

I'm Paul Casale. I'm a cardiologist. I do population health at New York-Presbyterian and lead an Accountable Care Organization for Weill Cornell, Columbia, and New York-Presbyterian.

Next, I'll turn to Lauran.

VICE CHAIR HARDIN: Good morning.

I'm Lauran Hardin. I'm a nurse and Senior Advisor and Vice President of National Healthcare & Housing Advisors. And I partner with health systems, communities, payers, and government to design models for underserved populations.

DR. KOSINSKI: I'm Larry Kosinski. I'm a gastroenterologist who's been involved in value-based care for the last decade. I'm the Founder and Chief Medical Officer of SonarMD, which was, actually, the first PTAC-recommended physician-focused payment model back in 2017. I'm honored to be on the Committee.

DR. WILER: Hi. I'm Jennifer Wiler, an emergency physician by training. I'm the Chief Quality and Patient Safety Officer for UCHealth Denver Metro. I'm a Professor of Emergency Medicine at the University of

Colorado School of Medicine and co-founder of UCHealth CARE Innovation Center, where we partner with digital health companies to grow and scale their solutions. I'm also a co-developer in an Alternative Payment Model that was considered by PTAC focused on acute unscheduled care.

Thank you.

DR. LIAO: Good morning.

Josh Liao. I'm an internal medicine physician at the University of Washington-Seattle, where I also serve as the Associate Chair for Health Systems in the Department of Medicine. I am fortunate to serve as the Enterprise Medical Director for Payment Strategy for our health system, and I lead a unit called the Value and Systems Science Lab, where we study and evaluate issues like payment models.

DR. SINOPOLI: Angelo Sinopoli, a pulmonary critical care physician, presently the Chief Network Officer for Upstream, which is a value-based, risk-bearing organization that partners with primary care docs and delivery systems to provide value-based services.

Prior to that, I was the Chief

Clinical Officer for Prisma Health and ran a large, integrated delivery system, and founded the Care Coordination Institute, which was an enablement company for networks.

Thank you.

DR. LIN: Good morning.

I'm Walter Lin, founder and CEO of Generation Clinical Partners; also, Public Policy Committee Member for the Society of Post-Acute and Long-Term Care. Our medical practice cares for frail Medicare beneficiaries in senior living organizations, primarily nursing homes and assisted living facilities.

DR. PULLURU: Hi. Chinni Pulluru. Good morning.

I'm a family physician by trade. I am the Vice President of Clinical Operations for Walmart Health & Wellness Omnichannel Care. The things that touch care delivery are clinics and telehealth, as well as all of the sort of policies around value-based care and transformation sit within my organization.

Prior to that, I led, as an Executive Medical Director, all things care delivery for DuPage Medical Group, now Duly, one of the largest, integrated multispecialty groups in the country, and led their value-

based care transformation platform to a total top cost of care.

DR. MILLS: Good morning.

I'm Terry Lee Mills. I'm a family physician, and I am Senior Vice President and Chief Medical Officer at Community Care of Oklahoma, a provider-led health plan.

My work has primarily, over the last 15 years, been in primary care practice transformation and quality improvement, and through that, I've had the opportunity to help lead and pilot four different CMMI[3] pilots, as well as two different ACOs, over multiple states.

So, pleased to be involved.

MR. STEINWALD: I'm Bruce Steinwald. I'm a health economist based right here in Washington, D.C. I've spent over 50 years doing health economics and health policy in private sector, academic, and government settings.

CHAIR CASALE: Jay is joining is remotely.

Jay, please introduce yourself.

DR. FELDSTEIN: Sure. My name is

3 Center for Medicare and Medicaid Innovation

Jay Feldstein. I'm trained as an emergency medicine physician. And currently, I'm the President and CEO of Philadelphia College of Osteopathic Medicine.

Prior to this position, I spent 15 years in the health insurance industry, in both commercial and government products.

CHAIR CASALE: Thank you.

*** Presentation: Payment Issues Related to Population-Based Total Cost of Care Models**

So now, let's move to our first presentation. Five PTAC members served on the Preliminary Comments Development Team, or PCDT, which has worked closely with staff to prepare for this meeting. Josh led the PCDT and I participated, along with Chinni, Walter, Lee, and Larry.

I'm thankful for the time and effort they put into organizing today's agenda.

We'll begin with the PCDT presenting some of the findings from their background materials, available on the ASPE PTAC website.

PTAC Members, you will have an opportunity to ask the PCDT any follow-up questions afterward.

So now, I'll turn it over to the

PCDT Lead. Josh?

DR. LIAO: Thanks, Paul.

I'm honored to give this presentation on behalf of the PCDT. While I'm the one giving the remarks, of course, this presentation is the product of a large amount of work from a number of people, including the PCDT co-members that you heard Paul just mention, as well as Dr. Lee Mills.

I also want to note the work and support of ASPE staff, as well as the team at NORC, for supporting the preparation of the materials and this presentation.

Next slide, please.

So, as Paul mentioned in his opening remarks, this public meeting and this PCDT presentation within it is really the third in a series of three meetings really focused on examining key issues related to the development and implementation of population-based total cost of care models, or PB-TCOC for short.

In March, as Paul mentioned, we, as a Committee, focused on foundational issues, definitions, and opportunities, following that up in June by focusing, in particular, on care delivery innovations within a PB-TCOC framework. Now, in September, we'll focus on

payment issues and methodology considerations.

The unifying objective of this series of meetings really is to explore options for incentivizing the desired care delivery innovations within PB-TCOC models and encouraging specialty integration. That is subjective, and this series of meetings is highly relevant to the work of PTAC, which deliberated on 28 proposed physician-focused payment models, many of which have sought to reduce TCOC and have raised issues regarding the issue of specialty integration.

In reviewing these proposals, the Committee has sought to understand the extent to which these proposals have met the Secretary's 10 regulatory criteria, including Criterion 2 related to Quality and Cost.

Next slide, please.

So, what are PB-TCOC models? Here, you see now PTAC's working definition, which is "an Alternative Payment Model in which participating entities assume accountability for quality and total cost of care and receive payments for all covered health care costs for a broadly-defined population with varying health care needs over the course of a year." We want to note that this definition will

likely continue to evolve as the Committee collects additional information from stakeholders.

Next slide, please.

So, as it pertains to payment features, one can imagine a whole host of model considerations and design features that bear careful consideration/deliberation, and I think we hope to get into many of these issues with our subject matter experts at this meeting.

But the PCDT also felt it was very important to begin with a proverbial end in sight at the beginning, to think about aligning this work and the conversation to come, in view of what we hope to achieve through these models.

And that's what you see here on this slide, not just the desired payment features, but also those desired care delivery features that these models may encourage, as well as, ultimately, the desired vision and culture for total cost of care accountability in the context of populations.

So, you see a list of each of those here. Now, this is not meant to be an exhaustive list, but simply high-priority items that the PCDT felt were important to elevate to

stimulate conversation.

You'll also notice a set of enablers, which are not perhaps themselves features per se, but were important elements that the PCDT felt, if present, could really enable and speed our progress in creating these features and, if absent, might potentially undercut our ability to do so.

So, under payment features that are desired, you see:

First, provider accountability and risk-bearing features, at the MD level actuarial risk.

Second, comprehensive participation strategy that encompasses both voluntary, as well as mandatory participation.

And third, as our feature is contemporaneous value-based payments, and by that, really timely payments that can be coupled to care transformation and redesign.

Fourth, financial accountability for not just quality, but also equity outcomes.

And fifth, provider and beneficiary incentives.

Identified enablers include flexibility for the accountable entities participating to determine how to structure

care delivery and integration between primary care, specialists, and subspecialists/ clinicians; multi-payer alignment on payment approaches and rules, and rewarding both improvement, as well as absolute levels of performance within these TCOC models.

Moving over to desired care delivery features, the first identified by the PCDT included multidisciplinary, team-based, patient-centered care; followed by balanced use of, and coordination between, primary and subspecialty care.

The team also identified targeted, population-based interventions to prevent or mitigate the populations' risk from developing adverse health outcomes, particularly those populations with complex needs.

And fourth, identification of health-related social needs and appropriate connection to resources and referrals.

Enablers that the PCDT identified included real-time access to actionable data; forums for sharing best practices, and access to information and metrics on them; infrastructure investments and staff, and things like information technology to enable value-based care; multi-payer alignment on

performance metrics; and incentivize improvements for quality, outcomes, and patient experience.

And finally, desired vision and culture. There were a number here.

First, a culture of accountability for clinical quality, equity, and cost outcomes simultaneously.

Second, a proactive and preventive care approach that prevents or mitigates populations' risks of developing adverse health outcomes.

Third, optimal outcomes and eradicated racial and socioeconomic health care disparities and inequity.

Fourth, care coordination that meets the needs of all populations, but, in particular, those that are underserved or historically marginalized.

Fifth, the use of evidence-based diagnostic and treatment protocols; dissemination and uptake of best practices; and participation in these TCOC models among a broad range of providers.

And, of course, in thinking through these, the PCDT recognizes that stakeholders have a number of options and a number of

different methodologies that can be used to achieve these and other population-based total cost of care goals.

Next slide, please.

In view of that, this slide really tries to encapsulate this point and list a set of salient opportunities and challenges that are associated with payment methodologies that could be used to drive population-based total cost of care models.

On the left, you see payment methodologies conceptualized along the spectrum, running from prospective capitation-based approaches on top running down to retrospective fee-for-service-based approaches that incorporate elements such as shared savings, plus or minus losses at the bottom.

Running along the spectrum, opportunities include incentives for providers to engage in care delivery transformation; clarity of provider and population alignment; flexibilities with respect to care delivery innovations and care networks; balancing between access and reduction in avoidable services; and ramp-up for providers that may have less population-based total cost of care model experience.

Likewise, challenges can span the spectrum and range from risk of under-provision of care and lower access to determining prospective budgets; risk adjustment; progressive difficulty performing against benchmarks; time delays; understanding performance and delivering financial incentives; and lastly, risk of over-provision of care.

Now, like the information on the prior slide, this is not meant to be an exhaustive list, but simply those that are high-priority and that PCDT wanted to surface for discussion. And any particular opportunity or challenge can exist in multiple methodologies and perhaps variations of those methodologies, but I think perhaps instructive is the ability to consider multiple opportunities and challenges simultaneously and to consider how relevant, more or less, these things may be in different payment methodologies.

Finally, as the comment at the bottom notes, certain elements here of opportunities and challenges may be characterized in some cases as more conceptual; in other cases as operational, but perhaps in

many cases, elements of both.

Next slide, please.

So, this slide applies that framework that I just reviewed, but puts it in table form and highlights a few select examples of methodologies for the full Committee's consideration.

In the first row, we have full capitation. The second is partial capitation, and the third is retrospective fee-for-service methods.

The opportunities and challenges in the middle columns are largely similar to those I just listed -- so, I won't review them here -- but are meant to, again, reflect how they exist along a spectrum across different methodologies.

In this table, you notice on the far right column that the PCDT has provided an example in real-world settings for each of these different payment methodologies, not because any example maybe fully encapsulates every opportunity or challenge, but to really comfortize this frame for the Committee and listeners' benefit.

Next slide, please.

So, extending that just one more

slide here, what you're seeing here is a similar framework looking at a spectrum of methodologies and opportunities and challenges, but here we've focused, as a PCDT, on episode-based payment methodologies as opposed to population-based methodologies.

Now, the reasons for highlighting these episode-based payment methodologies are at least twofold.

The first, as you remember in my earlier remarks, was that one of the overarching objectives is to address this issue of specialty integration, and with that perspective, thinking about how many population-based total cost of care models have engaged and addressed primary care infrastructure. But episode-based payments have been an important way that subspecialists have been engaged as well, so relevant to our conversation and consideration.

And second, many of these episode-based models have actually sought directly to address total cost of care, including a number of proposals that this Committee has entertained. And so, as we think about ways of integrating specialties within a population focus, the PCDT believes that this framework

applied to episode-based methodologies may be useful as well.

And we've given two examples from large Medicare programs, the Bundled Payments for Care Improvement Initiative, as well as Employer Centers of Excellence Networks examples, for everyone's consideration.

Next slide, please.

So now that we have discussed the design features, methodologies for how we might want to achieve them, the comparative opportunities and challenges that exist, I want to now focus on a number of model design considerations related to population-based total cost of care models.

The first, participation incentives and organizational requirements. Those include size and capabilities of accountable entities.

Second, up-front resources and infrastructure to support desired care delivery transformation.

The third is level of financial accountability for a range of outcomes, including clinical, quality, equity, and cost. And these outcomes can be at the level of clinician, entity, or perhaps another level.

Fourth, attribution, benchmarking,

and risk adjustment as key payment model features.

Next, selection and use of performance metrics.

Duration of accountability. So, 365 days, as often defined, or perhaps a different duration, shorter or longer.

Incentives to encourage clinical integration and integration between primary and subspecialty care.

Overlap between population-based total cost of care and other models, using a range of strategies, including things that have been proposed like nesting or carve-outs.

Incentives for screening and referral for health-related social needs.

And finally, encouragement of multi-payer alignment on model design components.

Now, each of these is important and could take up a long discussion unto themselves, but the PCDT felt that, in particular, the top five, as denoted by the asterisk, were of particular importance, and to support the conversation over the next few days, we wanted to highlight those. And we'll do that in the subsequent slides.

Next slide, please.

So, first off here, design considerations related to participation incentives and up-front resources and infrastructure. And by this, we mean that a major factor that can influence providers' decisions to participate in population-based total cost of care models is whether up-front resources and infrastructure are sufficient to support care delivery changes. Now, that's just one factor; there are others that are relevant as well.

One is the appropriateness of rules related to performance and accountability.

Second, consistency between model requirements and organizational capacities.

Third, whether payment appears reasonable and sufficient to cover the cost of services within these models.

And finally, whether participants are financially rewarded for improving patient outcomes and experience.

Next slide, please.

Considerations associated with the level of financial accountability, and by that, we mean the accountability related to the amount of financial upside or increased payments or downside, decreased payments, that

providers assume as participants in these TCOC models.

Now, these can be beset by a number of challenges, including those listed here. In particular, the PCDT believes that one of the challenges is including assigning accountability at different levels with a TCOC participant. This can happen at the overall entity level. It could happen at a lower level of entities within a TCOC participant, as well as at the level of individual clinicians or a smaller group of clinicians participating within a participating entity. And there are trade-offs, perhaps, to each of these.

Next slide, please.

Next, we'll talk about design considerations associated with attribution -- attribution being the effort to identify those individuals and beneficiaries whose care a participating entity is accountable for managing.

Challenges include ensuring clarity and consistency of that relationship between beneficiaries and the accountable PB-TCOC participant, particularly when beneficiaries are being seen regularly by multiple providers and groups.

Next slide.

With respect to benchmarks and risk adjustment, benchmarks, which are often based on historical averages, can establish incentives for participation in population-based total cost of care models and attempt to constrain spending growth. However, benchmarks can be challenged by the need to set and update benchmarks using a range of different factors, including geographic factors, organization-type factors, program factors, and the like.

Similarly, risk adjustment is the effort that seeks to enable fair comparison across entities and minimize risk selection; that is, actions by entities to select healthier or lower-cost patients. While this is a worthwhile effort, challenges can include capturing risk appropriately without inappropriately capturing coding changes, an issue observed in prior models.

Next slide, please.

Finally, considerations associated with the selection and use of performance metrics. While these population-based total cost of care models are typically focused on rewarding absolute achievement and performance, rewarding improvement and performance can

encourage a provider engagement and care delivery innovation. And this point acknowledges that different participants may begin at different levels, but that participation should encourage achievement, as well as improvement.

And the second point is to note that, even though not all metrics may be used for formal performance evaluation, given the risk of having too many metrics, that even if they're not used in determining payment, there are certain metrics that could be used to capture processes. For instance, the number of primary care and overall encounters. And these may be useful to monitor what's happening in population-based total cost of care models for the purposes of understanding what processes are related to achievement and improvement.

Next slide, please.

So, with this framing and context, I want to end this presentation by reviewing a few areas of focus for our discussion during this public meeting. These include a long-term vision of population-based total cost of care payment methodologies; payment model design considerations and financial incentives that are most important for encouraging provider

accountability; and successful care transformation in these TCOC models.

We'll also discuss strategies for improving clinical integration of primary care and subspecialty care; care delivery innovations for higher-cost or higher-risk populations; selection of performance metrics for these population-based total cost of care models; and finally, most important steps for maximizing the impact of these TCOC models on outcomes.

And collectively, I believe these are critical discussions as a group of issues for achieving that overarching goal that was discussed earlier, which is to examine the options for incentivizing the desired care delivery innovations within these total cost of care models and addressing the issue of specialty integration.

And with that, I'll pass it back to you, Paul.

CHAIR CASALE: Thank you, Josh, for a very comprehensive presentation.

So, before I open it up to the full Committee, do any of the PCDT members have anything to add?

Okay. And if not, then, PTAC

Members, any follow-up comments or questions for the PCDT?

And just as a reminder, if you have questions or comments, if you could just flip your name placard on its end? Thanks.

Angelo?

DR. SINOPOLI: Yes. Excellent oral presentation.

And as I heard you walk through and make some of the comments, in addition to what was on the slides, it triggered more, several comments from me than questions, but, as we hear SMEs[4] present today and tomorrow, just things that I think we ought to be looking for.

So, the first is, how do these practices pay for these initially? Over time, hopefully, they're generating enough shared savings, that this is an effective model. But those start-up costs are significant. And what can we look for in these models that can help those practices ramp up quickly and be successful quickly? That's one.

The second thing is, I think that there's going to have to be somewhere an effort around organizing the community beyond what the

4 Subject matter experts

primary care practice can do to affect the community-based organizations, the state agencies, et cetera. That is such an important part of the model, and we're not really spending a lot of time on that. I think that's much more important than I think the amount of time that we're devoting to it.

And then, you mentioned something about, where does the level of risk sit with the delivery system, the ACO, the provider, et cetera? I would just advise us not to miss the opportunity to think about this as we don't want these models to turn into a PPO[5] model, where the network or the system is taking the risk, but the practicing doctor is just fee-for-service practices. And we have an opportunity here to make sure that they are being either incentivized or put at risk in some reasonable way that incentivizes them to participate in these models, and they're just not the fee-for-service model, that somebody else up here is getting the capitated payment and taking the risk.

So, those are the three comments that I would make.

---

5 Preferred Provider Organization

CHAIR CASALE: Thanks, Angelo. Very helpful.

Lee, do have a -- no?

Other comments or questions for the PCDT?

MR. STEINWALD: I have one. Would you say that your perspective is multi-payer, as you kind of examine all of these issues, or more focused on Medicare populations?

DR. LIAO: Well, I'll certainly share my thoughts, and I welcome other PCDT members to share as well.

I think, from my perspective, absolutely, it's multi-payer. I think that's an easy thing to say and much more challenging to do. But, in multiple slides, we've highlighted where I think it's important to pursue things like payer alignment, not just in general, but specifically, payment approaches and rules, so that clinicians and organizations can redesign care and transform it in a way, and not have to address that variation.

We also highlight multi-payer alignment in performance metrics, and as I assume many people around the table know, that can be itself challenging. So, from my perspective, absolutely, multi-payer would be

the goal.

CHAIR CASALE: Great.

Just a few comments. Again, a lot in that presentation, all really helpful.

The slide, particularly, around the challenges and opportunities and that grade between capitation and fee-for-service is at least helpful in my thinking around this. And it also visually highlights that tremendous tension between that and how do you move that along.

And I think underlying a lot of the points -- and you did mention it -- is about having access to sort of timely and actionable data. Data is clearly going to be so important to move, you know, to both address the challenges and opportunities in moving towards these total cost of care models.

Yes, Lee?

DR. MILLS: Yes, thanks, Josh. Great presentation.

I'm just really struck by and highlighting the slide on page 6, which, essentially, is the continual tension in the concepts of attribution, benchmark, and risk adjustment, which, for a population-based model, is the framework and the skeleton that

makes it all work. But there will always be a tension between the fidelity, precision, and accuracy of those three inputs that went into the tension and wanting the perfect model, and the other end of the tension is contemporaneous, actionable data in a timescale you can act on it, and complexity, such that providers can actually operate to it.

And so, I just want to highlight those three foundational concepts. It's always going to be best fitting to the population in the context you're working in, that there really is no perfect model. And I'm really looking forward to hearing our subject matter experts comment on that.

CHAIR CASALE: Yes. Yes, thanks, Lee.

Chinni?

DR. PULLURU: I wanted to double-click on what Josh said as far as multi-payer involvement. I think that these models need to absolutely be multi-payer, but I think that Medicare can play a role in being a force for metric alignment, as well as, as everyone said, data-sharing. I think timeliness of data-sharing should be a fundamental sort of rite of entry into total cost of care platforms.

CHAIR CASALE: Great. Yes, thanks for that comment. Other thoughts or questions?

I know we will be delving into a lot of these areas with all our SMEs throughout the next couple of days, but I think this is a great foundational setting to begin the day.

Okay. So, again, thank you, Josh, and the rest of the PCDT. Very helpful background for our discussion.

So, at this time, we have a break until 9:55 a.m. Eastern time. Please join us then. We have a great lineup of guests for our first listening session of the day on the vision for developing successful PB-TCOC models.

Thank you.

(Whereupon, the above-entitled matter went off the record at 9:27 a.m. and resumed at 9:55 a.m.)

CHAIR CASALE: Welcome back.

I'm excited to welcome our first listening session. Josh and the PCDT helped us level-set with background information and our goals for this public meeting. Now, we've invited three outside experts to give short presentations on their vision for developing successful population-based total cost of care

models based on their experience.

Their full biographies are on the ASPE PTAC website. Their slides will be posted there after the public meeting as well.

After all three have presented, our Committee members will have plenty of time to ask questions.

*** Listening Session 1: Vision for Developing Successful PB-TCOC Models**

Presenting first, we have Dr. Mark Miller, who is the Executive Vice President of Health Care at Arnold Ventures.

Please begin, Mark.

DR. MILLER: Okay. Thank you for having me here.

We can move to the next slide.

I don't have any financial conflicts of interest, and the opinions I express here are my own. But, in this particular instance, the opinions also reflect the organization.

We can go to the next slide and just give you a little sense of who we are. So, Arnold Ventures is a philanthropy. We give out money for research, develop policy, technical assistance, communication, education, and that type of thing.

My particular portfolio is focused

on containing health care expenditures, and it's aimed at the three parties that end up paying for health care, which are employers, taxpayers, and then, households.

If we could go -- well, before we go to the next slide, I have portfolios that address issues in the commercial sector, price issues in the commercial sector; drug prices; incentives for providers and Medicare sustainability; also, care for complex populations. And in this context, a way to think about the last one is care for those beneficiaries who are dually eligible for Medicare and Medicaid.

We'll go to the next slide.

In the portfolio that is most relevant to the conversation here, we're interested in increasing the share of spending and enrollees in population-based models. We want to hold the providers -- we want to give the providers a financial incentive to provide high-quality care, but to also contain costs. And I also have research running trying to identify low-value care, so that that kind of information can be put in front of providers to help them to perform inside capitated systems, Accountable Care Organizations, and the like.

Another element of our strategy here is also to reduce fee-for-service payments for low-value care and, generally, make fee-for-service a less profitable environment to encourage providers to move into more population-based total cost of care models.

And then, finally, we also think an element of this is to align the consumer, the beneficiaries' incentive in this instance, so that they also are participatory in the incentives of the system of quality and containing cost.

We'll go to the next slide.

And so, then, I'll just walk through a set of principles here that guides the research and policy that we have been driving towards. As I said, we fund a tremendous amount of research, and then, we also talk to federal policymakers, both on the legislative side and on the executive side.

So, our work emphasizes a shift to population-based payment models. We have less interest in pursuing more of the episode-based types of models. We're concerned that going to those types of models is just fragmenting fee-for-service in a different form, and we think that the best incentive structure is to have

population-based models.

As I said, I think models that are more targeted or, in my opinion, more fragmented, dilute the incentives to contain cost and to improve quality.

We do think that there is a role for some of those kinds of elements in a population-based model, but it should be relatively limited, and that the emphasis should be on improving quality and controlling cost to the population level.

We think there should be a relatively limited set of tracks for people to get into the population-based models. We believe that the CMMI developed a lot of different models, and we think that that should be streamlined and directed towards population-based models. But we also think there should be tracks to help and encourage different kinds of providers and organizations to get into those models, lower-risk models. And when you have lower-risk models, you also have lower reward, but ways to kind of wrap providers and organizations in. But, ultimately, driving towards a two-sided risk model.

We also think that there are other ways to strengthen and simplify incentives for

participation in models. These are things like financial support for an organization or a set of providers to develop their systems, technical assistance. We also think there are some instances in which you may want to think about mandatory models.

And then, as I said -- and that's less about the conversation here -- we would also make fee-for-service, continue to make fee-for-service a less comfortable place to be for providers. And that could involve things like greater differentiation in what you get paid in the fee-for-service setting versus entering a population-based model, and also, things like allowing much greater flexibility when you go into a provider-based model, such as using telemedicine, those types of services.

We'll go to the next slide.

We also think that there are both immediate improvements to the benchmarks that need to be undertaken here -- I will leave this conversation to Mike [McWilliams] and to Mike [Chernew]-- but this is things like addressing the ratchet effect, the rural issues, regional adjustments. So, we think there are improvements there.

But, ultimately, I like the idea --

and again, I think the Mikes are responsible for a lot of this -- the notion of moving to more of an administrative benchmark that is a lot more predictable and stable.

Okay. And I also think that, in moving to that, you would have to take steps to assure that the Medicare program gets its savings as part of that.

And I also think an administrative benchmark would allow you to adjust to achieve certain policy objectives, like if there were issues around equity and those types of issues.

I think risk adjustment needs to be improved. And this is true of both if you're going to move to more of a capitated, two-sided risk arrangement and the Accountable Care Organization models, but also for managed care plans.

And I think part of the changes in the risk models should involve moving to factors that are less gameable in order to limit profits from coding.

And the model might ultimately have fewer factors that are less subject to gaming and depend more on reinsurance as a way to address variation in risk across different models.

Finally, I think that we need to improve how we pay primary care. Even outside of the accountable care models, I would have the fee schedule not pay primary care, or at least a good portion of primary care, on a service-by-service basis, and instead, pay more on a per-member-per-month basis, and would also try and incorporate those kinds of thoughts into a total cost of care model.

I think that primary care providers should probably have a greater role -- "should," not "probably" -- should have a greater role in steering patients through the care that they need. And I think paying more on a per-member-per-month basis, or not paying on a service-by-service basis, is a better way to reimburse primary care.

With that, I'll stop and that will be it. Thank you.

CHAIR CASALE: Thank you, Mark.

We're saving all questions for later.

So now, we have Dr. Michael McWilliams, the Warren Alpert Foundation Professor of Health Care Policy, who joins us from Harvard Medical School.

Please go ahead.

DR. McWILLIAMS: Thanks very much. It's really a pleasure to join you today, and thanks for inviting me to be part of this meeting.

You can just go ahead and advance to the next slide.

I just wanted to mention my disclosures. No real relevant financial conflicts. I did want to point out, however, that I serve as a Senior Advisor to CMMI. I am here in my other capacity today. So, nothing I say today should be construed as representing the views of CMMI or CMS.

