

PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL
ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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

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WEDNESDAY, JUNE 8, 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
ANGELO SINOPOLI, MD
BRUCE STEINWALD, MBA*
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS NOT IN ATTENDANCE

SOUJANYA R. PULLURU, MD

STAFF PRESENT

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

*Present via Webex

A-G-E-N-D-A

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

9:30 a.m.

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2
3 * VICE CHAIR HARDIN: Good morning and
4 welcome to Day 2 of this public meeting of the
5 Physician-Focused Payment Model Technical
6 Advisory Committee, known as PTAC.

7 I am Lauran Hardin, the Vice Chair
8 of PTAC. Thank you for tuning in. I would
9 like to welcome Dr. Liz Fowler, who is the
10 Deputy Administrator of the Centers for
11 Medicare & Medicaid Services and Director of
12 the Center for Medicare and Medicaid
13 Innovation.

14 Dr. Fowler previously served as
15 Executive Vice President of Programs at the
16 Commonwealth Fund and Vice President for Global
17 Health Policy at Johnson & Johnson.

18 She was Special Assistant to
19 President Obama on health care and economic
20 policy at the National Economic Council.

21 From 2008 to 2010, she also served
22 as Chief Health Counsel to the Senate Finance
23 Committee Chair where she played a critical
24 role in developing the Senate version of the
25 Affordable Care Act.

1 Welcome, Liz.

2 * **Elizabeth Fowler, JD, PhD, Deputy**
3 **Administrator, CMS¹, and Director,**
4 **Center for Medicare and Medicaid**
5 **Innovation (CMMI) Remarks**

6 DR. FOWLER: Thank you so much, Ms.
7 Hardin, and good morning, everyone.

8 I'm really delighted to be here with
9 members of the PTAC and everyone participating
10 in this Day 2 of the PTAC June 2022 public
11 meeting. I'm so glad to be here in person
12 today and to be able to join you.

13 The CMS Innovation Center's vision
14 is a health system that achieves equitable
15 outcomes through high-quality, affordable,
16 patient-centered care.

17 We very much appreciate the
18 partnership and collaboration of PTAC as we
19 strive to meet the ambitious goals embedded in
20 this vision.

21 I think many of you are already
22 familiar with the strategy that CMMI issued
23 last fall; but as you continue the discussion

1 Centers for Medicare & Medicaid Services

1 today on population-based total cost of care
2 models, I thought it might be helpful to
3 reiterate the five strategic objectives that
4 guide and prioritize our work and tell you what
5 we've been doing to try to reach our goals.

6 So, if you'll indulge me for a
7 little, as our first objective as part of the
8 strategy, it's -- we've put an emphasis on
9 driving accountable care.

10 And that means focusing on payment
11 and performance incentives and models, and
12 especially in total cost of care models, for
13 specialty and primary care providers, to
14 coordinate delivery of high-value care, and
15 reduce duplicative and low-value care.

16 We set an ambitious goal to have all
17 Medicare beneficiaries, and a vast majority of
18 Medicaid beneficiaries, in a care relationship
19 with accountability and quality -- for quality
20 and total cost by 2030. This means an ACO²,
21 advanced primary care or Medicare Advantage.

22 Although, I think we don't
23 automatically assume that MA³ plans are paying

2 Accountable Care Organization

3 Medicare Advantage

1 based on value. As we understand it, many of
2 them may receive capitation, but still pay
3 providers based on fee-for-service.

4 In February, we announced changes to
5 the CMS Innovation Center's Global and
6 Professional Direct Contracting model and the
7 transition to a new ACO REACH⁴ model.

8 And the design of REACH has laid a
9 lot of the groundwork for our thinking in terms
10 of how to advance equity. And the model can
11 also be critical to reaching our accountable
12 care goals.

13 Medicare Shared Savings Program and
14 our ACO programs at the Innovation Center need
15 to work together.

16 And with our colleagues at the
17 Center for Medicare, we published a piece in
18 the *New England Journal of Medicine* last month
19 that speaks to our shared vision of testing
20 certain aspects of new Innovation Center ACO
21 models that will inform the MSSP⁵ program.