If you would, then, move to the next one?

Okay. Just taking a step back and thinking about what we can and can't achieve through a population-based payment model, I think there are sort of more realistic and less realistic expectations.

In terms of the more realistic category, clearly, we can control spending growth, discourage overuse and smooth revenue during demand shocks such as pandemics. And we can also give providers more flexibility to select the right services for patients.

So, with revenue decoupled from

service selection, getting rid of those interfering fee-for-service incentives, providers are then freer to choose the right service for their patients. So, as a PCP[6], for example, I don't have to do 120 office visits a week to cover my practice expenses and salary, if that's not what serves my patients best. I tend to think of this flexibility as sort of a precondition for care delivery transformation.

In the less realistic category I think is, first, the notion that these models make prevention or improving health profitable. There's a fair amount of magical thinking out there that, simply by putting spending under a budget, we perfectly align the financial incentives in our system with the production of better health. And while it's certainly true that healthier populations need less care, making populations healthier is costly; the number that need to be treated is often high, and preventive efforts can induce utilization. So, the savings for prevention generally constitute partial offsets at best.

There is, similarly, overzealous thinking, I think, around pay-for-performance.

6 Primary care provider

Quality is just not nearly as contractable through the payable system as the emphasis in policy would suggest. The evidence on pay-for-performance is not encouraging. It's very hard to establish strong incentives to improve quality because quality is such a complex, multidimensional construct and a lot can go wrong, including wasteful responses like gaming or teaching to the test, diverting resources away from harder-to-measure, but important aspects of care, or exacerbating disparities because of inadequate risk adjustment.

But I think it's also important to note that it's okay that we can't contract directly for quality very well. We have lots of other reasons and ways to improve quality and make patients healthy. We just shouldn't sort of distract ourselves by thinking that everything can be programmed with payment incentives.

Quality will always be largely determined by the intrinsic motivation of providers and extrinsic competitive pressures to attract patients and clinicians. That is something I think we not only have to acknowledge when thinking about these payment models, but also actually embrace, as we think

about how to improve quality.

So, I generally see the total cost of care or the population-based payment component of ACO models, for example, as far more important and promising than the P4P[7] for component.

On the quality front, with the flexibility in place from that population-based payment, I tend to think that we should be spending more time and effort identifying changes in delivery that work. I refer to this as a shift from seeking successful measures to seeking measurable success.

If we can go to the next slide?

Briefly -- and this is something to cover a lot of ground here -- the evidence on ACOs. Much of what we know is from the first four years or so of the ACO programs because rigorous evaluation has just become harder and harder in recent years.

In terms of savings, there has clearly been behavioral change that has lowered spending. That is unambiguous, but the savings have also been unambiguously small.

However, it's really hard to

7 Pay-for-performance

interpret that because the incentives in these models have been very weak. So, ACOs have never really had a strong incentive to save. And we have seen larger savings where incentives are stronger, and I'm happy to go into more detail about that pattern, but the key point is that the pattern of savings suggests that, if we strengthen incentives, we could save more.

The savings seem to be driven more by a story of waste reduction than a story of integration, coordination, and prevention. I'm happy to talk about that more as well.

In terms of selection, there has been minimal patient-level risk selection, but ever since benchmarks started to converge from an ACO's own history to the regional rate, which is necessary at some point, we've seen pretty dramatic selective participation at the ACO and Tax ID participant level, favoring those with already low spending. That means that in recent years, the savings have been overstated by program comparisons of spending with benchmarks, and the resulting subsidies have probably negated much, if not all, of the true savings.

In terms of quality, the evidence is

limited, in part, because of data constraints. Certainly no evidence of quality getting worse, but improvements have been fairly small and scattered.

Patient experiences have been one bright spot. We've seen improvement in some domains there, but it's not clearly attributable to the pay-for-performance incentives. For example, our team found that improved overall care ratings were entirely concentrated among high-risk patients, and that suggests a potential effect of high-risk case management, which has probably been more motivated by the total cost of care component than the pay-for-performance component.

Next slide, please.

Okay. So, how can we design these models better? A lot to talk about here. And for a more detailed discussion, I'd refer you to this white paper I authored with Alice Chen and Michael Chernew. This was supported by Arnold Ventures and published by the USC[8]-Brookings Schaeffer Initiative for Health Policy.

Very briefly, first, I agree with

8 University of Southern California

Mark entirely about the need for a parsimonious, multi-tracked structure that accommodates different types of providers. And that would include a little-risk track for smaller organizations that provide less of the spectrum of care. Those organizations don't need as much, if any, downside risk to have strong incentives to lower spending. A low-risk track also helps promote entry and competition.

The key point here is that the same risk contract, the same terms can establish vastly different incentives, depending on the type of organization, because the incentives are stronger to reduce care provided by other providers.

In terms of downside risk, I think here the upsides tend to get overstated. The benefits really depend on participation incentive. When the model is voluntary and the fee-for-service alternative is not too bad, downside risk really just discourages participation. If you think about it, basically, if an ACO faces losses, it will exit a voluntary model. So, it is never really exposed to the downside risk anyway. So, its incentives are really not that strengthened by

it.

Making the population-based payment fully prospective, meaning -- all these models have a prospective element -- but, by this, I mean sort of up-front payments in advance, that's a feature that some providers or conveners desire. It can certainly have some behavioral effects, for example, due to loss aversion. It may also offer some advantages in terms of cash flow. But it's really not crucial to establishing incentives.

And a fee-for-service chassis with reconciliation does offer some advantages in terms of transaction cost. I think Mike Chernew is going to talk more about this.

Risk adjustment. So, what I'd like to stress here is that, traditionally, the emphasis on risk adjustment has been predicted accuracy or model fit, but we really need to trade off predictive accuracy to support the broader goals of the payment system.

For example, spending for historically marginalized populations tends to be similar or lower than for other populations. So, if you want to reallocate resources to providers serving those populations -- I would argue that we would do -- then we don't

necessarily want to add indicators of those groups to the risk adjustment model. That could make the model more predictive and set payment closer to current spending for those groups, more accurate, but that's not what we want.

We want to set payment above current spending for those groups. In some cases, we can do that simply by omitting indicators from the model, and in other cases, by taking additional steps to set payment above what's predicted by the model, as was done in the ACO REACH[9] Model.

Similarly, we'll need to do some things to the risk adjustment system to mitigate coding incentives. That might compromise fit or predictive accuracy, but it's a good trade-off to make.

I also agree with Mark about the importance of primary care capitation payments within a total cost of care model as a way to both dial up primary care spending and give primary care providers more flexibility and resources to leverage primary care in a way that can reduce waste and improve quality.

9 Realizing Equity, Access, and Community Health

And then, last, but certainly not least, is the importance of benchmarks. To date, benchmarks have been set according to observed or realized fee-for-service spending. You can think of that as sort of internal benchmark. That creates various ratchet effects that Mark mentioned. Those weaken ACO incentives to participate and save.

There are ACO-specific ratchets in which an ACO's own savings behavior pulls down its benchmark. So, it never has an incentive to save. That happens through the regional adjustments and rebasing between contract periods.

And there's a program-wide ratchet effect whereby ACOs' collective savings drag down benchmarks by slowing national or regional spending growth.

So, if benchmarks are set at a spending average, the realized spending average, by definition, about half of ACOs will always have spending above their benchmarks. This collective ratchet also means that, as ACOs save or they're not really given the room to innovate off a fee schedule, which is something that we want providers to be able to do in these models, if they do that, then their

benchmarks fall.

So, in the white paper, we advocate for decoupling benchmarks from observed spending, making them external or so-called administratively-set benchmarks.

In the next few slides, maybe if you could just sort of click through the animation here to let it wash over those in attendance? I think I'm probably almost out of time. So, I can come back to these, if you want, but perhaps just seeing this animation can sort of help let this concept sink in. And then, I just have a few comments on group- versus clinician-level incentives, and then, I'll stop.

All right. So, if you could pause here?

Given the physician focus of PTAC, I just wanted to touch on some theory about group-level versus clinician-level incentives. The purpose of contracting with groups is to pool risk and to encourage organizations to do what clinicians cannot, such as organizing care practices, making joint decisions about capacity, and managing the workforce professionals.

In general, devolving risk from the

group to the clinician level based on the clinician's own performance defeats that purpose. And alternatively, sharing risk with clinicians based on their collective performance, also, that doesn't affect clinician incentives much because of free-rider problems emerging. So, I have limited incentive to improve my own performance if my reward is determined largely by the performance of others.

Often, organizations will, nevertheless, do that or transmit very nominal risk to clinicians, as sort of a signal of organizational priorities. But, to be clear, neither of those really changes clinician incentives much.

So, in the end, beyond shifting internal competition from fee-for-service towards salary, changing clinician behavior is really largely a matter of non-financial incentives. It's a management challenge.

Next slide, please.

I have some thoughts here about issues in episode-based payment models, but why don't we skip ahead, because I think I'm out of time?

And I just wanted to note at the end

here that there have been very promising recent developments in the ACO REACH Model. I think the health equity benchmark adjustments really is a paradigm in Medicare payment policy.

Also, a number of changes proposed in the physician fee schedule proposed rule for the Shared Savings Programs are quite important, but, obviously, some areas that we still need to work on are listed here.

So, thanks very much, and I look forward to further discussion.

DR. CHERNEW: So, there, for example, is the Mount Auburn Physician Association, part of a bigger system. And then that gets funneled down to an individual provider. It could be a doctor, or some other clinician.

Some of these steps can be skipped, and the incentives can vary by steps. So, let me expand on these two bullet points for a second.

Next slide. So, for example, in an ACO, and I think this is really some of the original motivation for ACOs, the goal was to skip past the insurance carrier.

So to some extent, the original vision was to skip past the conveners and go

directly to the delivery system.

This could be sort of an Elliot Fisher version of an HMO[10] where you go to a hospital system, and the money goes straight from the payer, say Medicare, to the hospital system, and everything that's underneath it.

In a fee-for-service world, the money goes straight from the payer, say a Medicare, to a medical group. Sometimes an individual provider, if it's a solo practitioner.

So you can skip steps. Different arrangements work differently.

Next slide. In the incentives, and I think this is important, the incentives can vary by step. So you can have a population-based payment model going from Medicare to say an insurance carrier, or a convener ACO.

That could be population-based. Those organizations can in turn, pay the delivery system in a fee-for-service way.

And there's a whole bazillion different ways that fee-for-service can play out. It can be using a fee-for-service fee schedule; you can get payments by RVUs[11]; a

10 Health maintenance organization
11 Relative value units

bunch of other things.

The money can flow through a medical group. They can be given a budget with a bonus, for example, which could have some fee-for-service components to it.

They could be bonused for quality. They could be bonused for generating RVUs. They can be bonused for a whole series of things.

And then, of course, the incentives can be paid differently to the provider. And again, they can be paid a salary. Of course, they could also be paid a salary with a bonus, or some version of fee-for-service.

So, it would take me way more time than I have, and way more creativity than I have, to be able to sketch out all of the different versions of compensation that occur at these different steps in the system.

But it's important to understand that what you think might be going on at the source of funds level, may be very different than what happens as you move through the system.

And, for example, if the health care system is getting paid fee-for-service, when they decide how they're going to compensate say

individual medical groups within there, they're much more likely to bonus things that are consistent with the way they are paid.

So, in any case, hopefully that will lay out some thoughts for questions, but let's go to the next slide.

So, Michael again alluded to the non-financial incentives that can vary dramatically by step. In the fee-for-service system, typically we think that's where we use a lot of patient cost sharing. Of course, you get a patient cost sharing at MA[12]. You have a patient cost sharing in ACOs.

But in fee-for-service, that's really the main way in which you control utilization. And, a lot of the fee-for-service incentives, say in Medicare, can be undone by supplemental coverage.

So, you can put in place incentives, and it can be undone because people buy supplemental coverage.

By the way, I'm not going to talk a lot about prescription drugs, but this happens all the time in prescription drugs.

You put in sort of formulary

12 Medicare Advantage

restrictions, the drug companies put in place different co-pay assistance programs.

Then the employers put in place various co-pay accumulator programs to kind of try and undo that.

There's a constant back and forth in fee-for-service about how to both incent patients to use less, and then to dampen those incentives.

In ACOs, there's a ton of managerial incentives. Education, information, financial bonuses, administrative hurdles, investments, and care infrastructure.

MA can use many of those same tools. They also can use network design. Computer ACOs can also do things with network design. Prior auth, benefit design.

And, the MA plans themselves can put in place Alternative Payment Models, as it moves down to the delivery system.

So you can have Medicare paying a Medicare Advantage Plan, a population-based payment model.

The Medicare Advantage Plan can take that population-based model, change it however they want, and transfer those incentives to the delivery system as context, as they see fit in

the context.

Next slide.

So, there's a lot of attention, and there's been a lot of discussion around the cash flow. Who gets the money directly from say the organization, the payer at the top of the step.

So, let me make a general point, that the incentives refer to how profits are affected by utilization.

So basically, if I do an extra MRI, do I make more money or less money? They are typically holistic. And, what I mean by that is it doesn't matter what the incentives are on a particular day.

What matters is when you look back, say over a course of time, how much money do you have?

So, for example, in a simple setting, fee-for-service with a year-end reconciliation will have incentives similar to capitation.

So actually, I should say an ACO paying fee-for-service during the year with a year-end reconciliation, will have incentives similar to capitation when you pay the money up front, depending on the design, how fee-for-

service profits and penalties are offset.

So for example, if you are in an ACO that has symmetric, strong symmetric two-sided risk, and you're paid fee-for-service over the course of the year, but there's reconciliation at the end, the organization that does the MRI will lose any fee-for-service profits induced by the fee-for-service payment during the course of the year, by a penalty at the end of the year.

And again, the details of the model matter, but basically don't get distracted by the fee-for-service incentives that were happening during the year.

What matters is when you think back at the end of the year, what penalty are you going to pay, or what bonus are you going to lose or get, is what matters.

So I think what has to happen in these ACO models, is you need the cash flows on a daily basis to just facilitate operation.

It voids the need for the ACOs, that complex contracting across a whole bunch of different, unaffiliated providers.

You can simply pay a fee-for-service and assign the patients, align the patients, attribute the patients, whichever word you

prefer, to the ACO.

And that ACO doesn't necessarily have to contract for all the other organizations; they just become responsible in varying ways.

They have fewer tools in my opinion, than an MA plan, but their incentives are the same and depending on how they do that contracting, the fact that fee-for-service was going on underneath, is much less relevant.

So I think the concern that many people have that everything is built on a fee-for-service chassis, is really a bit of a red herring.

I think you have to think through in each model, what the incentives are to the organization. It's sort of at the end of whatever performance period you're concerned about.

Hopefully that was clear. If not, we'll have some time to chat about it.

Next slide.

So, the other thing that I think is important to understand here is, that all of these organizations, what matters, there's a relationship between sort of the higher levels of the steps, and the lower level of the step.

And, that relationship can be one that I would characterize as policing or partnering.

So, MA plans control the beneficiaries. You sign up with an MA plan, you're an MA plan enrollee. And, so when the MA plans build their networks, they have some leverage over providers.

If the providers don't sign up or agree to various utilization of new procedures or whatever it is, the MA plans can cut the providers out of the network. And, that leverage enables them to use some of the tools from the previous slide.

ACOs, they're either providers so the money goes directly to the hospital, or they have to recruit providers like in the case of a convener ACO.

So, if you're a convener ACO, you don't own the patients. You need to recruit the providers in order to get your patients. And, that gives the providers more leverage over the convening ACO.

So their ability to do things that the providers might not like, is much more limited in the ACO world.

In both cases, the MA plans or the

ACOs, convening ACOs, they can partner more or less with the underlying organizations that are delivering care, but the leverage matters, and it differs a little bit in the model.

And, that's much less related to the cash flow issues in my opinion, and much more related to who controls the patient, and what control over those patients gives the organization.

So, the cash flow from payer to provider to convener, or from payer to convener to provider, is really not central to the incentives, in my view.

I'm not going to argue it doesn't matter, but I just don't think it's central.

So if you wanted to pay the providers directly and have them hire a convener, an organization like say Halliday, which is now an ACO, to help provide information support and manage their patients, that's fine. The money goes to the provider, and the provider pays Halliday.

Or you could set up a contract where the money goes to Halliday, and they just agree to pay the provider.

In either case, the provider controls the patients and therefore, Halliday

has to come to the table recognizing that.

So, that's sort of my summary of this, and the theme of all of this is, I would spend less time focused on the cash flow issues, and more time focused on what the overall incentives are, and who has leverage in the varying bargaining relationships that occur across the different steps in my chart.

So, next slide and I think I'm finishing up.

(Pause.)

Do we have another slide?

There we go. I was finishing up.

So, thank you. As always, it's good to hear Mark and Michael talk. And, we look forward to your questions.

CHAIR CASALE: Great. Thanks, Mike.

So thank you all for very thoughtful presentations.

So we have some questions we would like all three of you to speak to, and then hopefully we'll have time, the Committee members can then ask some additional questions.

So, first question is, what do you think the vision should be for structuring the payment methodology of future population-based total cost of care models?

Now some of this you addressed in your presentations, but any specific comments would be helpful.

So, I'll start with Mark.

DR. MILLER: I mean I think I did talk about this and, in my layout.

The one other thing I would add to that, which I don't know if there's been a lot, either in my comments or, oh, actually, I want to say something else.

I appreciate the fact that Mike McWilliams said, you know, I agree with Mark, but I also want to point out here, my views of all of this have been shaped by the two Mikes.

So it's, I think the causation is reversed here, just so everybody follows here.

So, my principles, you know I think I addressed some of what you're asking here. One area that I didn't speak to, and I'm not sure there was a lot of, you know, discussion around it is, how the beneficiary is involved.

And, I think the, and this is kind of off on a different track, so I'll be very short and move on to, you can move on to other people.

I think beneficiaries should select either a primary care physician, or a physician

who is their primary contact. You know, if you have a heart condition, it might be a cardiologist.

And, that that should be a point where the beneficiary is engaged in, you know, the process of care.

And, that that allows the primary care physician, or primary contact, to engage in a greater level of steering.

And, that's one thing I'm not sure anybody spoke to, including myself, and it's a view that I have.

But with that, I'll stop and let you go on.

CHAIR CASALE: Thanks, Mark.

Michael McWilliams, again, you certainly have touched on some of this in your presentation, but any further thoughts around structuring payment methodology for total cost of care models?

DR. McWILLIAMS: Sure, thanks, Paul.

So, I first of all, I'll just pick up on that thread that Mark just laid down, and because I agree, and it was sort of one of the bullets in my very last slide.

I think we need to be thinking about how to cut beneficiaries in on the savings more

explicitly. There's a mechanism for doing that in MA, but not as much in the ACO models.

And, that seems to be feasible, although it's complicated but perhaps some at least premium buy-downs, you know, having a cut of the savings go to that, so that beneficiaries actually are drawn to more efficient providers, and actually can tangibly feel the benefits of, of a new payment system.

And, then sort of stepping back, I think you know, these models are focused on the traditional Medicare programs.

There is this sort of meta-question about where the, you know thinking in long-term vision for these models, we need a long-term vision for the Medicare program.

Medicare Advantage is expanding rapidly. Traditional Medicare is shrinking rapidly.

So I think we do need to think about how we're going to structure the Medicare program writ large, if we're going to be thinking about the long-run vision for APMs[13] and ACOs.

Assuming that we continue to have a

13 Alternative Payment Models

viable, traditional Medicare program, I think there is emerging consensus that an ACO-like payment system as a foundation makes sense with then some bundles, or episodes underneath it.

To some extent, I think both Mark and I touched on how that foundation should be sort of multi-track to accommodate more providers.

I think even in steady state, we want to make sure that entry is pretty easy, and there's sort of low risk for innovation.

And then finally, we probably need to be thinking more about participation incentives. So far, we have focused on carrots. There are really very few sticks.

There is sort of slow growth in scheduled fee increases, which makes fee-for-service less appealing.

But other than that, not a whole lot of reason for many providers to join other than being able to gain from efficiency, which hopefully will emerge as we redesign benchmarks.

But one thing that does play into participation incentives that I wanted to mention, is that we're probably not going to get very far if we keep taking every new

service and attaching a code to it, and putting it into the fee schedule.

Because a major advantage of these new payment models is to give providers the flexibility to innovate in care delivery, and do things off the fee schedule, and offer that to beneficiaries. And, to do so without revenue losses.

And, so if we keep putting it in the fee schedules, then we just keep allowing fee-for-service to support that care, and also risk running up spending.

CHAIR CASALE: Great, thanks, Michael.

Mike?

DR. CHERNEW: Yes, see that's such a huge question, I think our paper is probably 25 pages and reads like 100, the Brookings one.

I will say I'm speaking in my capacity as a professor, but I would refer people to the MedPAC chapter where some versions of this are outlined. Particularly the foundational ACO model.

Let me say a few quick things in response to your question. The first thing,

and there's a JAMA[14] Health Forum piece I think it was, where I outlined this view.

I think we need to move away from a test and diffuse mentality where we're constantly creating models, evaluating models, relaunching models, creating other models, without the acknowledgment that they all can conflict with each other.

So one test of a model that works, might not work if you launch it in the context of a whole bunch of other models.

So in there I said it's fine to let 1,000 flowers bloom; don't plant them all in the same hole.

So I think we need to move away from that type of thinking, towards a foundational-type model.

You've got three people here that basically agree that a population-based model foundation works, with episodes added on top of that in varying ways. So, I won't go, delve into that.

The only other thing I'll emphasize, because Michael's little graphics went by so quickly, that was like in my mind, we should

14 Journal of the American Medical Association

just spend time on this issue of administrative benchmarks.

But I think it's important to understand that the delivery system, in my opinion, needs some sense of direction.

And, for my taste, and I understand this is just me, some sense of budget and responsibility for managing economic and clinical outcomes.

And, administrative benchmarks do that in a way that doesn’t involve ratcheting the money away if they're successful, and give them a target in advance.

So, unlike a lot of these retrospective models where you wait until after the performance period, and then someone tells you what your benchmarks were, an administrative benchmark says to the organization, you get three percent more each year.

There's a ton of implementation issues, so I think there's a lot more work that needs to be done here.

So I don't mean to discuss it so glibly, but I think in my mind, we would move towards a more budgeted system, and administrative benchmarks are a way of doing

that. And, hopefully we can talk more about that.

The other, the last thing I'll say in this sphere, and I won't call this my vision, I'll call it my concern, is we cannot have an APM landscape if we have 80 percent of people in Medicare Advantage.

So, I don't consider Medicare Advantage policy central to how we design APMs in a technical sense, but it might be the most important thing to the future of Alternative Payment Models.

So, if you ask me one thing I could do to support alternatives, actually I would say two things because I'm not good at stopping at one, two things.

Thing number one is I would reform, that's code for cut, how we pay Medicare Advantage Plans; and two, I would build better Alternative Payment Models along the way as we have been discussing.

But don't think that you can build the perfect Alternative Payment Models if MA is so much more lucrative than in fee-for-service. It will swallow whatever you can do on the Alternative Payment Model side.

CHAIR CASALE: Great, thanks, Mike.

DR. CHERNEW: That might not be part of your purview.

CHAIR CASALE: Yes, thank you.

Before we move to the next question, I just want to get a sense of how many Committee members have questions. If they could just turn their placard, just so I manage the time okay for the moment.

Okay.

So, just moving again to the next question and again, a lot of this has been addressed in your presentations, but really looking for additional thoughts that you may have.

In thinking about the kinds of payment model design features and financial incentives that are most important, so what do you think are the most important features, and then can you point to any evidence regarding the effectiveness of these approaches?

So, starting with Michael McWilliams.

DR. McWILLIAMS: Sure, so I think my number one on this list would be reform of the way that benchmarks are set, as we've all been alluding to.

And, wish I could have gone through

those slides in a little bit more detail, but the sort of bottom line there as Mike was just describing, is that if we eliminate these, these ratchet effects, the incentives get much, much stronger to save and therefore, much, much stronger to participate.

And, it gives everyone a chance to prosper by providing more efficient care. And, gives everyone a chance to do better than they would in fee-for-service.

And, that's just not the case under benchmarking policy to date. So, that would be my number one.

I also think that we shouldn't be so afraid to increase savings rates.

You know, I think the pushback against that is that Medicare doesn't get a cut of the savings, but if we successfully move to a new payment system with an external, externally set benchmarks, then the program has an opportunity to set spending growth according to a rate that we desire.

And, that may be in the long run how Medicare can control spending, as opposed to partial savings along the way.

So I'll stop there because I think I, we haven't talked about episodes, and

there's a lot of thorny issues that arise with how to integrate them, that speak to sort of features of models, I suppose.

But I'll stop there.

CHAIR CASALE: Thanks, Michael.

Mike?

DR. CHERNEW: Yes, so my number one is also benchmarks. My number two is risk adjustment.

None of this works if you can't, and there's a lot of issues with risk adjustment and coding but I have to tell you, I think the status quo does much better in the ACO program, not the MA program, but in the ACO program.

I think the status quo does much better on risk adjustment than it does on benchmark setting. But risk adjustment would be number two.

Number three is attribution. Mark mentioned how people pick primary care providers. I think there's, we need to, one of the big challenges for this whole system of Alternative Payment Models, is unlike the Medicare Advantage program where you know who is enrolled because they have enrolled, is APMs don't.

Different people have different

views about how problematic those things are. But those are the sort of the three most important parameters of the design.

I will say overarching beyond all that, is some vision for how they're all going to fit together.

So, the right way to think through this, or at least the way I think through it, I won't call it the right way, the way I think through this, is there's certain care that we want not delivered. Mark mentioned low-value care.

We want high-value delivered, low-value care not delivered, just to simplify. And, the question is when the low-value care is eliminated, who gets to keep the savings? And, the system of APMs that you set up determine it.

So, if you set up a broad population-based ACO and you avoid a unnecessary admission to a SNF[15], or an unnecessary MRI, those savings, the bonus typically goes to the organization that employs that primary care doctor.

If you set up an episode-based

15 Skilled nursing facility

payment model where the, that MRI or SNF admission is part of the episode, the savings go to whoever you've assigned the episode to.

And, you want to make sure that when you set these up, that you give the savings to the organizations that are most likely to get the, to realize the savings.

But in doing so, you have to make sure that you don't siphon off all of the low-hanging fruit, that makes no one want to take on the broad population-based risk.

And, that's the core tension in how these are designed, and I think we're going to need some work to figure out how that plays out, and how you add those episodes in.

The last piece I'll say, and I make it last not because it's not as important. It might be in some ways, most important, it just scares me the most, is whether the participation is voluntary or mandatory.

If you're in a voluntary model, the model design gets very constrained by getting people to participate.

And, a mandatory model, and I know that I'm saying mandatory -- a heavily incented model, you have much more flexibility in how you set up these models.

And, so the problem with that, of course, is not all providers can succeed if they're mandated in. I don't see a lot of mandatory models, broad mandatory models, in our future.

But how we think through, that ends up, I think, being important for how this whole ecosystem of models will work together.

CHAIR CASALE: Great, thanks, thanks.

And, Mark?