22 We're working to design our models
23 to provide higher-quality, better-coordinated

4 Realizing Equity, Access, and Community Health

5 Medicare Shared Savings Program

1 care at the same or lower cost to Medicare
2 beneficiaries, and we aim to put the patient at
3 the center of the care team that provides high-
4 value, equitable, evidence-based care while
5 holding providers accountable.

6 We look forward to learning more
7 from PTAC and the speakers from the June public
8 meeting to help inform our work on this
9 objective.

10 I was fortunate to be able to meet
11 with the PTAC members in an executive session
12 to learn more about what happened yesterday and
13 a lot of the lessons from the speakers. I
14 unfortunately had to miss yesterday's meeting
15 due to another conflict.

16 Our second objective is advancing
17 health equity. We're committed to embedding
18 health equity into all aspects of our payment
19 and service delivery models.

20 And central to this work, if you
21 look at our models launched to date, we have
22 not necessarily been representative of patients
23 in low-income, Hispanic, and rural communities,
24 and we want to use all available levers to
25 ensure equitable access to the innovations

1 worth testing.

2 Is that my microphone? No?
3 Alright. We're working to design models to
4 increase participation among providers that
5 care for underserved populations and close
6 disparities in care and outcomes.

7 In December, we held a roundtable on
8 our health equity strategy. And in March of
9 this year, Dr. Dora Hughes, who is our Chief
10 Medical Officer, published a paper in *Health*
11 *Affairs* that talked about our strategy in a
12 little bit more detail regarding health equity.

13 And then in March, we held a
14 roundtable focused on safety net provider
15 participation in CMS Innovation models.

16 I'm interested to hear from your
17 speakers what more we can do to attract these
18 safety net providers in total cost of care
19 models.

20 Objective three is related to
21 supporting innovation. What more can we do to
22 support model participants? Looking for ways
23 to innovate care delivery approaches.

24 That includes actionable data,
25 learning collaboratives, payment flexibilities

1 available to model participants.

2 I heard today from members about the
3 need for really timely data, too, to make sure
4 that it actually is influencing decisions.

5 Our fourth objective is
6 affordability -- addressing affordability. We
7 have been very laser-focused on expenditures in
8 Medicare and Medicaid, but we also want to make
9 sure that our models have an impact on lowering
10 patients' out-of-pocket costs. And we're
11 looking for strategies that target health care
12 prices, affordability, and reducing low-value
13 and duplicative care.

14 Going forward, we're focusing on
15 payment and performance incentives in models,
16 and especially in total cost of care models,
17 for specialty and primary care providers to
18 coordinate delivery of high-quality care and,
19 as I said, reduce duplicative or low-value
20 care.

21 And then the final is, partner to
22 achieve health system transformation. And this
23 is part of -- as I think about this goal, it's
24 really around multi-payer alignment, and I have
25 heard very loud and clear the need to find ways

1 of engaging commercial payers, working closely
2 with states on Medicaid and other purchasers
3 and others to make sure that we're all aligned
4 and heading in the same direction.

5 It might not need to be as part of a
6 single model, but maybe there are aspects of
7 care where alignment makes the most sense, for
8 example, on quality metrics.

9 We're working towards our 2030 goal
10 for multi-payer payment alignment and all new
11 models, and asking stakeholders like you how we
12 can better align with private payers,
13 purchasers, and states.

14 We're actively engaging
15 stakeholders, leveraging existing and new
16 mechanisms to enhance engagement with patients,
17 providers, and payers, and we want to try to
18 improve transparency in our model design and
19 implementation.

20 We're holding listening sessions
21 with beneficiaries, health equity experts,
22 primary care, I mentioned safety net, specialty
23 providers, states, and payers.

24 And last month, Administrator
25 Chiquita Brooks-LaSure hosted a listening

1 session on dementia care, which is an area of
2 growing interest for the Innovation Center.

3 The Innovation Center will continue
4 to communicate and share our strategy through
5 conferences, podcasts, learning events, and
6 opportunities like the PTAC public meetings.

7 We're excited that the meeting here,
8 the presentations and discussions about
9 population-based total cost of care plan for
10 yesterday and today focusing on addressing some
11 of the same challenges that we're facing.

12 So maybe, in closing, I just want to
13 thank PTAC for their valued work and continued
14 support for health care transformation.

15 And also to thank the Committee for
16 putting together such a vigorous agenda and an
17 amazing panel of experts.

18 Again, just like the March meeting
19 and the meetings before, I'm consistently
20 impressed with the folks that you have
21 presenting and sharing their perspective.

22 So, thanks for your attention and
23 best wishes for a great second day.

24 VICE CHAIR HARDIN: Thank you so
25 much, Liz, for the time this morning and also

1 these very valuable comments.

2 We look forward to continuing to
3 collaborate with you and your team, and you're
4 welcome to stay.

5 There's some really interesting
6 speakers that really connect to the themes that
7 you raised, and I hope you get an opportunity
8 to hear them today.

9 So, you can move to the seating
10 area, if you'd like, but we also understand if
11 you have a busy schedule and have to go. We'll
12 definitely be sending you the notes and --

13 DR. FOWLER: I'll be dialing in.

14 VICE CHAIR HARDIN: -- you can
15 access the video.

16 DR. FOWLER: I will be listening.

17 Thank you.

18 VICE CHAIR HARDIN: Thank you so
19 much, Liz. I really appreciate your time.

20 * **Welcome and Population-Based Total**
21 **Cost of Care (PB-TCOC) Models Session**
22 **Day 2 Overview**

23 So, yesterday we had a variety of
24 experts present from academics and payers to
25 our very own Angelo Sinopoli.

1 They generously offered their
2 experience with care delivery in population-
3 based models.

4 Today, we have multiple presenters
5 and panelists ready to share their expertise
6 followed by a panel discussion. Then, we will
7 have a public comment period.

8 Public comments will be limited to
9 three minutes each. If you have not registered
10 in advance to give an oral public comment
11 tomorrow, but would like to, please email PTAC
12 registration at NORC, N-O-R-C dot org. Again,
13 that's ptacregistrsturation@norc.org.

14 Finally, the Committee will have a
15 discussion to shape our comments for the report
16 to the Secretary of HHS⁶ that we will issue
17 later after the series concludes.

18 * **PTAC Member Introductions**

19 Because we might have some new folks
20 who weren't able to join yesterday, I'd like
21 the Committee Members to please introduce
22 themselves.

23 Share your name and your

6 Health and Human Services

1 organization. And if you would like, you can
2 share a brief word about experience you may
3 have with population-based payment or total
4 cost of care models.

5 I'll start. I'm Lauran Hardin,
6 Senior Advisor for National Healthcare and
7 Housing Advisors, and have spent the past 20
8 years either directly delivering value-based
9 payment models and now partnering with states,
10 communities, health systems, and payers to
11 design models for population total cost of
12 care.

13 Paul?

14 CHAIR CASALE: Paul Casale. I'm a
15 cardiologist. I lead Population Health at
16 NewYork-Presbyterian, Weill Cornell and
17 Columbia. And also oversee NewYork Quality
18 Care, which is the MSSP ACO for NewYork-
19 Presbyterian, Weill Cornell and Columbia.

20 DR. FELDSTEIN: Hi. I'm Jay
21 Feldstein. I'm the President and CEO of
22 Philadelphia College of Osteopathic Medicine,
23 trained in emergency medicine, and I spent 15
24 years in the health insurance industry in both
25 commercial and government programs.

1 I have a lot of experience in
2 capitated products and group sharing
3 relationships.

4 DR. MILLS: Good morning. I'm Lee
5 Mills. I'm a family physician. I'm Senior
6 Vice President and Chief Medical Officer at
7 CommunityCare Managed Healthcare Plans of
8 Oklahoma.