DR. MILLER: Yes, of course everything got said in Mike's part, but I'll, so I'll just quickly hit a couple of points.

I completely agree on the benchmarks, and I think having them set, and if you can make sure that the programs' portions of the savings are set and then grant, you know, if people are accepting risks, they should be granted much greater flexibility underneath that.

I understand the notion that a fee-for-service system, with a reconciliation at the end, can perform very much like, you know, a capitated system.

But I also think that there should be some certainty and cash flow during the

course of the year so that you know where you stand. I think the surprise at the end of the year is very tough for people to deal with.

Other people have said this but I'll just restate it. We're all talking about these APMs and ACOs, and all the rest of it, but you have to go after fee-for-service and manage care around it. Otherwise, you just get arbitraging between different systems.

And then, finally, I thought the innovative thing I was going to say was to speak to the mandatory nature of models. I do think we should move more towards mandatory models, but of course Mike scooped me on that.

So, only thing left to add.

CHAIR CASALE: Thanks, Mark. So, one of the themes throughout our series of meetings this year, we've been grappling with the fact that providers are in different stages of readiness to move toward value-based care.

So in your view, what are the most important interim steps for increasing provider participation in value-based care models, helping providers assume greater levels of financial risk, and encouraging investments in care delivery transformation?

Mike Chernew, I'll start with you.

DR. CHERNEW: I'm glad that's the one I get to go first on.

Certainty about what the models are going to be like. I think it is really impossible to get providers to commit to doing all of this for a, you know, two- or three-year model where you're going to be told a benchmark after the end. And, you don't know how the next model is going to be layered on.

I just think if you could just tell providers, in my opinion, where things are going, I think they can begin to change their business models and manage around that.

Now, of course MA becomes confusing. They don't know how many patients will be in these models, so there's a lot of confusion.

But basically big picture, some certainty about where the system's going to look like, and what payment models are going to look like going forward, I think is by far the most important thing.

Within that, that certainty should be certainty, for example, there's no ratchet. If you tell a provider, come along and really try and become more efficient but by the way, in three years we're going to ratchet, we base you down so you're back at square one in three

years, that's not a very appealing process.

And, so I just don't think we should be afraid of providers prospering in these models.

If the providers can prosper in these models, but we can have top-line spending growth going at four percent and not five percent, or three percent and not five percent, you pick your number.

If we can get top-line spending growth at a sustainable rate, and providers can prosper underneath that by becoming more efficient, I think that's a win-win for everybody.

And, I think there's too much concern about as soon as providers seem to be doing well, we're going to take it all away because the program needs that money.

I think the basic game here is providers need to profit from improving efficiency, and at least in the Medicare program, that will help sustain them through a future of very flat fee increases.

CHAIR CASALE: Great, thanks, Mike.

Mark?

DR. MILLER: I'm going to let this one go by. I think a lot of what I have said

has been said, so I'll let this go to Mike.

CHAIR CASALE: Okay. And, then Michael?

DR. McWILLIAMS: Yes, I don't have much to add either. Completely agree with Mike that any interim step needs to be explicitly linked to where we're going in the long term, in order for it to be an effective interim step.

And, will say though, that there have been some interim steps recently taken, that I mentioned in the ACO REACH model, and the proposed rule within the Shared Savings Program.

Those include setting benchmarks higher for providers disproportionately serving underserved populations that not only helps address a resource disparity, but creates an incentive to attract those populations with enhanced care.

There is the, in the Shared savings Program proposed rule, beginning a movement towards an external benchmark update called the Accountable Care Respective Trend, that's proposed to be blended in the bench marking.

Other measures to sort of limit the ratcheting effects, and sort of slow

convergence of benchmarks to make sure the program remains attractive to providers with high spending. They're the ones that have the most savings potential.

So all those steps I think are important ones. And again, coming back to benchmarks, as long as they create opportunities as Mike said to prosper from providing more efficient care, under spending growth that we can live with, then that should draw more providers into the program, and create an incentive for investments from other sources, as well.

And, then of course there's still a lot of work to do. The primary care capitation, risk adjustment, mitigating coding incentives, figuring out how to cut beneficiaries into the savings.

And, then I think the last thing we haven't touched on is multi-payer alignment, which is very hard.

But I do think that we underestimate the importance of getting this right in Medicare. If we can get it right in Medicare, then we increase our chances of getting it right in Medicaid programs, increase our chances of leveraging federal dollars, which

amount to over half of the insured in this country.

To get federally covered or subsidized insurers onboard with the same sound design, and then I think it's much easier to hit a tipping point with the commercial insurers.

CHAIR CASALE: Great, thanks, Michael.

So the final question for the three of you before we open it up to the Committee members.

Just simply, are there any additional insights you'd like to share, about developing effective payment methodologies for population-based models?

Mark, I'll start with you.

DR. MILLER: Sorry, no, I'm going to, I'm just going to stand.

CHAIR CASALE: Okay, Michael McWilliams?

DR. McWILLIAMS: Yes, I'll hold, as well.

CHAIR CASALE: Okay, and Mike?

DR. CHERNEW: So now it's all on me.

CHAIR CASALE: Yes.

DR. CHERNEW: So I'll be quick.

I've heard a lot debate lately about things like Medicare Advantage for all. So there is a lot of value in my mind, that you can get from Medicare Advantage plans.

But if we're going to think about that, we need to really think about the design of Medicare Advantage because it was never designed to be as big as it is now.

And, so I don't know if you consider Medicare Advantage an Alternative Payment Model, but in some of the prep calls, it seemed like it might be.

And, if that's true, we really need to think about what we want through a Medicare Advantage type system, and how we want to leverage any efficiencies that the plans can gain.

Because I mentioned they do have the ability to gain some efficiencies and improve value. It's just we don't have a system that's well designed to pay them. And, rely on the fee-for-service benchmarks.

CHAIR CASALE: Great, thanks, Mike.

So we do have some time, so I'm going to turn to our PTAC members for questions.

So, Bruce?

MR. STEINWALD: Thanks. Hi, guys, thank you very much. That's good stuff.

Each of you had some interesting things to say about fee-for-service. Mark Miller said one of the principles is make fee-for-service less profitable.

Mike Chernew said that concern with the fee-for-service chassis is a bit of a red herring.

And, I think Mike McWilliams said if we continue to rely on fee schedules for payment to providers, we're not going to get very far. If I got that right.

So, my question is, what do you think is the role of fee-for-service? Should we discourage providers from continue to use it even if they're not, even if they're in Medicare Advantage plans, for example?

Can we do away with it? Should we try to do away with it? What do you think?

DR. CHERNEW: If I could just say briefly, I believe we're going to need a fee-for-service system. It sets the scoring for my colleague, actually Michael's colleague as well, Bruce Landon wrote something, is if you avoid an MRI, how much do you save?

Fee-for-service set the scoring

there. So I believe we need, but as Mark said, we need to continue to reform aspects of fee-for-service.

I don't think we can get rid of it. I would devote probably mildly less attention to some of the underlying details. There's certain things site neutral I think we need to fix.

So, I think we need to pay attention to fee-for-service because the underlying scoring system, but I don't think it should be, I don't think we should discourage it from existing.

I think we're going to need it in an APM world. I think if an organization wants to use it in varying levels of the steps, I think that's fine.

I think if we can get the top line right, we should let the part below that work out as it can.

And in Medicare, we should continue to try and reform it if -- you all know Bob Berenson, I think he used to be on PTAC, I'm not sure.

You should have him come talk about how to reform fee-for-service. But I do think it needs to exist.

DR. MILLER: I would agree with that set of comments. I think fee-for-service should be uncomfortable.

I also thought Michael's point, or Mike Chernew's point, sorry, point was is that if you're paying on fee-for-service but you have an incentive structure that sits over it, you don't have to worry as much. And, I subscribe to that.

But I do think the fee-for-service system should exist. I think it should be less profitable than moving to a better managed system.

And, I also think that there are distortions in the underlying fee-for-service structure in Medicare that should be corrected, you know, between what we pay for primary care, or cognitive specialties versus procedural specialties.

And, then as I said, I kind of think the way we, not kind of, the way we pay primary care on a, you know visit-by-visit basis, is not the way to approach that.

So no, I would not eliminate it. And, I think it is the reference point as Mike Chernew said. But would not eliminate it, just make it uncomfortable.

DR. McWILLIAMS: Yes, I would agree with all those comments as well.

And, I think it's good to distinguish sort of fee-for-service writ large as a payment system, and fee-for-service for keeping track and for paying sort of below a level of a risk-bearing organization, whether it's a plan or a provider organization.

And, I think this goes to sort of Mike's description of all the different levels in the system, and what I touched on with group- versus individual-level incentives.

In many cases, it may make a lot of sense to, for internal compensation, to pay on a fee-for-service basis for certain services.

And, also it may make sense at least in some markets, for there to be risk-bearing organizations responsible for the total cost of care.

But the way they transmit those incentives, are to the rest of the market, is by demanding efficiency.

And, from specialists or hospitals, downstream providers, who may be paid on, you know, on a fee-for-service basis.

But if there's, if the market is competitive and they're not, there's enough

ACOs that pay, you know a new payment system broadens, then there will be sufficient demand for efficiency, such that even fee-for-service pay providers have an incentive to be more efficient.

CHAIR CASALE: Thanks, Michael.

Larry?

DR. KOSINSKI: Well, actually Bruce asked the question that I was going to ask, but on the basis of the answers that we just heard, I'd like to force our three speakers into a little bit more granularity.

There are specialties, the one that I was raised in, gastroenterology, where 70 percent of the revenue of a GI[16] practice comes from one procedure that's performed for, on an elective basis.

And yet, where we need their performance and disease management for complex diseases, they are markedly undercompensated.

So, tell us, how do we get to where you want to get to, using a fee-for-service backbone? How do we make it unappealing?

What would be the steps?

CHAIR CASALE: Mark, I'm going to

16 Gastrointestinal

have you start since you mentioned about fee-for-service, making it uncomfortable.

So, thoughts about?

DR. MILLER: Yes, and I'm pretty sure the Mikes are going to be able to do a better job here.

But the point that I think, you know, the Mikes and myself have been saying is that there were terms used that you want to allow for innovation inside, you know, a, let's call it an accountable care model.

So while revenue may flow to the model, through the fee-for-service, you know, payment structure, it doesn't have to be in the end, after you reallocate based on performance, it doesn't have to all be paid exactly the way it would have been paid under fee-for-service.

This is what I meant by flexibility, particularly as the organization begins to accept risk, it should be allowed flexibility in order to provide incentives to individual providers who are in the system.

And, so I would see the answer to your question being that the compensation for that kind of consultation, would be adjusted in a way that would be attractive and supportive to that particular provider.

CHAIR CASALE: Michael McWilliams?

DR. McWILLIAMS: Right, no, I think this is really sort of, it's a good question and sort of digging into all the various ways that the incentives can be, or should be, transmitted.

You know, I tend to think of this sort of two models in mind. One, an organization model that employs the gastroenterologist, in which case you're talking about internal compensation.

The ownership model while, you know, it hasn't been shown to necessarily improve quality, it does simplify some things by having employment relationships in place. And, there can be sort of direct managerial control of practice.

We have historically not really done a good job in the medical profession of developing management techniques to manage physicians to generate what we care about, which is better patient care and patient experiences.

To me, that is sort of the major challenge ahead of us for, for quality.

But certainly one can imagine salarying a specialist from an internal

compensation standpoint, and then using various management strategies to, non-financial incentives, different practice environments, et cetera, to encourage the physician to practice as is in the best interest of, of society.

Or at least for patients. And, you know, with the risk-bearing organizations more efficiently.

It gets a little trickier when that specialist is not under an employment relationship, and this is sort of within a sort of affiliated network, or even just an unaffiliated referral.

Clearly there are opportunities for subcontracting, that can look like a fee-for-service but with an agreement that hey, we want to refer to a group that doesn't scope everyone.

And, for that, we'll pay you an additional care management fee, as well, so that you have the additional costs of better communication covered.

It could be a population-based payment sort of subcontract where it's just a fixed payment for the organization's, or practice's population.

And, that's basically sort of

carving out the GI services for that population in a sub-contract.

There have been various conversations about whether, what's the extent to which a payer like Medicare should step in and write that sub-contract as an episode.

But I generally, and then you could have a model as I said before, where the fee-for-service model works okay because there's just a competitive enough market that ACOs are going to refer to the more efficient, higher-quality gastroenterologist.

And, you know, to some extent, the savings do need to come from somewhere, and we probably, and we know we provide too much care.

It's certainly not in primary care, so there will be reduced income in certain specialties.

So I'll stop there, but I think it's sort of there's no one right answer, but the key is having that foundation, that population-based payment model foundation in place to then allow that sort of flexibility for the incentives to flow, both through financial and non-financial means.

CHAIR CASALE: Thanks, Michael.

Mike?

DR. CHERNEW: Yes, so to the extent that your question applies that Medicare or others, should do a better job on setting the relative fees across the thousands of fees that exist, I agree.

And, again, that's probably a Bob Berenson comment and maybe evolve into a discussion of the ruck, which I'd rather not have.

It certainly evolves into a discussion of site neutral payment, and a bunch of other things like that.

And, we have an existing process for setting fees. It's unbelievably cumbersome in a variety of ways, and we tend to want to add more codes.

And, we get challenged by all this new virtual care about how we're going to set up the fees.

That process should continue. The stakes of getting all of that right, or the harm of getting all of that wrong, in my view, is dampened when varying levels of payment or organization in the steps that I gave, can transform that.

So, if we can hold the Medicare Advantage plan to making sure that they've

recruited enough gastroenterologists, and that they're providing the services that are needed in high-value, and not the services that are not needed in low-value, the actual flow to the gastroenterologists or their practice, is less so.

And, certainly you don't want to be in a situation where you tell the provider organization that doing something's very profitable, and then you utilization review them away from actually doing it.

So, you don't want to step on the gas and the brake at the same time, but in the grand...so we should devote our time to getting those relevant fees right.

I just think in an existing fee-for-service system, we will never manage that right as technology changes, and a whole bunch of other things change.

So as long as you have some overarching, and I agree with Mark's characterization of what I said, as long as you have some overarching system that can manage care, change the referrals, change compensation, maybe an employment relationship, maybe in a bonus relationship, maybe in a quality payment system relationship.

I won't presume to know, you just have to worry less about the fact that inevitably, you're going to get these payment rates wrong, and you're not going to be able to risk-adjust them in things, and they're going to bump into each other.

So, I think we have to keep trying and just accept that we're only going to get so far in getting it right.

CHAIR CASALE: Thanks, Mike. Appreciate all those comments and appreciate the reference to Bob Berenson, who I think Bruce and I can remember probably at the first meeting, he made that comment.

You know we're going to start looking at models, but you know, we can do a lot with the fee schedule to align incentives.

So, Chinni, did you have a question?

DR. PULLURU: I did. Going back to, I love the slide Mike Chernew has with incentives that can vary by step, because I think it really illustrates that flow of funds that's so fundamental to the system.

But one of the things that we're seeing is, you know, with the advent of ACOs, all of a sudden hospital groups started employing a lot of primary care physicians,

right?

Shifted the demographics of employment. Medicare Advantage gave rise to payviders, and all of a sudden payers started having huge offsprings of primary care provider groups.

All of that lent itself to not necessarily having some of the flourishing of primary care and providers that I think Mike, you, you're advocating for.

And, so how would you think about, you know as adoption of Medicare Advantage grows, having certain, engendering a certain system that can provide for independence of attribution, but also function within the Medicare Advantage system?

DR. CHERNEW: As you probably know, I'd love to answer, in this case, I don't understand the question.

DR. PULLURU: Well, here providers, payers are often controlling Medicare Advantage attribution, right? They get enrollees, and then it's attributed to payer groups.

But if you think about with the advent of payviders, a lot of times that is consolidated in certain geographies. And, there isn't the choice.

And, then physicians, primary care physicians, oftentimes have to join entities that then can get this patient attribution in order to participate in a capitated plan.

How would you change that attribution model in order to encourage independence?

DR. CHERNEW: I might be more ambivalent on independence than you are. I am supportive of independence.

I think if you look at the work that say, we've done, Michael and I have done, others have done, the independence of the physicians, the primary care physicians from the hospital helps you, my joke -- I wish I could see you all, I can't tell if my jokes are bad. It’s hard to keep people out of the hospital if you're a hospital.

So I think there's some merit, and there's a lot of concern a consolidation on the commercial prices side, which seems a little bit out of scope for this conversation.

But I think the short answer to your question is, we, and Mark said this, we need to reform primary care payments for a bunch of reasons.

But the one that motivates me, quite

honestly, is we have no idea how to pay for all this virtual care. We have no idea how to pay for all these e-messages, and portal messages.

I was talking to a large group of primary care physician groups, so a bunch of America's Physician Groups, I think is what they're called, earlier last week.

And, you know, you could debate two or three percent updates or what's going on in macro, and macro is a whole separate issue.

But the real problem is the burden on primary care practitioners to practice independently, and all the various things they have to do, makes it really hard to be an independent primary care provider.

I don't think that's a fee schedule issue, honestly. I think that's an administrative burden issue of all the things that are going on with primary care, and all the various things we make them do.

It wouldn't bother me if they were in bigger systems, honestly, if I could control the prices of these big systems.

I think there’s going to be a lot of support for that integration. It's just you need to cap the proper amount of money because if you don't and they're owned by hospitals,

they'll save less money if they're independent than they can do through the referrals.

So, I don't know, we're getting close to, I don't know the time here, how we should do that is really challenging.

But I do think we have to rethink the unit of service of what primary care means. Because fee-for-service does a horrible job of creating the incentives for the unit of service that primary care practitioners provide.

And, so that requires, Mark said this, reforming the way primary care is paid, independent of what overarching system you lay on top, which you've been talking about today.

CHAIR CASALE: Great. Other comments, either Michael or Mark?

DR. McWILLIAMS: I think may understand where, where, maybe I'll try to rephrase this.

I think that maybe the concern is that primary care providers may be shifting to working with payviders that exclusively take care of Medicare Advantage enrollees, which may be fostering consolidation.

So, insofar as that's the concern, I think that this sort of like notion of MA poaching doctors, poaching patients, has

certainly been expressed.

I'm not, I haven't seen really rigorous evidence on the extent to which this has happened, but I will say that just taking a step back and sort of echoing some of the things, some of the comments that we made earlier, there is sort of a two-prong, two prongs of the consideration.

Or one is sort MA payments. We're subsidizing MA. So clearly to the extent that this is happening because a PCP can get paid 20 percent more if they go work for an MA payvider, they're going to do that.

And, on the one hand, that's good that MA is funneling more resources down to primary care. But it's not entirely clear from a programmatic standpoint, that we want to be subsidizing MA to the extent that we are.

And, then similarly, this is sort of motivation for addressing the primary care spending within the ACO models, our total cost of care models.

We have an opportunity, it's far simpler to do that if we capitate, or provide a global payment for primary care within an ACO model, that basically then allows us to set, you know, benchmarks or advance payments for

primary care, that are more easily dialed up.

And, so that can help sort of balance out primary care reimbursement. And, then across the board, I think there is consensus that we probably want to increase spending on primary care.

But again, it's that imbalance between sort of how we're paying and then how we pay in traditional Medicare, that may be leading to any sort of trend that you may have been referring to.

DR. MILLER: And, that's the only thing I'll add is, you know, early, and I think everybody said this in one form or another, and I said you have to pay attention to fee-for-service and managed care, and how it bumps into these particular models.

On the fee-for-service side, I would go to a PMPM[17] type of arrangement for primary care.

And, then just what Michael said on MA. If you overpay and you subsidize MA, then they're going to be poaching, and you're going to get these kinds of, or these kinds of impacts on the system.

17 Per member per month

CHAIR CASALE: Thank you. Just one last question, Jennifer?

DR. WILER: Thanks to our three speakers for a wonderful conversation.

Each of you has commented that voluntary participation in these models is problematic.

So I want to give you an opportunity to decide if your recommendation around ideal features for a model are either mandatory, or heavily incented, or does it not matter?

CHAIR CASALE: Mike Chernew, I'll let you start.

DR. CHERNEW: I started too. In our white paper, we basically had this feature varying by track.

So the gist of it is for large organizations, I think they should be heavily incented, and they should be heavily incented to incorporate two-sided risk in, sort of heavily incented in very strong models.

For small, independent physician groups, I actually think if you get rid of the track and do a bunch of other things, you could be fine with what I'll call MSSP[18] classic.

18 Medicare Shared Savings Program

I'll stop there. If it's unclear, Mike McWilliams will clarify.

CHAIR CASALE: All right, Michael, I'll let you go next.

DR. McWILLIAMS: Yes, I think that's right. I think first of all, you know, and sometimes we sort of dichotomize this distinction between voluntary and mandatory when really, it's just a spectrum of participation incentives in any sort of quote/unquote, mandatory model.

It's never really mandatory, there's just sort of whatever penalties or costs of not participating. It may be so extreme as to not get paid.

So, I think we should be thinking about it as a spectrum, and as Mike just said, and this is sort of the main point we make in our white paper, where on the spectrum is needed to get different types of providers in, differs.

And, so we should be thinking, we should have that in mind when we devise complimentary payment policies that make these models more or less attractive.

CHAIR CASALE: Mark, you get the last word.

DR. MILLER: Okay.

I agree. I tend towards heavily incented, and even moving into mandatory. And, by heavily incented, for example, again both on the fee-for-service side as a push, and as on the alternative model side as a pull.

And, I also think and we're way, there's way too little time to discuss this. There are circumstances we should consider for mandatory, because something Mike McWilliams said way early on in the conversation, this is getting harder and harder to study effects.

And, to the extent that you can have some mandatory elements to this, in order to get the research results you're looking for, I would push in that direction.

But we're way over time, and I blame both the Mikes for that.

CHAIR CASALE: Well, with that, I'd like to thank all of you for joining us this morning. You helped us cover a lot of ground during the session. You're certainly welcome to stay and listen as our meeting continues, but at this time we have a break until 11:25 Eastern time.

So, please join us then. We have a great lineup of guests for our second listening

session of the day. Thanks again.

(Whereupon, the above-entitled matter went off the record at 11:16 a.m. and resumed at 11:26 a.m.)

*** Listening Session 2: Payment Model Features Contributing to Successful PB-TCOC Models**

VICE CHAIR HARDIN: Welcome back. I'm Lauran Hardin, Vice Chair of PTAC. I'm pleased to welcome three experts for our second listening session. We've invited them to present on payment model features that contribute to successful population-based models. You can find their full biographies on the ASPE PTAC website, and their slides will be available online later.

Presenting first, we have Kristen Krzyzewski, who is the Chief Strategy and Program Development Officer at LTC ACO. Please begin, Kristen.

MS. KRZYZEWSKI: Thank you. And thank you for inviting me to participate in the session today. I am looking forward to discussing our population that we serve as an ACO and that is the long-term care beneficiary population of Medicare beneficiaries residing in nursing facilities.

So next slide, please. So we offer a unique perspective, I think, to the Committee in that we are an enhanced track MSSP ACO, and we are the first ACO to serve this particular subset of the population that resides in long-term care facilities.

We started in 2016 under Track 1. And in our second agreement period that began midyear 2019, we migrated to the enhanced track. And we originally started, we were part of the Genesis nursing facility chain. And we originally started with the Genesis physicians and nurse practitioners serving the beneficiaries that resided in the Genesis facilities.

In 2019, we began to expand outside of Genesis, recognizing that there was a lot of provider interest in this community to participate in value-based care and that we had some unique experience that we could bring to the table, and so we began to expand. And now in '22, we are serving approximately 20,000 beneficiaries that reside in 39 states with over 1,800 participating providers. So that's about 600 participating physicians and 1,200

participating nurse practitioners and PAs[19].

And so I just wanted to highlight how we are unique in many ways. And that is, again, with a relatively small population participating in the program, we have a very large benchmark per beneficiary. You can see here over time from 2019 through the latest settled period through 2021, our benchmark has been $30,000 or over per beneficiary per year. And that compares to the traditional ACO, the average ACO serving the Medicare population, which has a benchmark of around $11,000, $11,500. So we're significant serving a higher-risk, higher-needs population.

And you can see the savings that we've earned. COVID aside, because COVID certainly hit our population in a unique way, and we were very challenged during 2020. But setting that aside, we've earned the Medicare program in gross savings per beneficiary the highest of any ACO in the program in 2019 and in 2021. And I say that in 2021, noting that we still have some impact from the COVID PHE[20] and the pandemic.

So along the way, we've improved the

19 Physician assistants
20 Public health emergency

quality. And we're sharing in '21 at the highest sharing rate, quality adjusted sharing rate, of 75 percent.

So next slide, please. Thank you. So with all that said, we serve a really unique population within the program, not within long-term care but within the ACO program. Ninety-six percent of our folks are indeed institutionalized. So a couple folks fall out along the way. They may transition back to home, but the bulk of our population resides in a long-term care facility.

Eighty-eight percent of folks are dual eligible. And you can see the comparison here as we go to all MSSP ACOs. And this comes directly from our files from CMS, how we compare. We have a very elderly population with nearly 40 percent of our population age 85 and over.

We serve a more diverse population than traditional ACOs. And we use a lot of primary care. The model for this population really is primary care driven. Clearly, they have a lot of comorbid conditions. And you can see the incident rate of conditions compared to other ACOs, but the bulk of that is coordinated in the facility through the use of primary care

physicians and nurse practitioners and PAs.

There is a high utilization rate of hospice as you would expect. And we have a higher rate of death for this population that, you know, a significant portion is at the end of life. And we're helping manage quality and cost of care typically in a beneficiary's final years of life.

And just to note again, COVID, as you might expect, 46 percent of our population in 2020 had a diagnosis of COVID compared to four percent in the overall ACO population. But a smaller portion of our beneficiaries actually had what CMS classified as a COVID episode, in that -- CMS to exclude those costs from population, you had to have an inpatient hospital stay.

And a lot of our folks, because the PHE waived the three-day hospital stay, went straight to a post-acute or a SNF bed within the facility. So we had a lower rate of excluded costs that were truly COVID.

So as you can say, we serve a unique population. It's well-defined. And you'll hear through my message today consistency in saying that this unique population warrants a population-specific approach.

So next slide. Thanks. So first of all, there is a large market, talking about a specific population while there are certainly a lot of Medicare lives still in the fee-for-service program. To say about 800,000 is a significant population maybe seems strange. But given that this is a high-cost population with high risk, we think it's a unique, worthy population, subset of the population, to focus on, with lots of low-hanging opportunities to improve quality and the cost of care.

And the population is really underserved from a Medicare Advantage perspective. Just over 100,000 lives are in Medicare Advantage ISNPs[21]. And so this population really still resides in original Medicare.

And, you know, I have shown -- sort of our slice, we're serving about 20,000 there. Since there have been other programs, high-needs ACOs that serve this population, and other MSSP ACOs have come in to try to serve this population as well, so there is a small slice participating in value-based care. But the vast majority are still in what I'll call

21 Institutional Special Needs Plans

original fee-for-service, unmanaged sort of from the perspective that we're talking about today.

So this all compares to, you know, the average Medicare population where there is almost 50 percent in MA and a higher rate of uptake in value-based care programs. This population is underserved.