9 Involved in both commercial Medicare
10 Advantage and individual exchange space.
11 Experienced in medical group leadership.
12 Operating in MSSP and multiple CMMI value-based
13 models over the years.

14 DR. LIN: Good morning. I'm Walter
15 Lin, founder of Generation Clinical Partners.
16 We are a medical group focused on delivering
17 care to the frail, elderly, and senior living,
18 particularly nursing homes and assisted living
19 facilities.

20 DR. SINOPOLI: Good morning. I'm
21 Angelo Sinopoli. I'm a pulmonary critical care
22 physician by training. I've spent the last 20
23 years in population health. I've run large
24 integrated networks, and I've built enablement
25 companies.

1 Presently, I'm the Chief Network
2 Officer for UpStream, which is a company that
3 partners with primary care physicians to enable
4 them to participate in value-based
5 arrangements.

6 DR. LIAO: Good morning. Josh Liao.
7 I am an internal medicine physician on faculty
8 at the University of Washington.

9 There, I'm also the Enterprise
10 Medical Director for Payment Strategy, as well
11 as I lead a group that does research and
12 evaluation on payment and delivery models,
13 including total cost of care models.

14 And so, in those ways think about
15 how do we translate design and policy
16 evaluation into practice.

17 DR. WILER: Good morning. I'm
18 Jennifer Wiler. I'm the Chief Quality Officer
19 at UHealth's metro area.

20 I'm a tenured professor of emergency
21 medicine at the University of Colorado School
22 of Medicine, and I'm a cofounder of UHealth's
23 CARE Innovation Center, where we partner with
24 digital health companies to grow and scale
25 their solutions to improve the value and

1 outcomes of care for patients.

2 I was an original co-author of an
3 Alternative Payment Model.

4 DR. KOSINSKI: I'm Larry Kosinski.
5 I am a gastroenterologist and am the founder
6 and Chief Medical Officer of SonarMD, a company
7 that I founded back in 2016.

8 I've spent the last 10 years of my
9 career focused on value-based care, and I'm
10 happy to report that Sonar was the first PTAC-
11 recommended physician-focused payment model
12 back in 2016.

13 VICE CHAIR HARDIN: And, Bruce, we'd
14 like to ask you to introduce yourself from
15 Zoom.

16 MR. STEINWALD: I'm Bruce Steinwald.
17 I'm a health economist in Washington, D.C.,
18 although right now I'm in Massachusetts. And
19 this is my seventh year as a member of PTAC.

20 * **Listening Session on Assessing Best**
21 **Practices in Care Delivery for PB-**
22 **TCOC Models (Part 3)**

23 VICE CHAIR HARDIN: Thank you so
24 much, Committee members. As you can see, we
25 have a tremendous wealth of experience and

1 expertise on the panel.

2 So, at this time I'm very excited to
3 welcome our third listening session for this
4 two-day public meeting.

5 Paul, would you please come forward
6 and join the table.

7 (Pause.)

8 VICE CHAIR HARDIN: We've invited
9 three outside experts to give short
10 presentations based on their experience, and
11 then our Committee members will be able to ask
12 questions.

13 You can find our speakers' full
14 biographies on the ASPE PTAC website. Their
15 slides will be posted there after the public
16 meeting as well.

17 Presenting first we have Dr.
18 Christopher Chen, who is the Chief Executive
19 Officer of ChenMed.

20 Welcome and please begin, Chris.

21 DR. CHEN: Thank you very much.
22 Sorry I couldn't be there in person.

23 Well, my name is Chris Chen. I'm a
24 primary care doc and cardiologist. I'm also
25 the CEO of ChenMed. We're family-owned and

1 unlike any other type of practice that's out
2 there, but I believe that our model should be
3 much more universal, much more global.

4 ChenMed began in the 1980s, and we
5 had this mission that we wanted to serve. We
6 weren't trying to chase investor returns, but
7 by having mastered and standardized what we do,
8 we've actually surprisingly self-funded all of
9 our growth.