And this population, you know, folks do ask us, well, gee, aren't we trying to move away from institutionalizing beneficiaries and keeping them at home? And, yes, we applaud that and Medicaid incentives, and managed MLTSS[22] is doing a lot to keep people in the home.

The population, as we know, is aging. And there will continue to be a need for folks moving to long-term care. And as the population ages, the population that does reside in facilities will get older over time and so it will become higher-risk. So, again, a greater need for improved coordination of care.

Next slide, please. Thank you. So things that we think about, and we've thought and we've sort of lived through. In trying to

22 Managed Long Term Services and Supports

make our population work within this program, you know, it has been a challenge because this program wasn't necessarily designed for providers serving folks in the setting.

But some of our biggest challenges, we've worked through them. We've worked through a lot of the challenges in the program to make it successful. But we have recommendations on how we can do better and get more providers participating. Because at the end of the day, these providers want to participate in value-based care. But it really has not been designed with their specific population in mind or their specific needs.

So one of the things that is often a hindrance, one of the biggest things is just the TIN[23] exclusivity. I know this is not a new issue. But having a whole practice of being required or a TIN, billing TIN, to participate in the program, well, they may serve a mixed population. That creates confusion for trying to manage and isolate this true subset of the population, true long-term care.

And most of these, the providers serving folks in this setting, also serve

23 Tax identification number

individuals residing in assisted living facilities, potentially in the community. And so it's a mix. It's an array of risk profiles and potentially benchmarks.

So we're trying to navigate that. And I know ACO REACH has something to allow participation at the MPI[24] level. We think there is opportunity to further isolate within an MPI or a TIN a true population that is long-term care, and it's easy to do. CMS does that for us with that long-term institutionalized factor. So it's doable. We just need a way to attribute just that subset of the population and not penalize the providers who serve other populations in their practice.

Attribution is tricky for this population. A lot of folks are served through nurse practitioners and PAs. And we have found interestingly enough that requiring a physician, one physician visit from a participating provider can slow attribution by the true primary care providers.

And so, again, ACO REACH has allowed flexibilities in attribution. And it's something, again, in not requiring a physician

24 Medicare Provider Inventory

visit but just looking at the plurality of care, there are ways to reward providers who are delivering care to this population that are unique among other ACO populations.

Minimum participation levels are a challenge here. Thinking about this as really a building by building, maybe 120 beds in a building, not all are long-term care beds to meet 5,000 minimum threshold requirements in MSSP is a challenge. And I think that has been one of the primary reasons folks have not been able to participate in the program today. They have interest but haven't been able to.

So moving on. There is a lot here. So we can maybe circle in the discussion and questions. But benchmark development, this is a real concern for this population. As we think about moving towards administrative benchmarks in the future, which we support, we want to caution folks as programs are designed, and I actually just brought this up at NAACOS[25] to CMS last week, that the program is really designed to think about inefficient versus efficient participants in the program.

But folks and ACOs and providers

25 National Association of ACOs

that serve a really complex high-cost population will often be deemed inefficient and higher-cost relative to regional performance, risk-adjusted regional performance.

And so if we can't get the risk adjustment to actually accurately capture the risk of the population, then we are going to have problems under an administratively set benchmark. And so I urge CMS, the Committee here, to think about wanting to encourage ACOs and providers serving higher complex populations that they need to think almost as a third -- there is a third rail here and a third bucket. You've got inefficient, efficient, and then you have ACOs serving complex populations. There almost needs to be a third bucket.

Quality measures certainly weren't designed for our population. And we've had to work within that. Costs, the PHE, certainly, you know, we saw how the methodologies sort of penalized our population compared to others.

Telehealth, we want to be able to continue to use that because there are many attractive opportunities of coordinating care and improving care and then just trying to increase opportunities to data share.

So going on to the next slide, and

I'll wrap things up, and we can move it. But the key drivers for participation, as I said, there is a lot of interest. We see interested parties. They are concerned about risk of participating. So we participate as enhanced track. We don't pass that risk down to providers. And we think that has helped providers in their willingness to join the program and come in and migrate and improve performance over time.

But then I also cannot understate the importance of the five percent macro bonus, and our concern that that going away is really going to discourage providers from participating. So there are certainly obstacles. I think I've covered some of those.

And the last slide here, again, just reiterating that these providers want to participate in the program. There is a big opportunity to get folks, you know, migrated from original Medicare to value-based care, original Medicare, and so how do we do it? And I urge the Committee to think about how we can go back to CMS to encourage faster action and uptake among the providers serving this specific population. So thank you.

VICE CHAIR HARDIN: Thank you so

much, Kristen. We're saving all comments and questions from the Committee until the end of all presentations.

Next we have Jeff Micklos, the Executive Director of the Health Care Transformation Task Force. Please go ahead.

MR. MICKLOS: Thank you so much, and I appreciate the invitation to be with you today. The Task Force is a longtime observer and supporter of the PTAC. And I just want to say we really appreciate kind of how you're going about your work these days. It's really helpful to the field to have this august body weigh in with recommendations. So I appreciate being here today.

Next slide, please. So the Task Force is in its eighth year. It's an industry consortium comprised of providers, payers, purchasers, and patients, all committed to accelerating the pace of change to value-based transformation.

We support our members across all their lines of business in different populations that they serve. And so the overview slides that I will give you today are kind of at that higher level, reflecting a variety of perspectives within our membership.

Next slide. Next slide, please. Thank you. To give you a sense of our progress over those eight years, we had set ourselves a goal of having 75 percent of our payer and provider business in value-based payment arrangements by 2020.

We made great progress along that goal. We now have extended that goal so it will be 2025. I'll talk a little bit about some of the kind of limitations of that numeric goal. But it's still aspirational, and it really applies for all populations that are members of SERFF[26].

Next slide. And this will be in your materials, but just to give you a sense of kind of who is within our membership. We have large national payer and health systems. We have smaller -- we have single state Blues plans. We have other transformation support companies. We have a wide variety of perspectives within our membership.

Next slide. So it's always important for us when we talk about kind of designing a total cost of care payment model, it's to step back before you get into the

26 System for Electronic Rates & Forms Filing

specifics of a payment model and make sure that you have a foundation in place that can be successful.

So certainly a cultural commitment and serious government buy-in remain critical first steps. The Task Force has kind of prepared some practical resource tools for its members that are also available on our website around conducting a readiness assessment and doing some internal benchmarking. It is important that organizations know their own capabilities and limitations before choosing a particular payment model.

And then what APM opportunities are available to sustain change, and how do they align to the populations you are seeking to serve?

So clearly when you have a Medicare payment model from either MSSP or the Innovation Center, the parameters are pretty set, whereas there is a lot more flexibility in commercial models, Medicare Advantage arrangements, and Medicaid Managed Care to have those private parties to collaborate and partner in the best way.

And so we also think that we need to conduct a partnership evaluation. In addition

to evaluating yourself and your readiness, it's also important to look at the strengths and weaknesses of a potential partner and whether they are ready for now and capable over time.

And I say that in the context of our 75 by 2025 goal in that we had a number of members who really sought to sign up arrangements that would meet that standard but then found that some of the providers weren't necessarily ready to go in that direction as quickly.

And so it's really important that you make sure you evaluate that. It's important that our relationships are developed, and they can move along this continuum and be productive and not get into situations where you have to unwind arrangements.

When we talk about choosing the accountable care payment model, we really talk about that in a variety of ways. We have members that are all across the continuum. Some are at the early stages. Some have been doing this for a long time. We look at them as really on-ramps and low-risk models, whether that's one-sided risk on total cost of care or at-risk care management payments.

We see a lot more in the moderate

risk category right now with two-sided risk on total cost of care, capitation on a limited cost of care, or even capitation on limited cost of care with one-sided risk on total cost of care. So we're seeing that more in the commercial space and involving the Medicare Advantage area as well, and then we have full risk models where we are talking about capitation and with two-sided risk or global budgets.

Certainly, there is an ongoing interest in all of those. And there's certainly a feeling within our membership that would be great to have some more full-risk options available in the Medicare program currently.

Next slide. So for on-ramps and transformation supports, as everyone knows, addressing the investment risk and the business risk and financing of the start-up costs of infrastructure needs to overcome any barriers to entry. I think NAACOS has reported that, you know, the costs for setting up an ACO are $1 million plus to begin operations.

We're really excited about the ACO investment program that's been proposed in MSSP for 2023. The idea of being able to provide

up-front payments to help new providers come on board is really important to widen the on-ramp to have new providers come in.

I also think the way that proposal is designed is really effective in that there is an expectation that the investment dollars will be paid back. But however, if the entity would not realize shared savings by the end of the fifth year, those funds can be kind of held harmless against returning those funds, which creates stickiness in the program, allowing for providers to really have the full experience of a contract term, since we know that it takes several years really to kind of settle in and get to a place where you are operating in a successful way.

And, of course, we continue to see at-risk care management payments that also help with provider capacity building. It frees up the provider community to be able to serve individual patients as needed, as opposed to relying on revenue focusing on fee-for-service.

And then when we see in the private kind of partnership space in the commercial and some of the innovation that's happening in managed care, public program managed care, we see design of capital allocations and resource

contributions that are impacted by the form of the arrangement.

So it could be a direct contracting arrangement between a purchaser member and a provider. It could be a joint venture between payers and providers or even a clinically integrated network. And so, again, a lot of variability. Understanding kind of what you're trying to achieve and what your partners are able to achieve in the near term is critically important at the beginning stages.

Next slide. So for ongoing participation and protections and our incentives, they need to be properly calibrated financial incentives and rewards. And they need to be revisited and grow over time. It's very important for arrangements to be revisited periodically and adjusted as appropriate. I think as we've kind of seen our life cycle go, there is a lot more discussion about what are those kind of checkpoints, as it were, over the term of a contract and the importance of trust between partners and arrangements to be able to address things as needed as time goes on.

We want to ensure the proper flow-through of incentive payments to individual providers. There has been concern, of course,

that it's more at the accountable entity level and that individual providers are not necessarily seeing the full benefit of what their work is and therefore not maximizing their move to value.

I'm sure it's been discussed today already. Eliminating the ratcheting effect of current benchmark policies is really important to driving sustained provider participation, especially in a Medicare portfolio that primarily relies, if not almost exclusively relies, on voluntary arrangements.

So creating more reliable and predictable benchmarks is critical. And we think also that heading toward administrative benchmarks in Medicare is a good idea.

And then progression to incentivizing advanced risk arrangement adoption. So we've had a lot of interesting conversations over the past few years inside the Task Force about the right way to push providers along the risk continuum. Some felt that the pathway was a little fast, but now are concerned that maybe the proposed changes to the MSSP room won't move folks forward.

I think it's critical for any payer, public or private, to recognize that they

should have a variety of opportunities that meet the providers where they are and what they are able to accomplish. And I think some of our more advanced providers would say the same thing about their payer partners.

And then progression to incentivizing advanced risk adoption, you know, may employ some additional business tools that are critical to kind of supporting here, whether it's implementing reinsurance or stop-loss protection against outside, downside risk.

I think in the Medicare models, one major concern has been the retroactive benchmark adjustments. Those have really obviously soured some participants, and most recently we've seen kind of a departure of a large number of organizations because of a recent retroactive benchmarking change in the Bundled Payment for Care Initiatives Advanced program.

Next slide. So engaging specialists in accountable care arrangements, I know we'll get into this in more detail in the discussion, but this continues to be a challenge for many performance-based providers.

There is a number of reasons for that, but there is also one of the incentives

related to the advanced APM bonus that we believe is critical to continue the move toward value, and we definitely support legislation to do that this year. It would be great if we could achieve that objective.

But also by the way they calculate these scores, there may be a disincentive to really engage with a specialist because it may affect an organization's ability to recognize an advanced APM bonus payment. So that concern is something that future policymaking should address.

And then I think we're concerned about the future of the CMMI clinical episode models. We think more models addressing specialist engagement strategies are desirable across all model types.

I know Liz Fowler, CMMI Director Liz Fowler, made a comment last week at the NAACOS meeting that we will have more guidance and thinking from CMMI this fall on that topic. I will say also inside the Task Force, we are seeing more activity in the commercial space in trying to find out these effective arrangements to engage specialists, which can take many different forms.

Next slide. The Task Force has

spent time really thinking about value-based model overlap and alignment generally. And because APMs are becoming ubiquitous, it's making it difficult to kind of manage patient attribution and measure model impacts and appropriately credit providers with cost and quality improvements.

So as we look at these things, we really think that they need to work together and we need to find a path forward and not have a one size fits all.

So we think precedence determinations are important to drive desirable outcomes. That's more prevalent kind of in the public programs than in the commercial sector. We are a supporter of testing nesting of clinical episode models in ACOs. We'd love CMMI to do more in this area.

And then also we recommend kind of CMS pursue a hierarchical model alignment strategy that sets a consistent and predictable beneficiary attribution policy that shows preference to higher risk arrangements. Certainly, those total cost of care models should be recognized for the overall benefit that they are providing. And there are a number of directions we can talk about later

about what policy could look like in that area.

Next slide. And I think what's really critical inside the CMMI strategy refresh is the multi-payer alignment prong of what they're looking to achieve.

We all know that there needs to be greater consistency across models to increase adoption. Quality measurement is the one that gets a lot of conversation. However, there can be alignment. It can come in a bunch of different forms as long as we are trying to move away from an industry built on fee-for-service competition.

It does require a shared vision for how we move forward in regard to multi-payer alignment. But APM alignment does not mean a lack of competitive differentiation either. There are definitely things our members talk about that are competitive elements to their value-based care strategies. But there is also increasingly a recognition of areas where competition shouldn't rule, and that both payers and providers would be better served by trying to align key methodologies that include risk adjustment and patient attribution methodologies.

Next slide. So with that, I look

forward to the conversation. And I'll turn it back to our moderator.

VICE CHAIR HARDIN: Thank you so much, Jeff. Next we have Clare Wirth, the Director of Value-Based Care Research at the Advisory Board. Please begin.

MS. WIRTH: All right. Thank you. Good morning, everyone, and thank you for having me. If we can flip to the next slide, it should just be a title slide.

For those of you who are less familiar with the Advisory Board, we are a health care research firm based out of Washington, D.C., that has been around for about 40 years now. And I'm just delighted to share some of our latest research with all of you.

This year my team has been focused on commercial risk so in the next ten minutes or so, we are going to lift off and move from our Medicare focus and into commercial, how it has evolved, its future, and some key differences in terms of the care model and population health management approach from Medicare.

So I want to stay on this slide for just a moment and get to the punch line first.

Commercial risk in many ways will decide the fate of value-based care. And our contention at Advisory Board, and I'm sure many of you all, is that this movement towards value must keep going. So I know a lot of folks are skeptical given the pace of change that we've had to date. This does beg the question of commercial risk.

Medicare has had clear progression and a clear path towards value. And for commercial, I think, it's not a matter of if or when, but it's really a matter of how. And we see two main possible scenarios playing out for the future in commercial risk.

The first one is an industry-wide reimbursement standard in which we see both Medicare and commercial plans really aligning. So we would seize the commercial landscape, follow Medicare's lead in this way, especially Medicare Advantage, with that population-level type of payment structure and continuing along that sort of glide to risk.

The alternative scenario, the scenario below that, that uses a completely different game plan from Medicare. So really we see a split in which the commercial sector would anchor the payment approaches around

bundles, around episodes, focused on really consumer steerage.

And so what this means long-term is that we would need all industry players to operate in a hybrid world with split incentives, much like what we have today but in a more total cost of care ambition. Now there are two key themes that I want to get out here.

First is that each of these has trade-offs in terms of what each player can gain, how hard it is to accomplish, and where we net out as a whole in terms of an industry. And it is a question of which path we do achieve more savings, more efficiencies, either by mirroring the public approach or really tailoring the model to commercial needs.

And, of course, there are various pain points that would be different in terms of the roadblocks and giving up certain revenue streams.

The trade-off is one key theme.

The other key theme I want you to hear is agency. So in commercial, payers, providers, other support participants, they are the ones really designing these types of models for themselves, which is why, if we can go to the next slide here, that is why we have not

seen one clear roadmap in commercial.

And we've mostly seen various experimentation. There has been a bunch of fits and starts in commercial risk. Some are still going. Some have failed and disbanded. So I have a few examples here.

So, for example, Boeing and Providence, that fell apart. The finances didn't quite work there. Haven, we certainly saw some big splashy headlines but ultimately not necessarily the right timing, incentives, market power, or true collaboration.

Some that are continuing to go. Cigna still has a big emphasis on commercial, as well as at the state level Blue Cross/Blue Shield North Carolina, that is a really great example of a statewide effort to keep things moving.

Some of you all may look at this and think, well, we've had a lot of experimentation on the Medicare side, too, and that's, of course, right. As you all know, CMS has been experimenting and it's changing course, redefining, ditching models, encouraging the growth of the ones that have worked.

But generally, there is a roadmap to follow to inch us toward population-based risk

and that's something that's continuously pushing in that direction. In Medicare, we don't have that same consistency because there's not that central governing body.

And so these models -- the models that have continued what we've seen of organizations that have been successful in the commercial risk space, they have a heavy emphasis on that up-front investment that's necessary and have focused and are really keen on what their partner's needs are and actually compromising with one another. And those that have failed really have not had that same emphasis.

Another key difference in the commercial space is, of course, the role of employers here. Employers have to agree to these trade-offs as well in terms of what sacrifices they are willing to make, especially ones that their employees will tolerate when it comes to certain steerage, and we've seen focus on the Centers of Excellence but of course not much further.

If we can move to the next slide here, the role of employers is not the only key difference in the commercial risk landscape. In fact, the day-to-day clinical model can be

quite different from what we've worked in the senior population.

So, for example, in commercial, we do tend to have younger, healthier patients. So a lot of what you need to do in commercial risk is keep people, prevent people, from developing those conditions in the first place, making sure they don't overuse care when they need it and, of course, there is the focus on primary care utilization and condition management. Of course, in Medicare, there is a far greater emphasis on multiple chronic condition managing across multiple different specialists in addition to primary care.

In commercial, it is, of course, about whenever a patient does have a need, making sure you're getting them to the most cost-effective treatment options, providers, and site of care as quickly as possible.

And lastly, of course, we have the engagement of consumers. The commercial population certainly prefers lower cost as a big emphasis and preferred the convenience as well.

I'm going to move to the next slide. So after all of that and talking about the key differences of the population health approach,

it may sound like the industry should take a fundamentally different direction when it comes to commercial payments compared to Medicare. And it does beg the question of whether this commercial risk path is really all that viable.

But I want to remember here that we have two potential options, each with different trade-offs. So we have one where payers, providers, all the players involved here, compete to find these high-spend target areas and address partnerships on those. So, for example, identifying three to five core bundles in these high-cost areas, unique to commercial. So, for example, labor and delivery, and drive a majority of savings there.

And the flip side, of course, is that we can't have so many different bundles that providers are managing -- a bunch of different pieces here, and they're undermining their greater work rather than taking a holistic picture.

That said, though, it could really be narrowed and focus on the commercial patient's clinical needs and savings opportunities.

The other scenario here, diving a little bit deeper, moving towards what Medicare

is already doing, following a similar model, by definition is going to be more feasible for providers in terms of a day-to-day administrative basis.

But we're hearing more and more frequently that there is the complex quality metrics. I know that Jeff mentioned that before, that there is a lot of emphasis on how do we create some consistent quality metrics, but there is also some common processes that we could have included here with payers.

Ultimately, the industry does have to decide between having everyone follow a similar path as Medicare, which would be easier for providers, likely harder for employers to justify or pursue more narrowly scoped risk options in commercial. It is not necessarily clear which one that has got the savings and improvement for the broader industry in terms of what we can get behind.

I want to move to my next and final slide here. So I wanted to make you all aware that my team has done a lot of work here on this, and it's at advisory.com/vbc. The vast majority of what we publish this year is publicly available. So please feel free to dive into some of those resources.

That said, I do want to end on this message. I don't think there is any world in which there is no commercial risk whatsoever. But, of course, either path does come with challenges.

When I speak with plans, providers, like scientists, executives, all across the industry, one thing has become really clear, which is the risk -- excuse me, the journey to risk is as much of an adaptive challenge as it is a technical one.

And so some of the most progressive leaders in value-based care, certainly cited that they have fears. There are huge organizational cultural changes that have to be made in order to make progress. And so that tells me that this is very much of a choice that leaders can make and shape.

And so now is the time for providers, payers, and others to really dictate what that future is going to look like. And, of course, in terms of Medicare, but especially in commercial, it's a place where they have more agency. It's a place for them to play and have further control over what it is. And so ultimately the path that these leaders will take will decide whether the industry unites

around one industry-wide standard or remains split. Thank you.

VICE CHAIR HARDIN: Thank you so much, Clare. We want to thank each of you for sharing your very interesting and unique experiences.

We have some questions for all three of you to speak to. And then time permitting, Committee members will be able to ask questions, too.

So first of all, the first question I would like to ask is what specific kinds of payment model design features and financial incentives are most important for developing successful, total cost of care models? What does the evidence tell us about the effectiveness of these approaches? Jeff, would you start?

MR. MICKLOS: Sure, I'd be happy to. So I think we think of questions like this thematically to say what attracts, retains, and moves individuals to greater accountability?

And I think first and foremost, an appropriate investment in primary care has to be at the center of this. We certainly have advocated for an additional risk track in the Medicare Shared Savings Program for Medicare

populations, which could include a primary care capitation component on that.

We really think that the primary care models that have been tested at the CMS Innovation Center have been really kind of a mixed bag. But getting primary care, right, is critically important.

And then I think the on-ramps are really important as well. We want to make sure that organizations that can take on risk have access to those type of models. You know, but I definitely think that Clare makes some really important points about the viability in the commercial sector.

But I think on-ramps is really important. As I indicated in my opening remarks, I think the new proposal in the Medicare Shared Savings Program is a good idea in that way.

I think transparency and clarity of the model design and goals up front is really important. We need to be able to kind of have, you know, when people will be paid, how they will be evaluated on their performance clearly, and having access to appropriate data to trust to verify the numbers. Data and access to appropriate data continues to be a main kind of

complaint within our membership.

And then I will come back at least in the Medicare context and make a plea for some sort of mitigation strategy with regard to these retroactive benchmark adjustments.

You know, we view our relationship, our members' relationship, with CMS as a partnership. And we know CMS works hard to get the benchmarks right. But when they do need to correct them, there is significant financial consequences.

And as partners to get them in the program, we do think there should be some level of mitigation strategy to recognize kind of what could be a very material impact on providers, and we do believe that the agency has some authority to be able to mitigate that impact. So we would ask them to kind of think about that.

And then I think access to data to support the care delivery and being able to communicate effectively to the patients about what they are achieving is important. It may not go to a financial methodology or incentive, but there are appropriate programs out there that are holding specific providers accountable for how they are communicating with patients

and consumers. And that has been critically important so the consumers understand what's going on for them in the total cost of care arrangement and also to counter any concern that the use of the word value is actually a limitation and not a positive.

VICE CHAIR HARDIN: Thank you. Clare, how about from your perspective?

MS. WIRTH: Jeff hit on a bunch of things that came to mind for me as well. The one thing that I will go back to that he mentioned in his talk but didn't necessarily circle back there is the role of specialists in value-based care, so I certainly agree that primary care needs to become the anchoring model with anything in terms of population health management and the ease of what we can do and not just relying on the PCP, but the entire care team in that work, right? Making sure that APPs[27] are deployed as autonomously as possible by the state in which they operate in, having nurse care managers either circling around or virtually working with patients, ideally in person, and integrating behavioral health into primary care and pharmacists as

27 Alternative Payment Plans

well. A huge benefit there.

In addition to that, having specialists supporting primary care providers and managing these more complex patients, how do we create greater opportunities for collaboration? How do we make sure that specialists are sort of reverse referring patients back to primary care once they are well managed in specialty care? How do we make sure that they are available for one-off questions to make sure patients are getting the right treatment and manage well in primary care?

So that was the other thing that came to mind. And, of course, we've hit it a few times, but, how can we look for areas of consistent metrics across the areas and even thinking about what kind of consistency we can drive across these very different patient populations? What could we possibly keep consistent across commercial and Medicare?

VICE CHAIR HARDIN: Thank you, Clare. And Kristen, how about from your perspective?

MS. KRZYZEWSKI: Sure. Thank you. Yeah, so I have some very tactical recommendations. Just because of the way we're

living it, we're trying to get these providers from year to year to participate in this program, and what do we really worry about? What do our providers really worry about?

Well, number one is the benchmark. And there is no special message there, right? Everybody is worried about the benchmark. And the benchmark has to be sufficient or these providers are going to be scared and will stick to fee-for-service.

So we were very encouraged. And I like to think of it as CMS wrote a love letter to us with this physician fee schedule draft that came out, the proposed rule, especially to ACOs that are serving complex populations.

I mean, all ACOs, there are good things in there for all ACOs, but those of us who are serving complex populations were very happy to see the prior savings adjustment. Again, all ACOs would be happy about that. But we have a huge -- we're staring down the barrel of a huge ratchet at the end of our agreement period going into '24 based on the savings that I showed in my presentation.

If left as it currently is, we would substantially reduce our benchmark and a lot of the incentives to participate among our

providers would be eliminated off the bat. So by offering a prior savings adjustment, we applaud that. That's wonderful.

The unfortunate thing is, well, you need to think about complex populations when you design that adjustment because right now it's capped at five percent of the national fee-for-service expenditures, adjusted for each enrollment type.

Well, that's not risk-adjusted. So that cap is nearly meaningless to an ACO that serves -- our providers that serve a high-cost population. So we, of course, put these things in our comments.

So we applaud CMS, but we want them to take everything a step further and think through the impact on folks and ACOs and providers serving the highest-complex, highest-cost populations out there.

And, you know, we were certainly happy -- one way that they did it -- we think they did it really well was the negative regional adjustment cap that they are minimizing that. And then they are providing an offset to ACOs that serve a population that is highly complex or high-risk.

So that is one great way to say,

okay, we understand there is an interplay between efficiency and inefficient relative to regional performance. But you've got to factor in the risk of the population. And it may not be fully captured at the highest risk levels under the risk-adjustment methodology.

So, again, great things are happening. But take it a step further. The message is to always think through what are the incentives to ACOs that may be considered higher-cost than their regions but just due to the sheer population they are serving?

And one other thing that is critically important to growth in this program, is that five percent bonus on Part B billings and that incentive that will go away at the end of this performance year. That's payable in '24. We think that's a -- that really offsets the goals of trying to recruit providers into the program by letting that expire.

And we know that's not in CMS' hands. It requires Congressional activity and action, but we certainly are fully behind that being extended and creating an incentive.

And likewise, I know the last panel listening session talked about sort of penalties for folks who want to stay in fee-

for-service only and not participate in -- you know, and that may be one way again, if there are greater disparities between, if you participate in greater incentive and upside in folks participating in value-based care and APMs versus staying in fee-for-service, that your opportunities, financial opportunities, are going to weaken over time. Widening that disparity is also important to drive performance and participation in these programs. Thank you.

VICE CHAIR HARDIN: Thank you, Kristen. That's a perfect transition to our next question, which you started to address already, which is what payment methodology features are most important for managing the interrelationship between primary care and specialty care when designing population-based models?

If you can highlight any that are particularly important for high-cost, acutely ill patients that would be helpful. Kristen, if you would go first.

MS. KRZYZEWSKI: Yeah, sure. So I probably will be short in this area and let the others, Clare and Jeff, speak to this because our population, again, is really, the bulk of

the care delivery is through primary care in this setting.

And they live in a long-term care facility, it's nurse practitioners and the physicians that are seeing them and certainly then the staff of the facility that are there day-to-day. Of course, there is some coordination with specialists, but primary care is what we have to invest and invest more resources in in this setting.

And so I may not be fully answering your question, but for this population, we really want to see – have the leverage to offer a capitation to our participating primary care providers that recognizes the outsize role they play for this population in coordinating care.

So with that, I'll turn it back to you.

VICE CHAIR HARDIN: Thank you, Kristen. Jeff, how about from your perspective?

MR. MICKLOS: Well, I mean, I think Kristen continues to emphasize the importance of the advanced APM bonus payments. And the Task Force completely agrees.

I think that the financial incentive and the added payment to create that alignment

is critically important. And so something that needs to happen because if it doesn't get extended by Congress, we're going to be in a situation where it's going to be better for many providers to be back in MIPS[28]. And that's definitely moving backwards. And so that's an important point.

I think what we hear from accountable entity levels is their ability to engage their network providers really hinges upon them being able to reward them for their behavior.

And so more timely reconciliations of shared savings payments and things of that nature that can go to the entity level that can be distributed to individual providers more timely. A two-year lag period is a major challenge, especially for new providers that really you're trying to entice.

I think we had one remark recently about, you know, looking at clinical episode models, that it is hard to maybe engage a specialist in that way when they need to wait for that shared savings when they could really realize those funds just by doing a few

28 Merit-based Incentive Payment System

additional procedures.

So the more timely reconciliation around these payments, I think, is critically important.

Again, we did mention at the outset that the way that people think about engaging specialists probably also depends on who is leading the total cost of care model.

So we definitely hear within the Task Force membership that our health system-led ACOs, you know, have, you know, an easier way to think about how they manage both the clinical episode model and an ACO model and have very specific thoughts about how they could integrate that. And I'm sure that is true of multispecialty physician practices, too.

But as Kristen just indicated, you know, for many ACOs who really have been focused on that primary care piece, the strategies really continue to be challenging. And I think we probably need to see some innovation kind of beyond the Medicare space right now to understand that. And I do think that there is more discussion going on for other populations on that.

VICE CHAIR HARDIN: Thank you, Jeff.

Clare, how about from your perspective?

MS. WIRTH: From my perspective, when we did research on this last fall and we interviewed provider organizations, hospitals, hospices, health systems, and medical groups, they were pretty unclear with how they should be thinking about where to engage specialists in value-based care.

A lot of them had focused on primary care and hadn't yet gotten to the specialist area. And when we did that research, we really identified three main places to engage specialists.

So the first was how do we think about reducing low-value referrals? So creating some kind of referral consideration to keep more patients in primary care and/or thinking about how to maximize primary care access and capacity. So that was the first area.

The second was e-consult. This is an area folks had a lot of interest in. I know there is some reimbursement in this area, but perhaps an opportunity for more to provide that incentive so that specialists will answer the phone for PCPs and get that guidance back to them as quickly as possible in terms of next

steps for that patient.

And then the third area was referring patients back to primary care. So once they are well managed in specialty care, we see patients in that specialist's office for far beyond that and making sure specialists are able, they have the guidelines in place and the training to communicate to patients referring back to primary care.

So I know that middle one, the e-consults are an area for specific payment model changes. But those are the three opportunity areas that we gleaned from our research last year.

VICE CHAIR HARDIN: Very helpful. Thank you. Committee members, if you have a question, would you mind tipping your name tag? I want to get an idea of how many people may have questions. I think I'm going to go to those next. Angelo, would you like to go first?

DR. SINOPOLI: Yes. Thank you. So my first question is for Kristen. And first I want to applaud you for addressing the long-term care population. It sounds like you've got a great model in place.

I was just curious though, looking

at some of your early slides, you mentioned that you had 20,000 beneficiaries in 39 states. And when I do the math, that turns out to be about 500 patients per state and 11 patients per provider. So I'm just curious how you're engaging your providers, keeping them interested and activated since it is small populations.

MS. KRZYZEWSKI: Yeah, no, you're right. We are not even an inch deep really in this opportunity. There is so much more that can be done and so much more engagement to be had.

But first of all, this is a big transition for this population, right? This population, in a way, we're at the beginning days of value-based care for the providers serving this population. It might as well be 2013 or 2012 and not 2022.

So it's really going slow. It's talking about clearly the financial incentives, the portion of shared savings. Rewarding them really for the first time in what they are doing for this population because they oftentimes have just been the overlooked providers in this community.

So we are saying we see you. You

know, unlike maybe the ISNP that goes about working with the population that requires facility contracting, this is saying we need you, the primary care physician or a nurse practitioner in this setting, we see you. We are going to reward you for the role you play at long last.

And so it's communicating what value-based care, you know, 101 is all about, trying to find these providers in this setting, getting their attention and then also that five percent bonus. We cannot overstate the importance of that. That really is attractive. Because these providers don't just serve this population, they serve others. And if they can earn the five percent bonus through this vehicle, then that can be applied across the other populations they are serving.

So that has been a big reason that we have been able to garner their interest and participation in the program. Now once they are engaged, it is about sending them really on that pathway towards -- away from fee-for-service and the critical, again, basics, sharing the data.

They have never had any of this data. It is a big investment, getting them up

to speed, engaging with them on a monthly basis just so they understand the true performance of their population. So it's sort of ACO 101.

We, as I said, are back to 2012 days. But arming these providers with the information has been the key to change, as well as then continuing to support them with best practices and really engaging and sharing those best practices because we do have some big groups in that so they aren't, you know, equally disbursed.

We have small groups. We have big groups.

And trying to share those best practices from organization to organization and how we impact on medication management, the drive to de-prescribe for this population is very important so we're making inroads there, as well as the use of palliative care and advanced care planning.

So not rocket science, but it really is the blocking and tackling and giving these providers a voice and a view into the role and the important role that they do play.

DR. SINOPOLI: Thank you.

MS. KRZYZEWSKI: Sure.

VICE CHAIR HARDIN: Kristen, you really started to tap into another one of our

key questions, which I'd like to turn to Jeff and Clare. So when you think about different providers' different levels of readiness to move towards value-based payment, what do you think are the most important strategies for increasing provider participation?

How can we prepare providers to assume greater levels of financial risk and encourage investments in care delivery transformation? Clare, I'm going to turn that to you.

MS. WIRTH: The softball question. So this reminds me of some comments that I heard from Liz Fowler last fall that I think are really true, which is how do we recreate the sense of inevitability around the future of value-based care that has quite frankly been lost in the last five, six years, I want to say. When the ACA[29] came out, I do feel like there was this incredible focus and fire underneath executives across the country that, oh, if we don't do this, what is going to happen to us? And that sense of inevitability has really been lost.

So I think the clearest messages

29 Affordable Care Act

that can be sent around this is going to happen in the near-term, and we really are going to achieve, is going to be valuable.

The other thing is, of course, getting hospitals more onboard in some form or fashion. We talked a bit about penalties around their reimbursement. When I speak with independent medical groups, I think that they are pretty much understanding the future is value. Of course, they don't have to worry about the hospital revenue and losing that and demanding their own, excuse me, destroying their own demand in that regard. And so I think that would be the area that I would focus on.

VICE CHAIR HARDIN: And, Jeff, how about you?

MR. MICKLOS: Well, I just want to echo, first, Clare's point that, you know, the imperative for change has lessened. It certainly has. And I think it was starting to happen but probably exacerbated by the COVID experience.

I think it is interesting as we've gone over the last 18 months and had periodic conversations with our board about the impact of COVID, it actually shows that it should be -

- it actually should be a driver between more resilient opportunities when you are sharing risks between payers and providers.

You know, the providers didn't have the cash flow concerns that some that were not in those arrangements did. So they felt like they were on much, you know, greater footing. Of course, some of the payers within our membership who didn't have those type of advanced risk arrangements helped the providers out in other ways, but realized that was a stopgap measure and probably not a way to think about long-term sustainability and resilience. And so that's a theme that kind of continues to percolate here.

And then I think a new theme that people are grappling with, and it's kind of related, we have the inflation issue and the impact on business currently. That's clearly a clear and present danger.

But that is exacerbated by workforce shortages. And so there is that positive view about value that if you work smarter and more efficiently but through team-based care, you can address some of those workforce shortage issues, which are likely to grow and not kind of decrease over time.

I think it's also showing the changes of site of service, whether it's, you know, increased use of telehealth, some real hospital at home models that are very interested out there. So it is kind of the macro environment, I think, that's affecting that.

But I think it comes down to engagement of individual providers. You know, the ability for those who are new to it to kind of get that up-front per member per month care management fee gives them flexibility to think about practicing differently. So that changes their mindset a bit.

And I also think that, you know, good old peer-to-peer transparent, you know, evaluation across the team always seems to be a great driver. If you're not performing well versus your peer group, that always seems to be a good incentive to move in a positive direction.

And so I think some of those kind of still operational techniques in the beginning are important. But we do have to continue to reemphasize why this should still be the right direction for the system even if the moral imperative is not burning as bright in C-suites

these days.

VICE CHAIR HARDIN: Thank you.

MS. WIRTH: If I may, Jeff made me think of something. Jeff, I completely agree with everything you just said. One thing that I found interesting was after the pandemic, right after, even during, I heard from so many provider organizations, well, this is why we need to move to value. We have no fee-for-service reimbursement coming through the doors, and yet we're still getting our risk-based payment. And that has very much lessened over time.

In fact, I think that the lesson a lot of provider organizations took was the benefit of a hybrid model so that you have war time and peace time types of incentives so the value-based care reimbursement certainly helps during war time types of eras, but not to get rid of fee-for-service entirely so we can't rely on just that alone to be the propeller to value.

VICE CHAIR HARDIN: Kristen, did you want to add anything in addition?

MS. KRZYZEWSKI: Always, any opportunity. So, you know, as Clare and Jeff said, I mean, it's incentives, right? The

incentives, it's got to be more attractive appearing than fee-for-service, right? We've got to continue to move in the right direction to make sure that the incentives are sending folks and causing them to align with these value-based programs versus going back to fee-for-service and looking in MIPS, heaven forbid. Sorry. Let's not go back to MIPS, right? They like participating in APM and being excluded from MIPS, so incentives number one.

But, again, so much of what we have to say, and I think speaking for any ACO, any provider group serving complex populations, is CMS and CMMI needs to think about how the program that they're designing and the methods that they choose to deploy impact the ACOs serving complex populations.

You want more of these populations in the program. You want 100 percent of lives. Well, here are -- there are groups of lives that represent a disproportionate amount of the costs and expenditures.

And so let's make sure that everything we do, we think it through. Because the numbers, the numbers game are in for the traditional population, right? And so programs and policies are designed thinking with that in

mind and inadvertently could potentially hurt the groups that serve these highest-cost populations.

So it's in many different ways that we see sort of the nuances that get applied that hurt our types of providers and ACOs. And so, you know, we need to eliminate those.

And, again, I think CMS recognizes that, and they are trying to do things and offer programs that reward providers serving this. But let's just make sure we think through those incentives and the impacts.

And one last thing that I will speak to is just going back to sort of confusion. There is confusion among programs, high-needs populations, DCEs[30] and TIN overlap. And even just going through our last application cycle, I know there was feedback coming back through NAACOS, that trying to add new ACO participants through the MSSP program, we were getting hit with TIN overlaps, even if it was an MPI, and they participated long ago. There were unintended impacts, which are slowing the growth potentially in the MSSP program.

So providers are confused certainly

30 Direct Contracting Entities

in the space we see as they reach their -- they have outreach. There is prospective alignment only in DCE. There is retrospective in MSSP. It creates confusion. And while we applaud what -- there are positive things from ACO REACH. And we think 100 percent upside track and primary care capitation are really important to incorporate into MSSP.

We certainly like the idea of building on the chassis of MSSP and avoiding disruption and confusion among providers because that will slow the participation potentially down the road.

VICE CHAIR HARDIN: Wonderful.

MR. MICKLOS: If I may just add one more comment that I forgot to make. I think it's critically important for the PTAC. I'm sure many of them are aware of it.

I think the challenge in the Medicare space right now, or one of the challenges in the Medicare space, is how effective the Innovation Center can really be right now. You have a situation where as a business proposition, people are somewhat reticent to invest in those models if there is not going to necessarily be a favorable evaluation and an opportunity to scale that

model broadly.

So too many folks have invested money in models that have, you know, basically either ended after a time certain or have been continued in kind of a successor model that really doesn't have long-term success either.

And, you know, the one thing we talked about as a Task Force is in some ways the APMs are becoming a victim of their own success because they are ubiquitous now in a variety of different contexts, and it's really hard to find a comparison group.

And so I don't think that the chance of scaling a model out of CMS is getting any easier. If anything, it's getting harder. And so it's really important, at least in the Medicare context, that we think about MSSP as the platform for innovation on top of which we can layer the innovations that kind of come through the center. Because I do think fundamentally the construct that is in place with the Innovation Center is becoming more challenging for them every day.

VICE CHAIR HARDIN: That's a really interesting point. Lee, I'm going to turn it to you.

DR. MILLS: Great point, Jeff. And

that's actually kind of a nice segue. This question goes to Clare, but I would like the other two commenters' thoughts on it.

And I really appreciated your first slide, Clare, in focusing on risk. And I think I agree with you that probably after, you know, the ubiquitous pilots and all the many flavors through CMMI, it's what the commercial marketplace does with risk and value-based care that's going to decide the tipping point.

But I was a little bit struck and alarmed essentially by your described split between it's either going to be an industry-wide approach in risk methodology, or it's going to split, and commercial and public payers are going to go different ways in how to handle this risk.

You know, your last sentence, all industry players operate in a hybrid world with split incentives and processes to me seems like either the road to complete failure or complete fragmentation of the provider and hospital landscape into each -- everybody picks what they want to be experts in, and we have total fragmentation, right, which doesn't seem like a way forward for the country.

So I guess my two questions are,

first, what sort of time scale do you see that playing out over until we get to a tipping point where the path is decided, and/or what do you see as the key couple of influences that will help tip us to one side or the other in deciding what that path is going to be?

MS. WIRTH: Great questions, and thank you for summarizing that so well. I have quite a few thoughts. So your first question was around -- sorry. Can you say your first question again? I'm thinking of your second one there.

DR. MILLS: What is the time scale you see that playing out over?

MS. WIRTH: Yeah. So when we -- we had a whole bunch of interviews around this. One person said that the future of commercial risk is like playing the stock market or betting on the stock market and the future of that. I think it is highly variable and unpredictable. And in fact, when we've spoken with organizations, there doesn't seem to be any one clear direction of what they're trying to do.

So I could see a horizon of five to 10 years, and it's primarily driven from the employer market. So to get a little bit into

your next question of the key influences, something that is interesting is that employers are really frustrated right now.

When we interview employers, they are mad at the current state and how much they are spending on health care. That said, given the great resignation and all the forces that they are experiencing, their own type of workforce crisis, they are not really willing to take any big risks right now when it comes to their health care benefits and making any key changes.

And so I think what's causing the short-term, and why I don't think we'll see a ton of change in the next couple of years is the employer market being reticent to make any big changes to retain folks and attract folks. They certainly don't want health care to be the reason why folks won’t choose to stay with them or choose them as an employer. So I think the employer market is going to be a big driving force.

I think the other area that is interesting is the national health plans. When I talked to some of the national health plans, Cigna is very motivated when it comes to commercial risk. United Health Group has said

that value-based care is one of their top five priorities right now.

And so it will be interesting to see how much they can influence given their national scope, that said, of course in most markets, right, like, they are not making as big of an impact. So I think the health plan side is where we are seeing more pushes when it comes to commercial and less so on the provider side, the exceptions being the more progressive independent medical groups that are ready for this, and they want the consistency across their different patient sectors. Did I answer that fully, Lee?

VICE CHAIR HARDIN: And Walter?

DR. LIN: So I have a question for Kristen. And first, I just want to say congratulations on LTC ACO achieving the top per beneficiary savings in MSSP for two out of the last three years. That's really fantastic.

You know, you might know that we've been taking a journey along the population-based total cost of care models throughout this -- different aspects of these models throughout this year. And our prior public session back in June was around model considerations for care delivery around these total cost of care

models.

And I'm just wondering what your providers did that really helped LTC ACO achieve its per beneficiary savings. What kind of influences did your organization have, and what were the actions that really led to these savings?

And before you answer, I should just from a full disclosure standpoint say that I am especially interested in this answer because our practice is signed up to join LTC ACO starting January 1 of next year.

MS. KRZYZEWSKI: Wonderful. Glad to hear it. Welcome aboard. We'll begin onboarding momentarily. So, yeah, we, again, can't overstate the importance of the data sharing and meeting with providers.

First of all, what's been challenging is, before you even get to the cost of care and impacting the cost of care, is attribution. And attribution shouldn't be as challenging as it is. But we spend an inordinate amount of time with our providers. They know who the long-term care population is, right? They are in beds. We know who they are.

But getting the physician visit, and

if it's a nurse practitioner group that is delivering the primary care, getting them, you know, somehow working around this physician visit requirement. So we have a lot of activity. An inordinate amount of our value-based care resources are focused on how do we just actually work within the system to make sure that our primary care providers are recognized for the role that they have. So we spend a lot of time on that.

And so in that, there is a lot of encouragement of go see your patient, make sure you see your patient often. Make sure that care is being delivered, that annual wellness visit is being conducted, that the advanced care planning is happening.

So it's encouraging all the things, again, not rocket science. But just making sure -- we look at the data that the preventive care measures that we are measured by and we know are important, that that's happening, showing the provider in the group over the course of the year how they're progressing in all of these areas, not just from a cost perspective, attribution perspective, but then a quality of care perspective.

And so with all that said, that's a

lot of onboarding. I would say the first year of performance is really just orienting our providers on this whole. And then it's where do we go from here?

Once we understand the practice patterns and where folks are outliers from others, it's really digging down and focusing on, again, the use of palliative care, using the hospice care appropriately because for this population, we oftentimes see folks that are on hospice care for two or more years, longer than what the benefit was intended for.

And so it's using palliative care. It's having those discussions and supporting so we have resources. We're not trying to sell ACO on this call. But supporting our providers with those palliative care.

If they don't have the time, a lot of providers will say, I don't have the time to have those advanced care planning discussions. I know they're important, but I just don't have the time. And so supplementing resources and subsidizing resources for our providers so that they can get that work done if it's supplementing and they're open to it, with additional providers to go in and have some of those discussions that they are otherwise not

having.

But then, again, there is drive to de-prescribe, that we're working on medication management. So it's really at the end of the day trying to help prevent avoidable hospitalizations.

I mean, there is so many low-hanging fruit as you know in this population, if we just pay attention and reward our providers for paying attention to the total cost of care and being available through telehealth, supplementing with telehealth, so that around the clock, there is someone to call and someone available to make decisions about what is in the best interest of the beneficiary, and it is not necessarily oftentimes going to the hospital and going to the emergency room and going through that before they come back to the facility.

So, I will say it again. It's not rocket science, but it really is in execution, right? And, as you know, on the front line delivering care to this population, it's the day-to-day and being with the patient at the right time. And we are just trying to arm our providers with -- the intent of the program, the information to make better clinical

decisions for their patients.

VICE CHAIR HARDIN: And Angelo?

DR. SINOPOLI: Thank you. I know we're short on time. So this is a question based on my previous experiences, and it's aimed mainly at Clare and Jeff, I guess.

So in my experience managing Medicare patients, most of the benefit in value-based areas are due to utilization. It's managing and identifying those patients with chronic diseases, preventing progression, keeping them out of the ER[31], keeping readmissions low, keeping them out of the long-term care facilities, and shortening their stays in long-term care, et cetera, and that's the day-to-day approach to those patients.

For the commercial population, we saw just the opposite. And so although there are some employers whose employees may tend to reflect the Medicare population a little bit, most of the employers that we dealt with and the commercial products we dealt with are 80 to 90 percent focused on price, site of service, and hard UM[32] around procedures.

And so my question is, does the

31 Emergency room
32 Utilization management

commercial market care model really reflect that it's needed in the Medicare market? And is there really under this probably 80/20 rule here, where 20 percent of what we do for Medicare applies to the commercial and vice versa?

Those are really, in my experience, two very different models, two different approaches to negotiations at the table, two different kinds of negotiations. So I'm interested in your views about the expectations that those move along the path of value-based care hand-in-hand are really realistic.

MS. WIRTH: I'm happy to go first if you'd like.

MR. MICKLOS: Sure.

MS. WIRTH: So, Angelo, I think this is going to be the critical question that we need to answer when it comes to the future of value-based care. And my thought is that it is going to happen differently in different markets depending on the balance of populations and the level of partnership between plans and providers.

So a crucial element of making this work is going to be having plans and providers partner around what type of compromises they

can make in different patient populations.

That is also why what I presented, those two different scenarios, really are the futures that we expect could unravel in these different markets and why in the commercial space we thought about, there could be three to five core bundles that you focus on that would achieve some of those big cost reduction areas that you're talking about.

And so there would still be a focus on population health access for everybody, excuse me, primary access for everybody. But you would have things focused on certain therapeutic procedures for commercial, certainly something around chemotherapy is a huge cost driver in that patient population, so intentional efforts around there.

And then labor and delivery was another big cost area that we saw as an opportunity. And so could you have a world where you are focusing very specifically for commercial and still getting some of the broader benefits enough for everybody?

And so you have some of the Medicare model where you're not discriminating against commercial, who are certainly benefitting from some of that additional preventive care. But

you have intentional focus areas just like you would for Medicare.

So, I mean, we're always going to -- in population health management, we know one size doesn't fit all. And so to some degree in either direction, there is going to be some tailoring. But I think the balance is going to be challenging.

Angelo, I don't think there is an answer to your question besides that we're going to have to figure it out as we go. Because in my opinion, the real tension that we're going to feel in value-based care is across the next five to 10 years.

MR. MICKLOS: So, Dr. Sinopoli, I agree with what Clare said. And I accept your premise. I agree with your premise to the question.

I think what we are talking about are those areas where we think there is the greatest kind of overlap and impact. So primary care behavioral health integration, really important for all populations, especially coming out of the pandemic experience. And so there is an area that I think people are increasingly talking about.

I think, you know, in my view having

been in this role for seven plus years, I think we're seeing greater payer readiness on the commercial side. And so there is also -- you know, and one thing that we promoted on the Task Force is that Medicare Advantage provides a very flexible platform to be able to kind of advance value-based care, too.

And what we're hearing increasingly from the payers is as they get into MA and maybe they get into Medicaid Managed Care and they're obvious doing commercial, they're having, you know, very important conversations about what are those areas where you could have the most impact?

But, you know, as an overall proposition, no. The populations are different, and they create different areas. I also think it's going to be very interesting to see where the commercial payers draw the line on telehealth, access to telehealth, post-public health emergency. You know, Medicare will boomerang back to a very antiquated statute, which is going to be problematic for a lot of people. But there are very serious ongoing conversations about telehealth and changing sites of service even more so than I think probably prior to that.

So those are some areas where I know there is at least thought that there could be approaches that would apply across populations.

DR. SINOPOLI: Thank you.

VICE CHAIR HARDIN: Kristen, Clare, and Jeff, thank you so much for a very rich discussion. We're going to be breaking now for lunch until 1:30 p.m. Eastern, but we want to invite you to join us for the rest of the day virtually.

We really appreciate your time and perspectives. It was a very interesting dialogue. And we look forward to seeing everyone at 1:30 p.m. Eastern. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:45 p.m. and resumed at 1:30 p.m.)

*** Panel Discussion on Operational Considerations and Financial Incentives Related to Successful Implementing of PB-TCOC Models**

CHAIR CASALE: So, I'm excited to kick off our afternoon panel. At this time, I'll ask our panelists to go ahead and turn on the video if you haven't already.

We've invited a variety of esteemed experts from across the country who represent

many points of view.

We wanted to discuss payment considerations and financial incentives related to population-based total cost of care models, including how to improve the coordination between primary care and specialty care.

PTAC members, you'll have an opportunity to ask our guests follow-up questions as we go. The full biographies of our panelists can be found on the ASPE PTAC website along with other materials for today's meeting.

I'll briefly introduce our guests and their current organizations. First, we have Dr. Alice Chen, who is associate professor of public policy at the University of Southern California.

Maryellen Guinan is a policy manager joining us from America's Essential Hospitals. Next we have Kathleen Holt, who is the Associate Director at the Center for Medicare Advocacy. Greg Poulson joins us from Intermountain Healthcare, where he is the Senior Vice President of Policy.

And lastly, we have Katie Wunderlich, the Executive Director of the Maryland Health Services Cost Review

Commission. Let's get started.

For our first question, 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? Maryellen, I'm going to start with you.

MS. GUINAN: Sure, thank you to the PTAC for including us in today's important discussion. For those of you who are not as familiar with us, America's Essential Hospitals, we are an association and champion for safety-net hospitals dedicated to equitable high-quality care for all.

And that includes those who face social and financial barriers to care.

Just to give a context for my comments, essential hospitals and our members really shoulder a disproportionate share of the nation's uncompensated care, so keeping that in mind with three-quarters of our patients being uninsured or covered by Medicaid or Medicare.

And certainly, our members and hospitals largely understand and acknowledge, I think, the potential benefits of value-based

care in terms of improved health and reducing the effects and incidents of chronic disease, that's something certainly important for the populations served by Essential Hospitals.

And of course, lowering overall cost to the health care system.

I think it was touched upon earlier today, as well as that we saw additionally that organizations who are participating in value-based payment models also benefitted from the flexibility of those models to adapt care models to their patients' needs and circumstances during the COVID-19 pandemic. And so given the benefits of value-based care to patients, providers, payers, and really society as a whole, it's really critical, and that's why I'm glad we're having the conversation, to have a broad array of stakeholders participate in value-based payment reforms, particularly those who may not have been participating as robustly in the past. That is, providers that serve low-income, medically complex, marginalized, and underrepresented communities.

So, just in terms of your question, I think there are a few areas in terms of just improving the fact that care is very fragmented

right now under fee-for-service in terms of paying services piecemeal.

So, I would say there's a clear benefit from having a multidisciplinary care team, and the note there I would say is the importance of within that team, there's embedded not only the clinical components but also social workers, community health workers, and others in that care team, so that we really are driving at value from a perspective of not only efficiencies, but also equity.

I think there's also a need obviously to identify avoidable spending in terms of the specific types of services that could be reduced, but obviously without harm to the patient.

I think the issue and complexity here is in terms of identifying which types of services and the amounts of spending that should be avoided.

Inevitably, this will differ in terms of different patients, different conditions, and different providers.

And it's also something that undoubtedly will change over time as we have new technologies that come into place and whatnot. So, just something to keep in mind

there.

And then I'll just finally say I think funding and adequate funding is particularly important in terms of incentivizing certain providers and really driving at value.