10 We now, by the end of the year,
11 should be operating about 130 medical centers
12 across three brand names hitting roughly 40
13 cities and about 14 states.

14 As of this week, I believe we're
15 going to break 5,000 employees and, on average,
16 we've been growing about close to 40 percent
17 per year.

18 You know, our background is risk.
19 We believe that we are, like many people in the
20 room, a pioneer in risk in that we work 100
21 percent in a global risk model and, you know,
22 we're fully accountable for the total cost of
23 care.

24 That means on the spectrum of risk
25 there's, you know, fee-for-service, then

1 there's that small proportional jump into
2 value, and then you start to move down that
3 sort of, you know, slope towards the very far
4 end of that risk spectrum, and that's where we
5 are, where we hold full upside and full
6 downside, even stop loss A, B, and D. All
7 costs.

8 And historically, we have operated
9 in Medicare Advantage because it was really
10 well-suited and structured for, you know, the
11 type of care that we give in a risk-adjusted
12 global capitation model, especially in the
13 populations that we serve, which I'll talk
14 about shortly; however, we, too, have recently
15 applied to participate in the ACO REACH
16 demonstration model. Just saw Liz there. So,
17 excited that she had an opportunity to speak.

18 And so, we can now take this model
19 that is able to achieve the kind of outcomes
20 that I'm going to be sharing with you to not
21 just Medicare Advantage patients, but also
22 Medicare patients.

23 ChenMed has a focus. We serve
24 lower-income seniors with multiple chronic
25 conditions, and we have a mission-driven model

1 of love, accountability, and passion that
2 compels us to serve those whom a health care
3 system has essentially overlooked, forgotten,
4 and ignored.

5 By focusing on this target
6 population, we've become experts in their
7 needs, and we've actually designed a care team,
8 or care system, for them.

9 Let me just give you some
10 demographic numbers. Our patients are about 40
11 percent dual eligibles; 70 percent of our
12 patients are racially or ethnically diverse.

13 I have heard most recently that over
14 70 percent of our team, our care team, are
15 women of color.

16 Our patients typically have five or
17 more major chronic conditions, and our senior
18 medical centers are actually located in the
19 most underserved neighborhoods where our
20 patients live. So, we have boots on the
21 ground.

22 And these are often the patients
23 that make up a large share of the total cost in
24 the overall Medicare population.

25 We're very familiar with that 5

1 percent that accounts for 45 to 50 percent of
2 the cost or 15 percent that may account for 70
3 to 80 percent of the cost.

4 Those are our patients, but I'm
5 starting to believe that the method that we
6 call "transformative primary care" can
7 translate beyond our target population and can
8 benefit the broader American population.

9 So, let me just share with you what
10 we consider our model and what we consider what
11 transformative primary care is.

12 So, how does ChenMed work, and what
13 does it imply about our policies that can spur
14 others to work similarly?

15 We need more people joining us in
16 the way that we do things. So, here are some
17 differences.

18 We believe this, what we call "Type
19 1 traditional primary care." In short, this is
20 a narrow and reactive primary care model where
21 primary care doctors do not have
22 accountability, and they are rushed to do some
23 wellness visits and mostly churn through their
24 sicknesses trying to triage patients downstream
25 to the right specialists, which are typically

1 pills, procedures, and referrals, and they're
2 used as a tool within large health systems to
3 actually help to generate those downstream --
4 that downstream volume.

5 The problem is it doesn't solve
6 health. If you have more of that primary care,
7 you're not going to solve health, and it will
8 not lower cost. Evidence has demonstrated
9 that. And it doesn't address the whole person,
10 the physical, the mental, the social.

11 Then there's type 2 primary care.
12 We call that "advanced primary care." This is
13 worlds better.

14 Now, the financial accountability
15 through taking capitation is there to varying
16 degrees, but the strategies employed are --
17 sort of wrap-around to the PCPs⁷ that are going
18 after the finances.