I know we'll probably get into the specifics of design of models and perhaps up-front funding, but right now I'm more talking in terms of adequate funding for high-value services that have the potential to reduce avoidable spending.

For example, non-medical services like transportation to and from outpatient sites for follow-up care, or the screening for social determinants of health and subsequent referral process that's often resource-intensive and undertaken a lot of times by those community health workers that are part of the care team. But the reimbursement structures right now are not really adequate or there at all for those components of the care team.

And so certainly, providing that adequate funding for those services would be critical in terms of incentivizing these models.

I'll stop there and turn it over to the other members.

CHAIR CASALE: Thanks, Maryellen. Kathleen?

MS. HOLT: Thank you, and thank you for including me today. I am Kathleen Holt. I am an attorney and Associate Director at the Center for Medicare Advocacy.

We are a national nonprofit law firm dedicated to helping people get access to Medicare benefits and to maintaining the Medicare program.

I would suggest that a provider-supported wellness journey from birth to death could help maintain health, as well as grow trust relationships with practitioners, provide a baseline for continuous health care oversight, and presumably avoid more costly health care interventions later.

But without an aging wellness bridge between childhood pediatric checkups and age 65, to which many people don't have access or don't feel the need to access health care, many patients now arrive at Medicare age viewing health care providers as harbingers of aging diagnoses doom.

If patients haven't had continuous

meaningful experiences with the health care system throughout their lives instead of deferring necessary health care services, costly health care must then be addressed by Medicare coverage.

Individuals may have also developed an experiential and cultural distance from many years without relating to health care providers. To address a lack of treatment and trust disparities, new models should be flexible enough to bring more Medicare-covered health care to where and with whom patients' lives are centered, with the exception of, of course, for necessary critical care or required higher-technology interventions.

Patient-centered care involving skilled practitioners and trained aides should also include, with the patient's consent, broader-based trusted members of a patient's own community, including counselors, social workers, faith leaders, advocates, family, and friends.

Whether a patient lives alone, with a family, or in community with others, health care providers, including primary care practitioners and specialists, may develop care

plans with the patient, but achieving consistent longer-term care plan success with quality results will require coordination with providers, and this broader-based community health care implementation team who will assist in and hold each other accountable for attaining quality health care.

CHAIR CASALE: Thank you, Kathleen. Katie?

MS. WUNDERLICH: Good afternoon, everyone, and thank you very much for having me here today and participating on this roundtable discussion about value-based care arrangements and how we can continue to further their application.

My name again is Katie Wunderlich. I'm the Executive Director of the Maryland Health Services Cost Review Commission. And I think part of what I'm bringing today to this panel discussion is from a regulator's point of view.

So, just as way of background, the Health Services Cost Review Commission is a regulatory agency that sets primarily hospital rates but is also tasked with helping to develop and shape health care reform, both delivery reform and payment reform in the State

of Maryland.

And in the State of Maryland under our total cost of care model, we're tasked at a very global level looking at population-based budgets and population-based ways to address chronic conditions and utilization.

Our physicians, though, are on a fee-for-service structure, and so we have to develop voluntary programs that can bring in the physicians into value-based care arrangements.

It's really important and imperative and because our physicians can't engage on the national programs that we put together, what is meaningful and useful for physicians, specialists in Maryland.

We have one particular bundled payment program that really is structured for Maryland specialists.

In addition to selecting episodes for those bundled payments, providers are also asked to name what kinds of interventions they will deploy to reduce cost in those.

And of course, those are interventions that not only control the cost but also improve the quality of care delivered, the quality of outcomes, health outcomes, and

patient outcomes.

And so they can be around clinical care redesign and quality improvement, including medication reconciliation, standardized evidence-based protocols that are implemented for discharge planning and follow-up care, elimination of duplicative potentially avoidable complications, or low-value services.

Our providers also look at interventions around beneficiary and caregiver engagement because we know it is so important to engage patients and their families as we are looking to address value and improve health outcomes.

For instance, through patient education and shared decision-making, pre-admission, and post-discharge, implementing health literacy practices for patients and their family.

Another broad category is care coordination and care transition; a few panelists have touched on the importance of having interdisciplinary team meetings that address a patient's needs, progress, and situation; assigning a care manager; and enhancing the coordination of care as that patient goes across care settings, and then of

course, selecting the most cost-efficient and highest quality of care to deliver care for those patients.

And so from a regulator's point of view, we really do try to structure those programs so that physicians and specialists can enroll and engage in it to provide the right kind of infrastructure, data infrastructure, that they can use to support the goals of that value-based care arrangement.

And then also to the extent possible, align multi-payers, and so we have a Medicare program, we want to as best as possible align with other insurance programs that other insurers have so that it can maximize the physicians' efforts across their entire patient panel as opposed to just their Medicare patients.

Because we are of course looking at trying to improve health across the board. So, those are just a couple thoughts I had in terms of data, interventions, multi-payer alignment.

CHAIR CASALE: Thank you, Katie. Alice?

DR. CHEN: Hi, I'm Alice Chen. As you guys have heard, I am an associate professor at the University of Southern

California, and it's really a pleasure to be part of this panel, so thank you for having me.

I'm going to address this question from an academic perspective, and I think it's important to take stock of what we know that has worked.

And I'm going to focus first on the largest advanced payment models that we have, which are Accountable Care Organizations.

Research has shown that the Medicare Shared Savings Program ACOs have generated on average gross savings of about two to three percent. And the savings rates are higher among physician-led ACOs than other ACO constructs.

Physician-led ACOs have savings of about three to five percent per year. And we have also seen savings among programs at just Blue Cross Blue Shield's commercial ACOs, generating savings rates of about 3.4 percent.

So, it's pretty clear that there are savings that occur from these ACO constructs. As you've heard today already, these savings have been low, especially when you take into account the bonuses that are paid out of these models.

But even looking at the net savings,

having accounted for those bonuses, some of the early ACO models and other models have continued to generate cost savings.

The other important component here is quality of care, of course, and it appears that quality of care has not changed for the most part, neither gotten better nor gotten worse.

There's a few pieces of evidence out there showing there's some metrics of patient experience that might have improved, but it is an area that we'd hope to see bigger changes in terms of quality.

There are two other models I want to mention in addition to these ACO models, and the first is the episode-based payments, as Katie touched on. In Maryland, they're bundled payments.

The Medicare Comprehensive Joint Replacement Program is arguably the most successful bundled payment experiment in Medicare, generating on average three percent savings.

My own research shows that providers participating in these Medicare Comprehensive Joint Replacement Programs have changed their behavior also for not just their traditional

Medicare beneficiaries but also their Medicare Advantage beneficiaries and their commercially insured beneficiaries.

So, there's spill-overs that are created within the Medicare programs that can be realized to generate even larger savings. And in the commercial space, there has also been significant experiment with episode-based payments.

One study shows a 10 percent increase in savings across a couple different areas of care. While the efficacy of episode-based payments are really limited to certain disease areas, I think they can co-exist with a broader population-based ACO-type model.

And the last point I just want to touch on somewhat quickly is just capitation. We know that the literature tells us that Medicare Advantage saves on average 10 percent in cost relative to traditional Medicare.

Capitation obviously has no incentives for improvements in quality but again, capitated payments can be incorporated into something like an ACO model.

To summarize, I think the research that we have or the academic research shows that we need to continue moving towards a

multi-track population payment-based model, where providers are delegated financial risk.

And by putting risk and accountability to the providers, you're leaving accountability to people who are best positioned to judge what is high-value, what is low-value, and to be able to configure the delivery system to support higher-value care.

CHAIR CASALE: Thank you, Alice. Greg?

MR. POULSEN: Thanks for the opportunity to be with you all. As mentioned, I'm from Intermountain Healthcare. We're a fairly large, integrated health system I think mostly in the mountain West.

The thing that I guess I should mention is that we're about half prepaid at this point for the care that we provide, so we live in both of those worlds. I can tell you which one we'd rather live in, absolutely, it's the prepaid.

And we view pre-payment or capitation, if you will, as freedom. It's not risk, it's an opportunity to provide better care for people that we're able to serve.

So, with that in mind, I think to the question at hand, group pre-payment is we

think by far the most effective and has the greatest dramatic ability to improve both quality and cost.

Alice mentioned that the results so far are limited at least in what we're seeing in the current programs. We'd wholeheartedly agree with that, but we think that part of that is ultimately, the incentives need to reach provider organizations.

Many times it gets stuck today in payer organizations. Medicare Advantage, for example, the vast majority of Medicare, when it reaches the provider organizations, is fee-for-service.

It is not a population incentive, that hangs up, if you will, at the carrier level, the payer level. So, when it does reach the provider organizations, we think there's an opportunity for huge improvements.

And although there isn't a direct incentive for quality improvement, we think that the indirect incentive to keep people healthier, which is dramatically less expensive to care for, is profound.

Historically, exceptional groups have demonstrated that capitated payment can lead to huge improvements, both in cost and

quality. Unfortunately, those really, really successful, or at least some of those really, really successful organizations became part of larger organizations and both the systems and the culture that made them possible-I'm thinking of places like Healthcare Partners, Care More, Well Med-really a lot of the magic that was there was dissipated, and I think that's unfortunate.

Because I think if we're willing to go back and look at history, we can find examples where real dramatic improvements were made.

I think in this case and I think there are going to be questions later on that focus on this more directly, but thinking of primary care as an entity is frequently a mistake for the simple reason that care today effectively provided is clearly a team sport.

We see dramatically different outcomes associated with care when whole teams are involved. All of the folks who spoke prior to me mentioned the importance of engaging in the multidisciplinary approach to care management and care practice.

And also, the fact that in many, many instances today, it's becoming ambiguous

where one specialty ends and another begins, and technology is making those lines blurrier and blurrier through telehealth and through other capabilities that we'll have.

So, I think that my key point, providing accountability requires both culture and systems, and it requires organization to make that happen.

And one of the things that I think we're going to see is necessary is increased organization overtime, and we'll come back to that later. So, thanks for the opportunity to be with you all.

CHAIR CASALE: Thank you. Before we move to the next question, I just want to open it up to the Committee if you have specific questions related to this topic. Larry?

DR. KOSINSKI: I have one question for Alice. You made a statement that episode-based programs can coexist inside ACOs. Give me some granularity on that.

DR. CHEN: Thanks, Larry, for that question. It is a challenging question, I will say, and I think people are struggling with exactly how they coexist. But I think there are certain things that need to be identified.

When do episode-based payments work,

when do they not? Clearly, they work for certain things but not all things.

And then I think one wants to think about whether or not providers in an ACO have incentives or continued incentives to refer patients to episode-based providers if there are two different tracks of payments, one for the episode and one for the ACO.

As we currently have it, ACOs who are also providing episode-based payments will get their episode-based payment counted into their ACO spending, and episode-based providers will also benefit from that payment savings that they might reach from the bundled incentives they have.

That's one broad picture of how they might be able to coexist. I think there's certain things one needs to pay attention to. ACOs should be accountable for managing patients with multiple chronic conditions.

And it's a challenging population to take care of.

You don't want the episode-based payments to focus specifically on chronic conditions, maybe one or two, that would then take away incentives to coordinate across multiple chronic conditions.

So, that's all to say there is a way in which carve-outs can be made for episode-based payments, but there needs to be more thought in thinking about exactly which episode-based payments to include and how one would incorporate the payments across both kinds of schemes.

DR. KOSINSKI: One follow-up on that. Instead of carving out, how about nesting them in?

DR. CHEN: Absolutely, I'm also glad that you mentioned that. Nesting them in is also one definite incentive here.

I think the one thing I would mention here is you want to make sure that ACOs have an incentive to select or contract with more efficient providers.

And the contracts within ACOs themselves guide or incentivize ACOs to naturally do that already.

So, nesting the episode-based payments into the ACO-based payments fits well within the guidelines of making sure ACOs continue to seek out more efficient providers.

CHAIR CASALE: Jennifer?

DR. WILER: Thanks to each of our panelists for being here today.

My question is for Katie. Katie, you're leading essentially on behalf of the nation one of the largest pilots around total cost of care and have done so for a long period of time.

I'm curious if you could talk a little bit about unintended consequences of this approach, and what you all have seen, one, in terms of what those unintended consequences are, and then two, how to mitigate that.

MS. WUNDERLICH: Thank you for that question, and we have been under our global budget model that we've had in place since 2014, and in some parts of our state since 2010 have put hospitals under global budgets.

So, providing those financial incentives to reduce utilization. We do look for unintended consequences. One of the first and foremost ways that we try to make sure that we root out negative unintended consequences is through our quality programs.

And so we embed all quality payer programs around readmissions, complications, and patient satisfaction, QBR[33]. And so that's one of the ways in addition to the financial

33 Quality-Based Reimbursement

incentives of finding the most cost-efficient setting to provide care.

That does not mean that it is withholding care or restricting care to poor patient outcomes.

So, that's the first and foremost way we look at and protect the patients and the population against negative unintended consequences, is to make sure we have rigorous all-payer quality pay-for-performance programs.

And the second way, the other part of the unintended consequences I think is to the extent that an organization, a health system, is able to better manage chronic conditions to reduce the need for high-cost acute care services by putting things upstream.

Those are all very good measures, but to the extent that a hospital is guaranteed a population-based budget and population-based revenue without having to deliver those services in the inpatient side, they can accrue retained savings, so to speak, or additional health care dollars.

And what we're going through right now is making sure those health care dollars that are accrued because of lower utilization are deployed in the most effective way to

continue to support patient access, to continue to address chronic conditions and improve population health so that we not only improve the health of the population, but we continue to drive down the cost for the entire delivery system.

And so we've been at this for a while, since 2014, but really not that long when you think about it.

So, we are still understanding where the pitfalls are, understanding how we can make sure that health care resources and health care dollars that are provided on a population-based reimbursement system are not only driving down utilization and down some of those cost measures, but are also making sure to maintain or improve quality, both the quality of services and health outcomes for Marylanders.

CHAIR CASALE: Chinni?

DR. PULLURU: This is for Gregory. You had mentioned that about half of what you guys do now is pre-payment and spoke about a group pre-payment that then translates to getting down to the provider level.

And you had advocated for a higher provider level.

Can you speak to how you, one, make

that transition, but also when you look at the payment methodology out there, it's retrospective, often a long time after the initial investment is required, or the provider behavior need to be incented.

So, how did you manage that? And then if you had to speak to policy to govern that, how would you craft policy to govern that payment methodology?

MR. POULSEN: Thanks, that's a great question. I should be very, very clear, what I think is essential is that the incentive to the provider organization is there. In fact, reaching to the individual providers is maybe not the same thing.

In some organizations they attempt to do that, in others they do not.

Irrespective of that, I think the key is to have the culture of the organization transformed so that it focuses on keeping people as healthy as possible for the lowest as possible cost.

Organizations are good at that, they're good at many things. And what they focus on, what they talk about, the key performance indicators that they track, the goals they set, the year-end discussion of

performance, all of those things are incredibly relevant.

So, contrast two organizations, one of which is prepaid, when all of those KPIs[34] are around, how healthy are we keeping people?

We're looking at their whole lives as opposed to their specific episodes that are associated with it, and we're looking at the costs associated with that.

In a fee-for-service world, those kinds of discussions don't tend to have a natural occurrence. Instead, what's talked about is are revenues up, how many surgeries were we able to do, how many people did we see in our emergency room?

And those are all positive things when they occur. In an organization that is focused on pre-payment, it's how many did we avoid? How many surgeries were we able to prevent?

How many ER visits were we able to avoid because people were able to be seen in primary care settings or on telehealth, or they're maintaining their medications because of appropriate care management so they never

34 Key performance indicators

had a crisis.

It's not really, in my view, essential, and in fact, in many cases it's not even useful to have the providers individually incentivized financially, but rather, that the organization and its culture becomes coordinated around that.

And I think as we look at the organizations that have been most focused on this in the past and in the present, whether it's Kaiser or Geisinger or Intermountain, by and large, we don't have incentives that reach the individual, at least not in a very, very direct way.

And there are some examples from the late 1980s, early 1990s where those incentives became perverse. And so we discourage the idea of an individual physician, for example, being incentivized in a way that might encourage them to withhold care.

Rather, we think that's the role of the organization. So, hopefully that was helpful. Did I cover your question appropriately?

DR. PULLURU: You did.

CHAIR CASALE: Lauran?

VICE CHAIR HARDIN: This is a

question for the group overall and definitely to Greg and Katie as well. As you see the Administration's focus on equity and social determinants of health, and nationally as we're starting to understand the importance of community-based organization relationships and other networks to actually achieve the outcomes with the clients we're serving, how do you see payment shifting?

Right now we're looking at incentives going to provider organizations or providers, but what do you see coming as the importance of those equity-focused social determinant of health organizations emerge as key partners in achieving the outcomes?

MS. WUNDERLICH: I can take a stab at that. In Maryland and under our structure, a lot of the care and the outreach happens from hospitals.

When we put forward initiatives to focus on behavioral health or diabetes or other chronic conditions facing Marylanders that have been long-standing health disparities, we've been trying to work at this for the last 30 years, some of these maternal child health disparities, diabetes, others.

But as we're looking at how are we

effectively communicating and connecting with the community so that at the on the ground level, we can improve health and improve those disparities.

In Maryland, a lot of that goes through the hospitals, and so we're trying to make sure that as a global budget payment goes to a hospital and as we have special funds available for hospitals for chronic disease management, that there's a requirement and expectation that they will meaningfully partner with their community-based organizations.

During COVID-19, we had a community vaccination program that we were able to free up global budget dollars to do community-based vaccination work.

And it really required hospitals to work with their faith-based organizations, with their community centers, with primary care and FQHCs[35] to reach patients on the ground.

And that really is the way that I think we can on a long-lasting basis affect chronic disease management in connecting with patients on a granular and on-the-street level.

MR. POULSEN: If I could jump in and

35 Federally Qualified Health Centers

just add to that, I agree with everything Katie said and what she talked about is at a state level, what can be done.

Individual organizations, if given the correct incentives, which I think prepayment is, have a remarkable opportunity and commitment. And I think they've got a really, really good track record of focusing on people where they live.

The challenges that are faced by individuals vary, they vary both across demographic types and within demographic types. And the key is to identify what is most relevant to help each individual live the healthiest life that she or he can and bring those resources to bear.

And it turns out that's good not only for individuals in maximizing the health, it's also very, very good from a financial perspective because you mitigate all kinds of down-wind clinical problems that cost a lot of money.

And so whether it's going into, in the case of my own organization, a huge focus on for instance prenatal care, which is going to vary hugely depending on the type of population.

We have immigrant populations and refugee populations who have very, very different expectations for what constitutes good prenatal care, and being able to meet them where they live and be able to provide the services that will maximize the likelihood that they'll have a healthy infant is enormously beneficial to them, to their baby, and from a financial perspective.

This is one of those wonderful, rare examples, and it's not just that one, it covers people with diabetes, it covers people with asthma, it covers people in unsafe living conditions.

It's seniors with homes that pose risks for falls and other things, all of those things, the mitigation tends to both help the people and be less expensive.

So, that's why I am so convinced that we are going down a path towards prepayment that will yield results in equity, as well as in cost and quality savings for the population at large.

MS. GUINAN: If I may, can I just jump in on the equity side? Because I do appreciate you raising that and I appreciate also the mention earlier today on the vision

and culture, strongly emphasizing equity and eradicating disparities.

I think in terms of the responsibility, the community partners really are key and whether that's a shared accountability that's built into a model is something that I think merits further discussion.

But I agree with Katie that right now it's really the hospitals that are serving the role as convener and the ones that are quite honestly with recent policies that have been finalized are on the hook for screening and the referral from a reporting standpoint on at least the inpatient measures.

And so the fact that those are already in place at the hospital level, we'd certainly want any future models to align with the responsibilities that hospitals already will have in terms of screening for social determinants and connecting to community-based organizations and referral sources.

The shared accountability may come into play perhaps in terms of data, in terms of how to share data more seamlessly between medical and non-medical providers is an area that's been somewhat sticky so far.

And certainly, having a better feedback loop between the medical and non-medical would help in terms of tracking outcomes and as part of a value-based model.

And I think that's something to be considered.

DR. CHEN: Just to quickly add to what my panelists have also already said, I think the way we are currently doing it, or at least the ACO REACH model is doing it, is to allow for higher spending for certain populations.

And the one thing that is unclear is how much additional dollars need to be allocated to addressing health equity concerns. And I think this is an area of experimentation that is needed in trying to figure out what that appropriate level is.

CHAIR CASALE: One question for Katie. You mentioned you are doing some bundles in the Maryland program, I think you said. I'm just curious, are they generally around procedures, clinical conditions?

I just wondered what your experience has been in Maryland around the bundles?

MS. WUNDERLICH: Thank you for that. We just started in 2022, calendar year 2022, so

we were working to put together what bundle that would be. We have some constraints because of our model.

Our physicians aren't able to participate in the national models. Our waivers around accountability and value-based payment are through the hospitals.

We were trying to craft a physician-owned, a physician-directed model program that we could fit under our own.

So, it took us a while to figure it out, but we did. We started in 2022 with three specialty areas, gastroenterology and general surgery, orthopedics and neurosurgery, and cardiology.

And so we used the Prometheus episode approach, and we have episodes within those specialty areas. We hope to add additional areas in the future, but for this year those are the three big ones.

CHAIR CASALE: Thank you. Moving to the next question, what do you see as the best options for structuring the payment methodology for population-based models?

You've addressed some of this in some of your answers, but if you could expand on that? And also, what are some strategies and

interim steps that can help providers successfully transition to increase financial risk?

Alice, I'm going to start with you.

DR. CHEN: I think there are several steps that need to be taken here to restructure payment methodology that encourages both initial participation and sustained participation.

To address I think the first issue of how can we help providers take on increased risk, a qualitative study from the RAND Organization and the American Medical Association found that it's particularly challenging for smaller practices to take on the infrastructure investments that are needed to succeed in these advanced payment models.

And so I think something that needs to be done is to have a track that allows for smaller organizations to take on low-risk options that encourage participations.

Now, should they want to progress towards larger level of population-based risk covering total cost of care in the future, they can, but this low-risk option should be made available for them to participate.

I think the other really important

point here is about benchmarks and how we're benchmarking providers and their ability to save money. There needs to be some on-ramp for new providers to be willing to join.

And I think setting benchmarks based on historical fee-for-service spending as customarily done is a really good helpful starting point. The question is how do you then take into account incentives to then encourage savings?

And something that needs to be done with caution is squeezing budgets over time should be done gradually rather than abruptly.

And I have some research with Michael McWilliams that shows that when you change the benchmarks in a large way, and you reduce those benchmarks making it more difficult for, say, Accountable Care Organizations to spend below benchmark, it leads to really large drop-out from the program.

And unsurprisingly, the people who are dropping out or the organizations that are dropping out are the ones who are unable to achieve savings in the prior years.

And these are the high spenders that you particularly want to be participating in the program. So, I think care needs to be done

when trying to incentivize reductions in spending when think about that benchmark.

And the last point I would say here is just about how benchmark levels should be updated. Currently, what's happening is benchmarks are being updated based on historical spending.

This kind of re-basing based on previous years' performance will penalize providers who have achieved savings in the previous years.

In other words, the providers who reduce spending will end up with lower budgets in the next year, and that's a perverse incentive.

So, I think to summarize, we want to encourage providers who are high spenders to reduce their spending, yes. But their benchmarks cannot be lowered so severely that they find it unappealing to participate to start with.

And to increase participation, set benchmarks initially based on fee-for-service spending and then update them based on some administrative growth factors.

And this is something that Maryland's done, which maybe Katie can talk

more about. But Maryland's global budget revenue model sets this budget spending growth rate at the outset of the program at 3.58 percent.

So, we have precedents for this kind of model.

CHAIR CASALE: Katie, actually, you're next.

MS. WUNDERLICH: I do want to piggyback on something that Alice did mention because it's one of the things that we've had experience within terms of the larger organizations were able to absorb risk and take on risk in a way that smaller providers.

And if we're talking about physicians and physician practices, smaller practices are not able to.

So, in order to take on that risk, a provider needs to make sure they know how to use and analyze the patient data they have.

How can they make sure that they're using it, that they understand it, to the extent that larger organizations have that infrastructure and have more of that ability to risk stratify to add options.

It's easier to start with the larger organizations and more difficult for the

smaller providers.

And we've certainly seen that, we have a primary care program that provides non-claims-based payments to primary care providers for advanced primary care.

But for the small primary care providers, we also partner them with care transformation organizations to help provide that infrastructure that they'll need to better take care of and manage their patients under a total cost of care model, global budget model.

So, that's what I would say, I think the options could be more aggressive for larger organizations but perhaps a little more cautious with smaller provider groups.

And then using data, making sure that providers in the program know how to use the data they have to best manage their patient population.

CHAIR CASALE: Greg?

MR. POULSEN: I'll try and be really brief. Again, I think that terminology is interesting here.

We've spent decades talking about prepayment as being risk and anybody who has lived through the last three years as a provider recognizes fee-for-service is risk

too.

The number of hospitals that have been dramatically impacted as their volumes went way down and then way up and then way down again, the impact of that is dramatic, and the associated costs are dramatic.

And so to imply that that's not a high-risk environment, whether you're a physician or a hospital or a nursing home, is a misstatement.

The flip side, of course, is to say that if you have pre-payment, you have an opportunity, you have freedom to treat people more effectively and in ways that you may not have otherwise, I think is really, really important to insert into the discussion.

In our communities, we've had broad rural prepayment in a few areas and the whole community with the exception of some payers. But we got a lot of payers to work together on that, and we saw whole communities really effectively making themselves healthier at lower cost.

And that was, again, a triple-aim kind of a win, which I think is really remarkable and would never have been possible in a fee-for-service world.

The other thing that I think is really relevant is if you look at the regulations, a dramatic percentage of the regulations that hospitals and physicians have to deal with and are burdensome to them, tremendously burdensome in many cases, are related to fee-for-service payment.

On the one hand, all of the details of the whole billing and collection process is unbelievably complex and expensive to the point where the billing office is associated with providers consumes a shockingly high percentage of their total resources.

We all know that.

But the other one is to simply look at all of the challenges that are faced in complying with things like fraud and abuse and stark regulations which, oh, by the way, are simply there to prevent providers from being seduced by the incentive that we gave them in the first place when we paid them fee-for-service.

So, taking those kinds of things and streamlining them has the potential to have huge benefits.

And today organizations and individual physicians who have tried and been

deeply embedded in prepayment find it to be dramatically more attractive than the old system, if you will.

And yet, as a nation and as policymakers, and we're all guilty, I certainly am, we still refer to the one as being a risk situation and the other one not.

And I think that mischaracterizes the situation and language matters. So, let me stop there.

CHAIR CASALE: Maryellen?

MS. GUINAN: Thanks for the question, and I think this question specifically around getting more providers to take on more risk is one that we know, at least in our own discussions with the CMS Innovation Center, is top of mind in terms of the Innovation Center actually looking at how to define the safety net being a subset of the providers that are not yet participating as fully as they should.

And as Alice alluded to, these are providers that often, these high-cost folks, we want in value-based care because of the populations they treat really can benefit the most from care coordination.

So, number one, in terms of

incentivizing participation from a broad number of providers but also looking particularly at perhaps safety net providers in particular, where today we don't have a codified definition of what we call an essential hospital in terms of policymaking or for public health purposes.