19 So, let me tell you what I mean.
20 These are sort of like financial measures.
21 These are, you know, advanced primary care
22 groups out there that their primary goal is to
23 chase after risk-adjustment squeezing the

7 Primary care providers

1 downstream providers, you know, whipping them
2 for cost and for pricing, using third-party
3 vendors a lot.

4 And in that environment, you know,
5 actually results do improve. You get better
6 outcomes, and you do get some lower costs, but
7 the issue is there are complaints and -- from
8 patients, there's potential for malalignment
9 between patient and provider, and then there's
10 also incomplete realization of true goals.

11 What I'd like to introduce you to
12 today is what we call "type 3 transformative
13 primary care," which we believe we are helping
14 to create and pioneer and lead in the U.S.
15 today, and this is where there's this true
16 proactive, holistic, clinical model.

17 See, it's the same, you know,
18 economic structure as the previous advanced
19 primary care type 2 model, but the solutions
20 come through the PCP. The accurate risk
21 picture comes through the PCP's deep patient
22 engagement.

23 Our PCPs, believe it or not, spend
24 about nine to 12 months training and learning
25 to lead teams, influence patients, master

1 customer service, understand medical economics,
2 differentiate documentation and care for
3 outcomes versus for billing, and more.

4 And we actually train our doctors
5 differently. We don't joke anymore. We
6 actually tell them seriously, doctor, when you
7 join, it's a one-year fellowship. Do not think
8 of this as you're an attending. You are a
9 well-paid fellowship, right?

10 And we put them through this
11 training, and let me tell you the three things
12 that we focus very deeply on in which we think
13 we are helping to forward the field of medicine
14 and training in. So, three areas.

15 Number 1, we train doctors to think
16 holistically. Historically, PCPs have solved
17 problems through pills, procedures, and
18 referrals.

19 We have learned that about 20
20 percent of a true patient's health is really --
21 involves pills, procedures, and referrals, what
22 we learned in training.

23 The other 80 percent of the equation
24 is moving, you know, most of these patients
25 upstream to focus on things that, for example,

1 are lifestyles and behavior, social
2 determinants of care.

3 And, of course, we have not yet
4 figured out a way to modify genetics yet, but
5 maybe one day.

6 And so, as doctors, as we think
7 holistically and are training doctors to think
8 holistically, there's something that we must
9 sort of develop in our physicians.

10 Second of all, we train our doctors
11 to focus on prevention. Now, Paul, I know
12 you're at Presbyterian, you know.

13 I'm a doc. I finished my training
14 at a Harvard hospital, and then I went to
15 Cornell and felt very good about myself.

16 Came to South Florida with the
17 equivalent of five board certifications, you
18 can ask Bruce Lerman if he thought I did a good
19 job. I think he still thinks very highly of me.

20 But what was crazy was my very first
21 patient was a heart failure patient, and I
22 said, well, "I got this," and that patient got
23 readmitted and died.

24 And so, I discovered very quickly
25 that I did not know that doctors do not know --

1 they are not trained in prevention.

2 For something as simple as heart
3 failure in which I'm probably, at the time, was
4 one of the highest trained, you know,
5 cardiologists in the state at the time who did
6 not know how to prevent what, quite frankly, is
7 one of the most preventable and leading causes
8 of admission in America today. We believe
9 today that 90 percent of heart failure
10 admissions are preventable.

11 Talk to any emergency room doctor.
12 They'll give you a similar number: 80 to 90
13 percent. And we demonstrated that particularly
14 in patients with multiple chronic conditions.

15 So, we are training doctors to move
16 upstream. We are creating workflows that do
17 not exist.

18 We have evidence, we have data that
19 surpasses many of the academic institutions
20 that I've worked at because we are so broadly
21 distributed and because we have access to the
22 full source of all the datasets to create these
23 workflows in prevention.

24 And third, we're training doctors
25 how to win.

1 What I've discovered is that
2 doctors, during our training process, were not
3 taught to be accountable for outcomes.

4 We are altruistic people that are
5 mission-driven. It's a calling, but yet we
6 aren't taught how to win.

7 We are taught, and we come in
8 wanting to win, but not taught how to win. And
9 the only way that you know if you're winning or
10 not is you have to measure it.