So, I think we would advocate for that type of definition as a way to target model development, design, and evaluation, implementation as well, and also to just target resources and make sure that we're aligning all these incentives with the providers that are providing care.

And I can go into that in more detail in terms of discussion.

I would also say in terms of the fairness of metrics as being a component that would be attractive to providers, particularly talking about essential hospitals and the safety net.

Currently, a lot of metrics that are used or most of the metrics that are used do not include risk adjustment for social risk.

We have some models in terms of the readmission program looking at dual eligibility and peer grouping, but we really haven't seen that in terms of measure-specific adjustments

accounting for those social risk factors.

And yet we know that the lack of risk adjustment for those social determinants or social drivers really has an impact on readmission rates, viability to, for example, get follow-up care or have transportation to visits, food and security, and the list goes on.

So, definitely wanting to enhance the social risk adjustment side of these models. And then I would also say, as I alluded to earlier, the up-front funding, I think we're very much supportive, and we're pleased to see that CMS is proposing the advanced payments in terms of the Shared Savings Program.

The caveat, I think I would say there, and this may go against the panel a little bit, is that I don't believe we want any distinctions between what CMS has defined as low-revenue versus high-revenue ACOs.

That can get into a two-player system in terms of pitting the provider-led ACOs against the hospital-led, which are often those high-revenue folks.

And so I think providing that up-front funding to all providers, but again in

particular, the safety net is something that could help incentivize more providers to join in on value-based care.

And then finally, I'll just say having a guide path to risk is always appreciated, and we also saw this in terms of recent proposals in the Shared Savings Program.

And I think again just having that opportunity for the most number of providers and not limited to just small providers, but also those that we know many of our members are on slim to negative margins and don't have those resources.

And so allowing them to stay in the one-sided risk for a little bit longer and gain that experience is also critical. Thanks.

CHAIR CASALE: Kathleen?

MS. HOLT: I think I can best contribute to this part of our conversation by offering a cautionary tale about providers and financial risk as it relates to patient access to practitioners.

With limited exceptions for emergency services, Medicare providers are typically not required to serve patients.

In response to current Medicare payment programs, more and more providers are

declining to serve high-resource-need patients because of negative financial impact.

Alternatively, if providers do serve high-resource-need patients, those patients may not be given all the health care services they need. So, how do we know about these access problems?

We hear about them from providers and patients, and you may ask, where's the data to support access problems? Unfortunately, no data is collected to measure care that is not provided, including in the current value-based payment programs.

It's necessarily more costly to serve a high-resource-need patients.

As consideration is given to new payment models, I would ask that models properly account for patients who would otherwise be left out of care because access to health care is a growing problem.

A standardized model or models may be needed to accommodate the tens of millions of patients who make up the vast majority of Medicare data aggregators, but consider would one model allow equal access to health care for all patients, especially patients who are considered high-resource outliers?

Or is there no one size fits all model?

In various model option deliberations, please consider the patients who are outliers, who are the most vulnerable, highest-resource-need human beings living with conditions such as paralysis, Parkinson's, multiple sclerosis, ALS, post-stroke, or any number of other longer-term and chronic conditions, be able to access necessary services through the model.

Ultimately, if every Medicare patient’s equal access to health care services as every other Medicare patient, you will have been successful in choosing the correct balance of financial incentives to influence and incent a provider's risk tolerance with a commitment to serve all patients and achieve appropriate reimbursement.

Thank you.

CHAIR CASALE: Before we move to the next question, I just wanted to turn to the Committee members. Any questions from the Committee to our panelists on this specific question?

Hearing none, next question is a theme that has emerged throughout this year, is

aligning primary care and specialty care. What are the best financial incentives to encourage better coordination and alignment between primary care and specialty care?

We'd like to understand how best to engage specialists. Gregory, I'll start with you.

MR. POULSEN: I'd like to piggyback my answer little bit on that last question because I think that as we contemplate in a fee-for-service world the most vulnerable and in many instances the most challenging patients to see, what's the downside to an organization if they don't provide that care?

They lose a little bit of fee-for-service, and oh, by the way, the patient shows up and pays them big fee-for-service when they have a catastrophe that ends up in the emergency room and then the ICU[36].

On the other hand, in a prepaid world, you've got tremendous incentives to focus on the needs of that person before they become a catastrophe.

I would argue that the most effective way to ensure the most vulnerable

36 Intensive care unit

receive care, the most needy receive care, is through an appropriate pre-payment mechanism.

Which leads us then to the issues of how do we coordinate primary care and secondary care? And I think there are probably three main models that are being contemplated.

One of them is the old gatekeeper model. I would argue that one is remarkably unattractive because it irritates primary care docs, it irritates secondary care docs, and most of all, it irritates beneficiaries.

It doesn't work for anybody. So, if I could, I'd sweep that one off the table right away.

The second one is the idea of using a combination, we talked about this back with the first question, of bundled payment working in secondary care and overall prepayment and primary care.

At that point, the primary care clinician or primary care team, which I hope is the case, would look at when an appropriate time is to go and bring in a specialist who then has a holistic bundle to try and provide the services effectively and return them to their state of health and well-being in primary care.

Of course, you've all mentioned, all of my colleagues have mentioned, the huge challenge that we have in defining when a bundle begins and ends. It's incredibly complicated.

There are a few things that are fairly straightforward. Think of a hip replacement or something like that as being relatively easy to put into a bundle. The trick is knowing if the bundle itself is appropriate.

As I think it was Alice who mentioned, relatively modest improvements in the cost associated with a bundled payment, we've seen something that works far more effectively is where the bundle is for the disease rather than the treatment because in many instances, we've all seen the examples where back surgery was found not to be the appropriate intervention.

And avoiding that not only reduced the cost, but it also reduced the likelihood of a bad outcome associated with that invasive procedure. So, trying to define what a bundle is, when it's appropriate, those are the huge challenges.

Creating integrated teams, you're

not going to be surprised based on everything that I've said that integrated teams we think is the far more effective way to do it, where you've got specialists working with primary care physicians to know when an appropriate treatment is required, when it can be avoided by early intervention, and when we can take care of them effectively with the after-care so that no reoccurrence is likely to happen.

And I think this ends up being really important. We've certainly seen it in our organization, when the specialists and the primary cares physicians work together as a team, the outcomes are dramatically better.

We start to see a reduction in the number of times when specialist care in the traditional sense is incurred because the specialist actually participates early.

Mental health integration may be the most frequently discussed example, where having mental health specialists help primary care physicians to make a more effective diagnosis, and in many cases provide direct treatment instantaneously as opposed to try and bring them to a mental health professional who, oh, by the way, is in short supply and, yes, we can get you in next February.

So, there's a whole series of we think highly beneficial mechanicals that occur when primary care and secondary care work very, very much hand in glove.

And that's hard to do in a fee-for-service world, very, very easy to do in a prepaid world.

CHAIR CASALE: Go ahead, Angelo.

DR. SINOPOLI: This question is for Greg. How many independent physicians are in your broader network, and how do you engage those primary care specialists to participate in the models you're describing?

MR. POULSEN: It's a great question. Many people ask us how are you different from, say, a Kaiser Permanente?

And we are just about 50 percent of our clinicians, both primary and secondary care, are employed, and about 50 percent are not employed by us and are affiliated.

And what we have essentially done is to say we'd love to have you, the employment decision that you make is based on the way that you want to manage your finances and run your office.

That's great, we're delighted either way. Some people love to be an entrepreneur,

some people hate the idea, and great, make that decision. But what is not negotiable is whether you're going to be a team player.

And by that we mean you need to engage in the rules of when you work with your colleagues, whether they're another independent physician or one of our employed physicians, you will work with the tools that are maximizing value to your patients.

So, for instance, you will share data with all of your physician colleagues that care for that patient as they will with you. And so there are a series of things that don't require employment in order to be engaged as a team member.

So, we expect as part of the deal if you want to provide care with our team and to our beneficiaries that you will be a team member.

It doesn't require employment, but it absolutely requires coordination, it requires collegiality, it absolutely requires sharing of information and applying best practices when they're known.

CHAIR CASALE: Maryellen, I'll turn to you next.

MS. GUINAN: Sure, and I agree

wholeheartedly with Greg in terms of integration being key.

I think specialists are obviously key partners in terms of delivering value-based care but really need to have the proper staff integration, as well as training in terms of actually increasing efficiency and lowering cost. Along with that, I think a lot of success in terms of that integration relies, and Greg noted this as well, in terms of effective communication, having an integrated medical record, as well as having a single shared treatment plan in terms of having everyone on the same page.

Also, speaking of data, specifically transparently sharing data, I think that's also key in terms of the specialist side.

Without data, I think specialists often have no idea where or how their care actually stacks up and if there are potentially efficiencies that can be incorporated into their outcomes or their care plans to provide better outcomes at lower costs.

And so sharing that data with specialists I think is a way to attract them to this type of integration and have them have a little buy-in in terms of their role.

I think an example, and I think Greg alluded to this as well, in terms of mental health and behavioral health is a prime example in terms of where integration has worked really well.

And that's because as many of our hospitals deal with patients that suffer from behavioral health issues, they often find that patients are seeking treatment and episodic care from the ED[37], which contributes to rising health care costs, readmission rates, and overall just fragmented care.

And so we've seen our members integrate behavioral health with primary care as a solution to disparities in behavioral health treatment while also addressing the interconnectedness that we know is between physical and behavioral health.

We also have heard from folks about the use of e-consults as an effective mechanism between primary care and specialty, and I believe that was raised earlier today so I won't go into that in too much detail.

But I definitely support that in terms of having timely and efficient care and

37 Emergency department

having that loop between primary care and specialty care.

I'll also just note in terms of some of the specialties that have thrived, obviously orthopedics comes to mind, probably because of the Comprehensive Joint Replacement Model that exists.

So, definitely noteworthy in terms of their expanding participation into bundle payment arrangements. However, a lot of the specialty value-based care programs are really focused on, again, those episodes of care, like a hip and knee surgery.

So, I think if we're looking for that population-based model, we need to get the other specialties involved, whether that's directly or if it's that the primary care still serves as the quarterback.

But it's improving the integration, and that's an area that should be examined.

CHAIR CASALE: Alice?

DR. CHEN: I think I agree with a lot of what's been said.

What's interesting to me is, as Greg mentioned, it's like a culture of collegiality, and I think short of having people buy into that culture, which I agree is very important,

there is also just this reality that as the fee-for-service payment model diverges in its financial incentives from advanced payment models, specialists will naturally also be inclined to participate and to buy into that type of culture.

Something to note is that CMS projections suggest that the fee-for-service payments for Medicare are going to rise at a rate that's approximately 0.7 percent below the rate of inflation through 2030.

So, the margins for fee-for-service are starting to fall in terms of real dollar values, and I think this is where specialists can realize that making more money by being an efficient provider within an advanced payment model like an ACO can be better and more lucrative than being a non-ACO provider just accepting fee-for-service.

And the last thing I would mention here is, as many of my fellow panelists have already talked about, management teams or care teams. What I want to add here is just this piece of a management team.

I think the management team should reflect the views of both primary care physicians and specialists. Physician

leadership is likely to have a very important implication for the evolution of strategic design.

And survey data has shown that specialists are less likely to perceive that joining an advanced payment model has changed how they practice medicine, has affected their compensation.

There are some qualitative studies out there showing that surgery was not part of an ACO strategic vision, at least in the early days. So, I think including specialists in this discussion of strategic vision and leadership will also be serving an important component here.

CHAIR CASALE: Thank you. Kathleen?

MS. HOLT: I'm going to pick up on what everyone else has already talked about from a patient perspective.

Joint coordination should occur between primary care, specialty care, as well as patients to initiate, adjust, and successfully make progress to efficiently and effectively achieve patients' stated outcome goals.

How do we do this? Some patients will have realistic goals to achieve a higher

level of function.

Some will have goals to return to previous level of function, some will seek to maintain their current function, while others will strive to slow the loss of function due to a necessarily deteriorating condition.

So, while practitioner skills and case management processes may not differ from one patient to the next, providers' joint approach to each patient's health care should respect and adapt to each patient's individual treatment goals, collectively agreeing on and creating a strategy to measure goal progress as a joint health care team will necessarily better coordinate and align primary care, specialty care, and the patient.

By managing cases this way, financial incentives for practitioners may, for example, include shared payment tied to each provider's percentage of total time dedicated to a patient with additional joint incentive provider payment for working together to successfully achieve patients' goals.

CHAIR CASALE: Thank you. I'm going to open it up to the Committee for questions. I'm happy to start off.

Greg, you've referenced a few times

the integrated care teams, and I just wondered if you could describe those in terms of who is on those teams, and do they vary based on the clinical conditions of the patients?

And then finally, in terms of accountability for quality and cost within this integrated team structure, who is accountable ultimately for those measures?

MR. POULSEN: Great questions.

The integrated care teams are very much fluid, and they tend to be built around either a specific patient need that happens when patients have dramatic needs, when somebody develops cancer and there's a fairly significant kind of need that's going to be multidisciplinary.

It also tends to be built around general needs.

A number of folks mentioned mental health integration. We started to do that about 25 years ago and that was built around the obvious need that primary care physicians had to understand more effectively the reasons that some people were acquiring care more frequently than others when they appeared to have a very small underlying condition.

And it became more apparent that

there was a behavioral health component to that and so being able to identify, treat, and know when appropriate referral was necessary was part of the deal.

And so that was a broad need that was apparent, and so the organization undertook that with everybody's enthusiastic engagement because the need was so obvious.

The ones where the need may not be as obvious until somebody brings it up, and this is a real example in joint replacement, where a number of the surgeons said we spend an awful lot of time talking to people and discouraging them from getting --

They don't come in saying I've got knee pain, they come in saying I need my knee replaced because my next-door neighbor did.

And so coming up with an integrated approach that helped to get somebody who was significantly less expensive than an orthopedic surgeon to have the discussion with folks and say let's talk about what your knee pain is and what the appropriate steps are to try and get an improvement there.

And interestingly enough, pushed by the surgeons who in a fee-for-service world would have said keep your hands off my

potential patient.

And so that one was one that came up and is now loved by the surgeons who spend less of their time in office doing things that they don't think is the highest and best use of their training.

And you asked where's the accountability? For us, the accountability tends to be at the organizational level.

Through KPIs and other things, we track that as best we can, and I will tell you absolutely our metrics are imperfect but they're better than what we've had in the past, and they're hopefully getting better every year so that people can look at that and say, are we doing everything that's beneficial to people, are we avoiding doing things that are unnecessary, and are we keeping people happy and keeping them as healthy in their own minds as they expect to be?

I really, really loved what Kathy talked about. People's expectations of what their health should be is going to vary from person to person.

Being able to meet those expectations and help them on their journey we think is really important.

So, that's one of the important things we track and are in our KPIs that are shared with everybody.

CHAIR CASALE: My other question is really for all the panelists.

Several of you have talked about data in various contexts, including engaging specialists, and I'm just curious, as a cardiologist, I speak to a lot of cardiologists, and they complain the data they get is not timely, it's not actionable.

And I'm curious how you've been able to address some of those challenges around getting data either to the specialists or just in general to the providers.

MR. POULSEN: I apologize, I shouldn't jump right back in after answering the last question but just let me say again, provider organizations are in a dramatically better position than insurance organizations to do that.

If you did a cardiology procedure yesterday, we know about it today, and we can coordinate and report on that. The insurer will find it out after a bill has come and they have adjudicated it and they've put it into their database.

And with luck, 30, 60, 90, or more days from now, you may get information back that said, huh, we're kind of surprised you did this procedure, how come you did it?

MS. WUNDERLICH: If I can jump in also on that question, I think understanding data around your patients is really important to making sure you're successful as a provider in reducing unnecessary costs and improving quality and outcomes.

In Maryland, like many other states, we have a health information exchange, a common HIE[38] platform that all of our hospitals are connected to, and we've also done a big push to get ambulatory care providers also connected.

So, that will provide real-time alerts for when a patient who is attributed to you, you have a clinical relationship with, you'll get an alert if they go to the emergency department, if they have an admission to the hospital, if they have a procedure.

And so that real-time data allows multiple providers across the spectrum to connect and see what their patient is doing in different areas.

38 Health information exchange

It also has an option for care management and care alerts so the providers can put in -- if there is a point of contact for a care manager for a particular patient, that person's contact information can be included so that if they go to the emergency department in the CRIS[39] HIE record, you'll see what that patient's care management team looks like, if there's a care alert, et cetera.

So, I think having data that multiple providers can access and learn from for their particular patients is extremely important in terms of coordinating across providers.

And then also on the HIE there's also a prescription drug recordkeeping also so physicians can know the prescriptions that are prescribed to that patient.

MS. GUINAN: And Paul, I'll just echo and sympathize with you, the lack of data is not there on the (audio interference) super helpful in terms of workflow and shared care plan. There's that other side of the claims-based data that we know from providers there's a data lag.

39 Critical Research Information System

Especially quality metrics can be two or three years, the data lag that we're looking at. So, it's not a great real-time perspective in terms of those metrics.

And so that's certainly a challenge in wanting to get more prospective and real-time data to providers is key.

The other thing I just wanted to mention in terms of the accountability side of your question, speaking to hospitals, there is this notion of, again, that e-consult model, wanting to get the specialists involved.

But there's also a voicing of being housed in the primary care is a positive thing in terms of continuity of care for patients and keeping them connected to a system and a provider.

And so wanting to have the specialists come in but also leaving it in the provider side. And quite honestly, that also probably helps on the social determinant side of things because I think we know primary care, they're not so far along, but they're I believe a little further along than specialists in terms of developing the infrastructure to address both the clinical and social needs of patients.

So, something to consider on the accountability side.

CHAIR CASALE: Larry?

DR. KOSINSKI: Great session, I'm learning a lot from all of you. My question is going to go out to whoever feels comfortable addressing it.

We've heard a lot from each of you about the Comprehensive Joint Replacement Model, bundled payment for procedure-type services. What type of team-based reimbursement models have you developed for chronic disease management, patients with either single or multiple chronic diseases?

How do you distribute payments and incentivize across the primary specialty interface there?

MR. POULSEN: I'll jump into the silence by saying I don't think it works.

I think in fact, as Michael Porter and Bob Caplan wrote a Harvard Business Review article a long time ago, a decade ago, and a colleague and I wrote a counterpoint was how to pay for health care.

And it was about bundled payments. Ours was called the case for capitation; you can guess where it came from. And our point

was for all of those things, the bundle that you're looking at is care for person over a period of time.

And the longest period of time you can define is effective because by definition, these diseases are not going away and if not cared for, they're going to get worse.

If cared for effectively, they may not, they may actually improve.

So, in our view, my view certainly, that's the key there, to say that's not a bundle, that's the whole-person care.

And oh, by the way, the deviations they have in their care pathway, they may end up developing some other issue that's not specifically related to their congestive heart failure or their fill in the blank.

But it's going to be dramatically impacted by that and to care for them as though they were a bunch of individual diagnoses is not going to be effective, it's not going to be healthy, and it's not going to be satisfying.

So, we need to look at that person from a whole perspective, which is why I think we have to pay them from a whole perspective.

CHAIR CASALE: Any other comments? If not, Bruce?

MR. STEINWALD: Is there time?

CHAIR CASALE: Yes, there's always time for your questions.

MR. STEINWALD: Earlier today in another panel, we had a robust discussion of the role of fee-for-service and value-based care going forward.

Paul, I'll start with you because I think at one point you said if the organization has the proper incentives, you don't think they necessarily have to devolve down to the individual practitioner.

And at the time you said that, I wondered if that meant you were indifferent about whether that practitioner was paid fee-for-service or salary or through some other methodology.

So, my question for all of you is do you think going forward we should be trying to phase out fee-for-service compensation, or is there an ongoing or at least necessary role for fee-for-service under value-based payment systems?

CHAIR CASALE: Greg, I'll let you start and then I saw Alice leaning in.

MR. POULSEN: I'll try and be quick because I know we're getting short on time.

CHAIR CASALE: That's okay, we can go over a few minutes.

MR. POULSEN: My prejudice is that anytime we're unsure whether the procedure may end up becoming unnecessary but done for financial reasons, fee-for-service is perverse. And most of the time in today's world, unfortunately, I believe that to be the case.

So, we're moving in our organization wherever we possibly can. This is one advantage to having employed physicians, is we can move to salaries. We haven't figured out how to do a salary for people who don't work for our organization directly.

We think that tends to be a more effective way. The however is with appropriate metrics, KPIs, and other things that are shared, you can overcome perverse payment mechanisms.

I just hate the fact, though, that we have to overcome something perverse. The payment mechanism ought to reinforce doing the right thing, not pushing you in the wrong direction.

So, in my view I'd love to see fee-for-service history.

DR. CHEN: I probably have a more

mixed or nuanced perspective on this. I think it's not controversial to say that fee-for-service is inefficient and creates perverse incentives, as Greg has pointed out and others on the panel as well.

We've seen other countries do this, where there's fee-for-service with global caps on what one can spend. That limits some of the incentives of fee-for-service, of I'm just going to bill and spend.

And there are mechanisms that one can design that we I think are in the process of doing in terms of changing the fee-for-service rates into something that looks more capitated, or some combination of capitated with fee-for-service, which can be changed with things like bonus payments or penalties.

It shifts the incentives that are inherently there with a fee-for-service, of let's just bill and spend.

And so in that sense, I think one could devise a system that reduces the inherent inefficiencies with fee-for-service without completely abolishing it.

And it does have I think the benefit of just knowing how much you actually are saving and spending when you still have some

sort of fee-for-service benchmark.

But I absolutely agree, like it doesn't make sense to continue adding in more fees and services for new things, including things like telehealth and other new technologies.

CHAIR CASALE: Thank you so much.

On behalf of the Committee and our audience, I want to thank all of our panelists for their insights today. We're very grateful that you've been generous in sharing your expertise.

At this time, we have a break until 3:15 p.m. Eastern Time. We will reflect on the day and discuss some potential comments for the report to the Secretary.

Thank you very much.

(Whereupon, the above-entitled matter went off the record at 3:00 p.m. and resumed at 3:15 p.m.)

*** Committee Discussion**

Welcome back. As you know, PTAC will be issuing a report to the Secretary of HHS that will summarize our key findings from all three of our public meetings on population-based total cost of care.

First, we have some time for some

general discussion to reflect on what we've learned throughout the day from the various presentations and the Q&A sessions, even though we have more presenters tomorrow.

So, for Committee members, you do have a document on potential topics for deliberation tucked into the pocket of your binder to help guide the conversation.

Before we get to that, after our general discussion about what we learned today, we will focus on potential comments for the report to the Secretary.

So, a little bit later the staff will walk us through slides summarizing those potential comments. But first, let me just open it up to the Committee members for any particular reactions to the day.

DR. KOSINSKI: I'll open it up.

With rare exception and using only scientific reasons to maintain it, I think most of the experts we listened to today would like to see fee-for-service either drastically changed or eliminated completely.

And as you and I were just discussing, we've even seen the other extreme was that all physicians should be salaried. One of the main takeaways here is that fee-for-

service needs drastic repair.

And this albatross that we have called the RUC[40] has just created an abomination of a system that is doing nothing to help us get fee-for-service under any control.

CHAIR CASALE: Thanks for those comments, Larry.

MR. STEINWALD: I'll add to that. The irony to me, and I forget who to attribute this to, this might have been Bob Berenson, who said we need to fix fee-for-service before we abolish it.

And part of the reason for that came out in some of these discussions, it's scorekeeping, it's not like we think it's a good way to pay people, but it's not a bad way to keep score.

But then you have to fix it to keep the score right too. So, I give up.

DR. KOSINSKI: The best line was from Mark, fee-for-service needs to be less appealing.

DR. PULLURU: Uncomfortable.

DR. KOSINSKI: Uncomfortable, that was it. Yes.

---

40 Relative Value Scale (RVS) Update Committee

DR. PULLURU: It's a good line.

And one of the things that surprised me about what was a theme I heard from multiple people is incent the organization not the provider, but then the other side, I found that in conflict with the theory that the provider should flourish.

And I see how this plays out a lot of times in hospital-based ACOs or payvider organization where when there's a profit, it doesn't go to the provider, and it's under the auspice of developing infrastructure, but that the provider is not flourishing.

So, it seemed like there was some conflict in thought there.

DR. FELDSTEIN: Paul, I don't know if you can see my hand raised here.

CHAIR CASALE: Sorry, Jay, thank you, go ahead.

DR. FELDSTEIN: One, I totally agree with what Chinni just said. When it goes to the organization, the provider suffers, they don't reap the benefit of their behavior or their changes necessarily, whether it's in future compensation or whatever.

The other thing which was abundantly clear is no one's figured out how to handle the

specialists in the capitated system. And everybody was great on theory today, but when Larry pressed for specifics, we didn't really hear any.

And I think the third thing is people have been trying to figure out how to properly compensate primary care for 40 years. And we're still not there.

There needs to be the mindset of it's an investment and where the capital for that is going to come from, whether we're going to rob Peter to pay Paul in the overall dollars within the system remains to be seen, but it's got to be addressed.

CHAIR CASALE: Thanks, Jay.

I would think just to your comments, what we heard from Intermountain around who should be accountable and metrics and things, and his suggestion was that it's not just a team effort but with advancements in technology, et cetera, it is not clearly going to be a primary care doctor or specialist who is going to be primarily accountable.

It needs to be this blended.

And again, I think he was moving towards with that, that the incentive really isn't primary care specialists but that it gets

back to this around most of the payment would be salary based with some piece that potentially could be bonus as opposed to incentivizing for a specific behavior, whether it's for specialists in particular.

You had your hand up, right? Who was next? Jennifer was next? I'm sorry.

DR. WILER: I heard a couple of interesting things today. The first is creating this sense of inevitability that there will be a shift, where there was this sense of both urgency and inevitability before.

And I thought it was interesting to hear about the market forces which are probably obvious, but to state them explicitly in the employer market, around maybe the lack of interest from an employer perspective because they are currently risk-adverse to making benefit changes.

I thought that was a really important and interesting call-out.

We talk a lot about nested care models but much to the conversation we were just having, we don't talk a lot about nested incentives and around a deliberate strategy for engagement in each of those tiers that we saw in one of our first presentations.

And then I feel like we didn't really hear an answer but what was described was a continuum around moving away from current state, from everything to making participation in these programs mandatory or at least highly incented.

And so trying to figure out what this strategy is around incenting at every layer of care delivery. But that at least many of the folks that we heard from today agree multi-payer strategy is critical to success.

CHAIR CASALE: I appreciate those comments.

DR. MILLS: I appreciate it, next time I'll get my thoughts in order.

I agree with all those comments but back to Larry's point, I thought it was significant that we didn't hear an answer to what's the magic solution to a value-based or total cost of care model in paying both specialists and primary care.

There may be other deep thinkers but if the group we had together today essentially said in their silence there is no magic path, it's total population-based, cost of care, capitation.

Whether that's the primary care

doctor or cardiologist or heart issue, there is an owner that gathers a team of professionals and that's who owns the risk and responsibility.

And there might be as an aside some episode-defined bundles that could work and make sense. That's the answer I think to our question, in one sense.