11 So, we actually make our PCPs
12 accountable for an outcome. We expect our PCPs
13 to reduce hospitalizations by 50 percent.

14 It is not enough to try. We do not
15 give out trophies for trying. We are unique in
16 that we give trophies for winning, and,
17 therefore, we believe that we, our doctors, are
18 accountable for improving the patient's health
19 outcome across the spectrum because you cannot
20 improve what you do not measure. And so, we
21 measure everything.

22 We have folks with -- several
23 analytics people. In our organization, we have
24 well over 300 -- it would be close to 400 data
25 scientists and software engineers in our

1 organization that's partnered with us. And so,
2 we take our tech and we take our analytics
3 very, very seriously.

4 So, what is our care model? It's
5 very simple. If you just take concierge
6 medicine and put it on steroids, you got it.

7 So, our PCPs have very small patient
8 panels. Typically about 400 to 1. Concierge
9 is typically 600 to 1. In our neighborhoods,
10 it's typically 3,000 to 1 because they are
11 deeply underserved, right? High deprivation
12 indexes.

13 And this allows the PCP to have a
14 deep relationship when we see our patients
15 monthly, at a minimum, to manage their complex
16 diseases.

17 And our doctors, they are surrounded
18 with a care team, and they give their patients
19 their cell phone numbers.

20 And then we give them a whole host
21 of capabilities in terms of case managers, care
22 coordinators, care promoters, pharmacy
23 services, and we wrap around that PCP, but the
24 PCP leads the team. We believe that we are the
25 largest physician leadership organization in

1 the country.

2 And so, we believe that the most
3 important element to our PCP success is to
4 learn to get patient trust. You cannot modify
5 behavior and move upstream without earning
6 patient trust.

7 So, the way we do this is with these
8 frequent visits, with the cell phone, you know,
9 giving away your cell phone number, with
10 meeting with the families, wrapping around in
11 the home.

12 And it's not just the PCP and their
13 care team, but their care team reports to the
14 PCP. PCP is ultimately accountable.

15 And so, we are focused and in line
16 with the patient in creating a plan, a very
17 customized plan with that patient, with all
18 these resources, to improve health and
19 ultimately reduce hospitalization rates.

20 Another highlight is a deep
21 investment in overcoming social determinants of
22 health. We offer door-to-doctor transportation
23 through our MA benefits. We plan to do that so
24 our doctors can come to us immediately any time
25 during office hours.

1 And then in the off hours, we have
2 different resources depending on the markets
3 that we're in given that we're in so many
4 cities.

5 We, you know, we provide on-site lab
6 draws. We do on-site medication dispensing for
7 85 to 90 percent of our medications. We have
8 all tier 1 specialties on site. We have
9 diabetic resources. We do cooking classes,
10 social classes, Zumba classes, tai chi classes
11 to reduce hip fractures and falls, you name it.

12 And we do that in addition, and we
13 marry that -- those resources with end-to-end,
14 purpose-built technology developed specifically
15 for outcomes, not to increase revenues and
16 billing. That is not the goal.

17 We have our own EMR⁸ -- so, that's
18 very unique -- and then we develop our
19 workflows in that EMR.

20 ChenMed is a primary care company,
21 but we're responsible for everything.
22 Therefore, if a ChenMed patient needs care
23 beyond what we can offer within our employed

8 Electronic medical record

1 primary care staff and our tier 1 specialists,
2 then the PCP remains the quarterback no matter
3 where they go.

4 And, again, we have these central
5 analytics teams that they partner with our
6 patients to focus people through more high-
7 value, better-outcome specialists.

8 We are tracking this data, and we
9 are tracking who follows evidence-based
10 medicine, because we even have central
11 specialty centers of expertise within our
12 organization, but the key point is the patient
13 remains our patient regardless of where they
14 go.

15 We are fully accountable for
16 everything that happens no matter where the
17 patient goes, and the financial model supports
18 that