So, the second observation that I'm still struck by is this concept that what happens in the commercial employer purchased risk area is going to be the tipping point for what happens in the future of health care in the country.

And it's really, really scary to feel like how risk is handled in the Medicare population versus the commercial population could go two dramatically different directions.

Because I would submit to you that most providers, either physician practice or hospital, cannot operate two different economic models with different incentives. It can't be done effectively.

So, it's either going to be we've got to thread the needle and find a risk model and schema that can meet the different needs of those two populations, which I think could be

done, or we're heading towards just a fragmentation into disruptive, niche market provider organizations that fit only one need and pretty much ignore or abandon the other needs.

I think we have a pretty stark future. One of those two futures will come to pass, and my instinct is a five-to-10-year timeframe is probably accurate.

CHAIR CASALE: Angelo?

DR. SINOPOLI: I agree with everything that Lee just said too, particularly about the commercial payers.

The other thing that I kept hearing and I've heard all through the day today is stuff that we already know but just made it even more abundantly clear is the dichotomy between an organization like Intermountain.

Because the reason they can get engagement of a specialist even though they're independent is because they own 50 percent, the majority, of the pre-payment contracts in that market.

So, for the specialists to survive, they've got to be a team player. That's very different than in the rural South, in Mississippi and in places where that doesn't

exist.

So, it's easy if I own all the contracts in that market to get the specialists to collaborate.

We've got to figure out for the rest of the country beyond those top 12 organizations that do that how do we engage specialists there, even the primary care doctors in those markets who don't even have ACOs in those markets to help pull them together.

They don't have the data, they don't have the resources, they don't have those teams, nobody is providing that for them. How do we incentivize that?

Because that's 80 percent of the population across the country. It's not the Intermountain, it's not the Geisingers, et cetera. So, I'm still at a loss for how to make that happen.

CHAIR CASALE: I think Josh was next and then Bruce.

MR. STEINWALD: I'll go because I'm one off from the previous comment.

I admit to having a bit of a bias against high-end consulting groups and their analysis of health care and a lot of them have

health care practices, as you know.

That remark about commercial risk, it doesn't sit right with me. I'd like a lot more evidence of that to believe that's really an important factor. I don't know how it would matter to what we do here anyway.

I'm not sure I believe it, put it that way.

DR. SINOPOLI: When you say that, are you saying you don't believe it is what's going to direct how we're going to move into value-based care?

MR. STEINWALD: If I understand what she was saying, that's the main factor that's going to be the tipping point of how we proceed down the path of health reform or anything else.

DR. SINOPOLI: I would agree with you. I don't agree that's the tipping point because it is such a different model, just from my own personal experience, all of these contracts are all about three things.

They're about price, it's all price-sensitive, it's all about site of care because of the hospital-based billing procedures, and

it's all about hard UM.[41]

Those are the three things that every employer hits on because their populations, typically 80 percent of them are not chronic care management, Medicare-like patients.

They're young healthy people with gyms at their workplace, and the ones that we evaluated, their biggest spend over the course of the year was delivering babies, and we couldn't do anything to intervene with that.

There wasn't much we could do other than work on price, educate them, et cetera. And there are some employers that look a little bit more like Medicare but it's not Medicare.

And you can spread those teams across, it's just the effectiveness of the ROI[42] on those patient populations is so small compared to a Medicare population where you're hitting huge chunks of ROI for those teams.

It just doesn't make financial sense for a managed care organization to manage them exactly the same way. It's going to be about price, site of care, and UM for procedures, that's basically what it is.

41 Utilization Management
42 Return on investment

CHAIR CASALE: Josh, you put your card down, did you want to make a comment?

DR. LIAO: I agree with that and I'm glad Bruce went first, thank you. Shifting from that a little bit, I've written all of this in pencil so to speak, awaiting tomorrow's comments, but I had one overarching comment and three smaller takeaways.

The first from the first listening session was this idea of we're focused on payment models, and I think that's appropriate.

But what I took away from that was also step back and see the bigger picture of if you don't consider MA an APM, then a reform or a change there must be done in the pure fee schedule.

And without those changes, whatever we do within APM so to speak may be limited. That's something I'll take with me from today.

The other three things I heard clearly, Chinni mentioned providers prospering, and I heard this theme of there needs to be an incentive to be in these models.

Some of the SMEs talked about the five percent APM bonus. We heard this morning about externally-set benchmarks which are meant to create more incentive to be in I think Mike

McWilliams called it the wedge.

But it any case, I think the incentive is there. How we do that I think is very important. The APM bonus is useful. I think as we all know, it's a rate increase which is anchored in the fee-for-service approach, not necessarily a value-based approach.

So, how we go forward in creating that incentive I think is key. That was the first. The second is I heard the desire across SMEs around simplicity, so a small number of tracks, culling down the number of models.

And yet, the tension, there was also this idea that you can't call providers efficient or inefficient, some would take care of complex patients may be inefficient but that may be appropriately so.

And I started thinking about the organizations that were represented today and how likely in different parts of their care they would be more or less efficient.

And so in the pursuit of simplicity, I think we can't have it both ways, there's maybe a trade-off there.

And then the last thing is going back to earlier comments, almost everyone said

episodes, maybe with one clear exception, most people said episodes.

They came right up to it, and they said some episodes, some type of interaction, and they left it there.

Again, let's see what we learn tomorrow but I do think what I took away from that is whether it's three or five or in the commercial or in Maryland or from our higher-level policy from this morning, it's there.

So, I tend to agree with Lee, it's there but really taking the next step in a very practical way, I'm channeling my inner Larry here, I think is really critical for us.

Not that it's not important to hear that, but I heard that repeated enough, though nobody stressed it, and I would love for us to take the next step in figuring out what does it look like?

CHAIR CASALE: Jay, your hand is up?

DR. FELDSTEIN: I put it down.

CHAIR CASALE: OK. Chinni?

DR. PULLURU: A couple of things I didn't hear.

One was the waste, everyone talked about health care and specialty primary care, capitated. No one talked about how much money

the health care dollars spend on stuff like RCM[43] collection, on things like eligibility.

So, if you look at a dollar slide, I remember in the statistics it was $0.10 went to the doctor, provider, workforce.

What always confounds me about these conversations is that you can have the same amount of money go to the providers if you just looked at simplifying models and taking out some of the other crap or waste.

The other thing that I didn't hear is speaking that most of America lives in, geographically anyway, rural areas where there is no primary care physician. So, speaking to what Angelo said, what do you do with health care?

How do you capitate to a primary care physician when there is none? Because a lot of places, the company I work for, we're in a lot of places where the pharmacist is the only health care entity in town.

Forget specialists, they actually don't have primary care docs. So, then how do you solve for that problem? It felt a lot like we were solving for areas that are familiar to

43 Revenue cycle management

all of us, suburban America, but most of America isn't there.

CHAIR CASALE: Thanks, Chinni. Angelo?

DR. SINOPOLI: The last comment I wanted to make was I also heard some comments during the discussion today regarding if you create the appropriate payment model, then things will align themselves and follow.

And then I heard other comments there that that wasn't true. I probably lean on the side of that's not necessarily true.

I think the payment models give you the ability and I heard the word freedom, you kept using the word freedom, to create the kind of care models you need and gives you the freedom to pay for them the way you need to pay for them.

I think that's a strong takeaway from today, that really the key to success is the team-based care and the care model. And then we need the freedom from the payment model to allow us to accomplish those things within the care model.

CHAIR CASALE: Thanks, Angelo. Jennifer?

DR. WILER: What I like about

discussions like today is it shows the practical polarity of how challenging this is.

And what I mean is we had academics and policy experts, much to Chinni's point, that talked about the challenges regarding benchmarking and risk adjustment and attribution, all of which are totally appropriate.

And then we had someone only in the long-term care space talking about basic blocking and tackling and how hard that was, and how there's been nearly a decade's worth of work.

And they are just at the base of sharing data and how challenging that is.

So, I just wanted to acknowledge that again, I hope we continue to not only surface what might be an approach from a policy perspective but also how we might be able to help from a practical perspective, recognizing these many issues that we've covered over these educational sessions are not just about suburban America where there's a high rate of commercial insurance that may impact the local Medicare population.

CHAIR CASALE: Josh?

DR. LIAO: Just a quick comment.

I want to circle back on what Angelo said. I tend to lean on that side as well.

Incentives are really about goals and internal and external goals, and so the implicit idea here is that the goal would be to create revenue in such a way to forward the organizational mission.

That's an important one of course, but I think it's fair to say as clinicians around the table that clinical teams are driven by many other things besides that, being a good citizen and team member of the group, guarantor of societal resources and advocate for your patients, a practice of evidence-based medicine, feeling a sense of mastery and autonomy in the job.

I don't think those things are directly designable per se in a payment model, but I think we should acknowledge that those non-financial incentives can be subsumed if the payment models aren't set up the right way, and not assume that most people walk around as economists thinking about their marginal utility all the time.

CHAIR CASALE: You're speaking Bruce's language there, margin and utility.

Just a few additional comments. I

was thinking about the conversations, and I was thinking about the comments around CJR[44]. Alice particularly said it's probably the most successful program.

There's a lot of reasons for that.

And then there was another comment about the incentives really should be more at the system level and not at the provider level, but I have to tell you, having implemented the CJR, the incentive to the provider was major engagement in moving that to be successful.

So, it's not clear to me. That one is easier to put an incentive to a provider, it's clear they did the surgery, other things are obviously not as clean.

But it was a clear example of how a financial incentive, which of course is coupled with it turns out to be better care for the patient in terms of coordinating care, keeping them out of subacute rehab, and sending them home, all those things that also align.

At any rate, in terms of how do you engage specialists and then where the incentive lies, I think we still have a lot of room to understand that.

---

44 Comprehensive Care for Joint Replacement

And then I know we talk about this at every meeting and brought it up a little bit in some of the questions around data. Intermountain again is more in the model that may be they can have data that they can provide more real-time just because of their system.

But that's not most places and most places, if they're in a program, they are relying on claims data, which again has a huge lag.

And their current priority I don't think really has an investment in the EHR[45] data in a way to get that to the providers currently.

So, that timely data piece, which we hear over and over again, is still a major challenge to sort through.

DR. PULLURU: I'm surprised that turnaround of data is not a core MA competency for payers when they bid for MA plans. Because most MA private payers, their data turnaround time is actually worse than CMS.

CHAIR CASALE: Yes, that's true. We're approaching time for...any other comments? This has all been really helpful.

45 Electronic health record

Walter? We haven't heard from Walter.

DR. LIN: I've just been soaking it in and a lot of the comments I wanted to make were made. Just a word of hope, we heard from LTC ACO, and one of the things I really appreciated about their presentation was they actually went through the numbers.

I keep on saying I want to see some numbers, I want to see some numbers, and they actually showed us the numbers, saving between $3,500 and $5,500 per beneficiary off of a $30,000 baseline.

So, do the math, 12 to 16 percent savings. And I think that just shows what can be achieved. Granted, it's a very specialized population but what can be achieved with the value-based journey that we're on.

*** Review of Draft Comments for the Report to the Secretary: Part 1**

CHAIR CASALE: We're just about at the time that I'm going to Audrey McDowell from the PTAC Staff to walk us through slides on potential comments for the Committee's report to the Secretary based on this year's work.

Committee members, you have a copy of these potential comments in the left pocket of your binder. As Audrey goes through the

slides, you can flip your name card up if you have comments.

Audrey, I'm going to turn to you.

MS. McDOWELL: Thanks, Paul, and actually, the slides are in a tab in your binder, it's the second to last tab.

As you know, this is the third in a series of three public meetings that PTAC has held related to development and implementation of population-based total cost of care models.

PTAC will be developing a report to the Secretary that summarizes what the Committee has learned during these three meetings, and we'll be including specific comments and recommendations to the Secretary as part of that RTS where appropriate.

In addition to thinking about what you have learned today, we also want to have a structured discussion over the next two days about potential comments that you might want to include in the RTS based on what you've heard across all three meetings.

And so to facilitate this discussion, we'll be walking through some potential comments related to a list of topics that loosely generally follows the organization of the PCDT's overview slides.

As we know, the topics in the overview slides were not meant to be exhaustive, so there could be additional topics that you might want to add.

And these potential comments are not intended to be exhaustive. They're just designed to elicit your feedback so the staff will have a sense of what we want to do in terms of your comments for the report to the Secretary.

Having said that, Amy, if you can pull up the slides that would be helpful.

Again, if you look at Slide 3, you'll see that we have an outline of topics that more or less follows what we discussed with the PCDT, desired vision and culture, definitions, desired care delivery features, enablers to support the desired care delivery features, designed payment features, enablers to support the payment features, model design considerations, and desired performance measurement features.

This is also potentially a structure for the report to the Secretary but again, we look forward to any comments and suggestions that you have related to the topic themselves, as well as the organization of those topics.

So, if you could, Amy, pull up Slide 5, that would be great. We want to just review the list of the desired vision and culture points that the PCDT had identified, and I'm not going to read each of these items.

What we're going to do is give you a chance to look at what's on the slide and see if there's anything that you would add. You already heard from the PCDT about desired vision and culture.

We want to see if based on anything you heard today or any additional thoughts based on what you've heard previously, is there anything else that you would add to the desired vision and culture for value-based transformation?

CHAIR CASALE: Jennifer?

DR. WILER: Can you just clarify for us, I assume all the comments we just made will be translated?

MS. McDOWELL: Correct, we will be translating those, exactly. That's part of the challenge. These slides don't take into account what we are learning over the next few days.

Hearing none, I assume we can move forward.

CHAIR CASALE: Hold on one second.

DR. MILLS: I see these were lifted off the PCDT slides which I like. Number 7 though strikes me. As worded, it doesn't really describe a vision and culture statement, it's more of a tactical operational statement.

We might think about rewording that differently or striking it from the list either way.

MR. STEINWALD: Parsimony, somebody used that word earlier, and it's one I hadn't seen in a while. It's a desirable feature of almost anything, so I think striking it might be a good idea.

DR. SINOPOLI: And I don't know if this belongs in vision or not, but for me it certainly does.

For us to be able to restratify and base our care on data-driven processes, that really should be driving a lot of our decision-making, and maybe that's not in vision and culture, but to me it's certainly culture and data-driven decisions as opposed to anecdotal decisions.

DR. MILLS: Angelo, one way to work that it may reflect some of the conversation prior to here which was moving actionable timely data to the health data utility concept,

that's a vision and cultural statement to work towards.

DR. FELDSTEIN: Angelo, you could use that as number one culture accountability for clinical, quality, equity, and collective outcomes based on actionable data.

DR. SINOPOLI: I could add it to number one.

MS. McDOWELL: Any other thoughts on this slide? We'll be going back and working further with the PCDT after this meeting to further refine the comments and then coming back to the Committee to make sure we've captured what you said.

If you can move to Slide 7, again, this is from the PCDT presentation. We just want to confirm if you have anything else that you would like to add? This is Subtopic 2A for anyone that's looking through the document.

Anything you'd like to add to services included in total cost of care? This is related to core benefits, supplemental benefits, pharmacy benefits.

And again, this is at a high level. The actual report to the Secretary will have more detail, but trying to capture what kinds of statements you might want to make to the

Secretary.

CHAIR CASALE: Jennifer?

DR. WILER: I'm not sure if this is the right place to capture it, but there was conversation today in our previous sessions around capital costs.

Actionable data is when we focused on a lot, in our care coordination sessions, we also talked about infrastructure costs, and we heard a little bit about it on our long-term care example today from an ACO perspective.

So, if it's appropriate to add that as a call-out.

MS. McDOWELL: Anything else?

DR. LIN: The first bullet point about defining TCOC as including Medicare Part A and Part B expenditures, does that conflict with our working definition of TCOC models, which assumes accountability for quality and TCOC for all covered health care costs?

So, in other words, Part D expenditures? We had touched upon this in our admin session earlier this morning, but there are some discussions on PBMs[46] and drug costs and device costs.

46 Pharmacy benefits managers

MS. McDOWELL: I think the reason why it's written that way, and I think this is part of what you guys had said back in March, but obviously we've evolved since March, was that TCOC is currently defined in Medicare APMs as including the Part A and Part B.

But obviously we've heard discussion about the importance of the Part D expenses. So, I guess you guys need to figure out what you would want to recommend to the Secretary regarding that.

But then there's also been discussion that there are complexities in adding additional services to TCOC.

DR. KOSINSKI: I had the same thoughts as Walter when I read it at first, but your last major bullet does address that. That's why I felt like it was at least represented on the slide.

DR. LIAO: I think another potential way to address Walter's point is in the third bullet, in the long-term, the end of it says a definition of TCOC should be allowed to differ.

I think what we're hearing here is they can differ even now, so it may be helpful to pull that concept up and move that into a nearer-term issue but leave it the way Walter

talks about in the last bullet.

DR. MILLS: I know we've had a conversation back and forth on this, but I would encourage to leave it out, leave the bullet point about testing the impact, so considering models where it could be included.

The reality is the vast majority of Part D costs are not in the control of the physician team, no matter how well they coordinate or care-manage a patient.

It's contract prices, and Medicare is negotiating those, and there are just way more influences that exceed any physician's ability or influence.

MS. McDOWELL: Any other thoughts? Let's move to the next slide, Subtopic 2B. Again, this was an attempt to list some things we had heard about, financial and non-financial incentives.

We've just heard you guys talk a little bit earlier about some of the non-financial incentives. But if there's specific things you want to add now, you can let us know.

DR. SINOPOLI: It's kind of covered, Audrey, but on the next slide where it talks about encouraging the high-touch team-based

models, some of where I'm questioning is does there need to be a bullet around somehow financially incentivizing that to happen?

Because we say it should happen, but it's implied I guess that financially we need to support that. It would be clearer to put it in this slide.

DR. LIAO: I agree with Angelo's comments and on Slide 8, at least from my opinion, I don't know that you can design morale and autonomy in, but I think you could envision payment models that could counteract those.

So, maybe just a few words either accounting for that in payment model design might be useful.

DR. MILLS: Still on Slide 8, Subtopic 2B, I think the second bullet point is interesting, and I agree that it's there. The glide path, all the speakers spoke to the glide path is a value-based model.

It starts with no downside and limited upside. We didn't hear anybody say that glide path should be fee-for-service with a pay-for-performance bonus or should be a shared savings model. You never heard those words uttered today.

And so the glide path is you are in value-based payment with everybody else, it's just you start with more up, less down, and gradually shift over time.

MR. STEINWALD: Should we make fee-for-service uncomfortable?

I think the sense of that is -- maybe this is obvious, but one of the reasons we're doing it is to encourage them to go into value-based payment models, make it uncomfortable to stay where they are.

So, I think somewhere that concept should be represented.

MS. McDOWELL: Anything else?

We can go to Slide 10, which is Subtopic 3A and again, this is just going one by one through the items that the PCDT had identified as desired care delivery features in identifying some potential comments that you may want to make, but feel free to refine or take things out, make revisions.

Let's move on to Slide 11, balanced use of and coordination between primary care and specialty care. I anticipate that's one where you are likely to have more to say both today, as well as tomorrow because we'll be hearing more about that.

DR. LIAO: This is a minor comment, but just in the first bullet related to PCPs playing a major role in reducing cost, I might just consider removing or addressing that.

The reasons for that include I think what Jay and others have described as an investment of primary care and not tying that too much to cost reduction.

Michael talked about how there are cost offsets for preventative care, but it ought to be something we should do. So, just be wary of that as we word it.

CHAIR CASALE: I have the same sentiment. I feel like we should remove that part of that sentence.

DR. KOSINSKI: Bullet number 4 is more of a tactic.

MS. McDOWELL: Do you want to delete it?

DR. MILLS: It does speak to the balanced use of -- so you're right, it's a way to be tracking and judging your balance.

DR. KOSINSKI: It's a tactic, though.

DR. MILLS: To Larry's point, it is a tactic.

DR. WILER: I like the idea of

keeping in the sentiment that we heard at our last session around models that were highly effective in terms of outcomes, cost reduction, and quality that described high utilization from an engagement perspective and touches.

So, I totally agree with you around the tactic is monitoring the data with some, how this principle of actually, there's more work being done by different members of the care team that can be highly effective and reduce costs.

DR. KOSINSKI: Yes, the bullet doesn't tell us what to do with the data, it just says to monitor it.

CHAIR CASALE: Right, but I think Jennifer is suggesting to call out the piece about the multiple encounters and the value of the high-touches.

DR. KOSINSKI: But it should lead to an action and not just monitoring it?

CHAIR CASALE: Eliminating the monitoring data, as you said, but keeping the part about the value of the multiple touches is an effective way of coordinating care.

DR. LIAO: To the extent that reflects coordination, there may be a way to incorporate that into the bullet below related

to coordination and alignment between primary care and specialty care providers.

DR. PULLURU: Yes, I was thinking combining that with the bullet point below and just putting improving coordination and alignment, including high-touch care when necessary between primary care and specialty.

DR. SINOPOLI: My only concern about combining those two is that refocuses on the doctor-to-doctor touches when I think we really need to be moving to non-physician touches.

How do we highlight both of those ideas?

DR. WILER: I was thinking the same thing but maybe by calling it care team as opposed to provider, which I think we're not saying explicitly but we should.

DR. PULLURU: Or you can keep it separate and take away the data and talk about encourage care-team-based care or high-touch care as appropriate.

MS. McDOWELL: Anything else on that slide?

DR. MILLS: The last bullet still strikes me off tone, incentivize specialists' participation and engagement with, it just really sounds like you're throwing money at the

specialist to get them to take the primary care doctor's phone call.

So, somehow we're talking about including, we're baking into the model specialist coordination involvement.

The concept is sound, the word incentivize I think especially is a fee-for-service sounding term, so we want to just reword that a little bit.

MR. STEINWALD: Or eliminate it because you've already got specialist and primary care physician coordination and consultation already in two bullets.

MS. McDOWELL: Anything else on this slide? Let's move to Slide 12.

DR. WILER: I guess what I'm thinking on this one, and we heard this again from our long-term care presenter today, but we heard it in the past and maybe it's because I'm in the quality and safety space, but an adverse health outcome is unexpected or unanticipated, where as we age, there will be a progression of disease that we cannot prevent but try to mitigate.

What we're trying to capture is that these complex patients require a special focus, special care team, special resources that may

be different from other patient populations but not necessarily mitigating adverse health outcomes.

It doesn't, I don't think, fully describe what we're trying to focus on.

MR. STEINWALD: Just as a point of order, I don't know that you can say rising risk in the first bullet and then have quote marks around it in the last bullet.

Couldn't you just make it a little simpler, use risk stratification to identify needs, coordinate care, and manage transitions? I don't know why you need to say high-risk, low-risk, rising risk.

Because it's a continuum, it's not three different unique things.

DR. MILLS: I was going to make the same point to strike that with high risk, low risk, rising risk, make it read right because you use risk stratification for all kinds of reasons in the population health model and those three categories often --

MR. STEINWALD: On the third bullet point, balanced focus on reducing costs on high-risk patients and increasing investment in primary care, I think that is all true.

The phrase for lower-risk patients,

the investment in primary care isn't focused on lower-risk patients, it's just investment in primary care to achieve short- and longer-term reduction.

So, I would just strike that phrase for lower-risk patients.

DR. LIAO: I was going to say just quickly I think the title has complex needs in it, and we don't really call that out in the bullets below, so maybe some way of working that in.

Also, I think saying risk but not saying risk of what, like costly care or bad outcomes, I think we can append that somehow throughout the slide would be good.

DR. LIN: In terms of the targeted population-based interventions for population with complex needs, LTC today did say there was a big focus on using palliative care, advanced care discussions, even hospice in this population.

I'm not sure if you wanted to call this out here, but I think there is a big trend with that right now.

DR. SINOPOLI: Maybe part of what this slide was trying to get to was at least in the data that we looked at over the years,

there's high-risk complex patients that have intense care management around them actually have fewer gaps in care than that 70 percent of the patients that are out there that aren't being managed because nobody is managing them.

So, ignoring that 70 percent of the population is probably not a wise thing to do. So, somehow in here identifying that there needs to be some type of gap closure data process that identifies those patients and gets those gaps closed I think is probably what this is trying to get to.

So, somehow leaving that in there I think would be good.

MS. McDOWELL: Anything else? Moving onto Slide 13.

DR. LIAO: Just minor, but I think in the second bullet when we're talking about high-risk patients, at least my interpretation is high-risk of having care affected by the social drivers of health, which is distinct from the prior slide.

So, I would just try to make that clear. I also think in the third bullet we say in the near term which makes me want to lead in the longer term.

So, I think we actually get at that

in the latter half of that bullet, that may be useful to add.

DR. SINOPOLI: And we may not be mature enough yet to incorporate this, but typically when we're talking about social needs and social determinants of health, we're talking about identifying those and referring those.

We rarely talk about expecting some outcome or holding somebody accountable for that. And so there's this missing piece around the communities there that somehow we need to begin to incorporate into our models and thinking.

DR. PULLURU: One of the things that came up earlier today was incentivizing partnership with community organizations.

Do we want to craft some language around tying reimbursement, for example an ACO REACH where it's tied to that, tying reimbursement towards actually having those community partnerships?

DR. SINOPOLI: I like that.

VICE CHAIR HARDIN: We did hear really clearly here, as well as previously, about the real issue of navigating to nowhere.

The stuff beyond incentivizing

screening or incentivizing partnerships is how are we actually investing in building this system of response? And how is that system sharing in the accountability or rewards for total cost of care?

CHAIR CASALE: I guess I'm struggling a little with the first one where it says the primary care is making referrals in a way that minimizes provider burden.

That is important, but I think making referrals that are effective and minimize provider burden, I think there needs to be something else there about the referrals and the process being effective for the patient.

And then adding the minimizing burden. DR. SINOPOLI: Yes, that could actually be two different bullets because I can tell you that referring to the community-based organization is extremely administratively burdensome and problematic.

And so incentivizing the process to streamline, that would be good.

DR. MILLS: I was going to point out that adding the phrase making referrals in that first bullet, that's a tactic, that's one way to meet social needs. It's not all about

referrals. Really great care teams have the people in the team that can meet some of those needs, so I might just strike that clause, the rest of it works.

MS. McDOWELL: Anything else?

DR. MILLS: I really do appreciate the third bullet in trying to come up with a defined social needs screening instrument.

There's just not a PHQ9[47] of social needs yet, and I don't think most operators care which one they need to use, they just say four organizations make them use four different ones.

MS. McDOWELL: We are almost at 4:15 p.m. Do you want to do another slide?

CHAIR CASALE: Do we have time tomorrow?

MS. McDOWELL: Yes, we have time tomorrow.

*** Closing Remarks**

CHAIR CASALE: I think the consensus is to defer the rest until tomorrow. So, with that, I want to thank everyone for participating today, our expert presenters, my

47 Patient Health Questionnaire-9

PTAC colleagues, and those listening in.

There's more to cover on payment considerations and financial incentives for total cost of care models. We'll be back tomorrow morning at 8:45 a.m. Eastern.

*** Adjourn**

We'll feature two listening sessions, as well as time for public comments. We hope you will join us then. Thank you, this meeting is adjourned for the day.

(Whereupon, the above-entitled matter went off the record at 4:12 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Meeting

Before: PTAC

Date: 09-19-22

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter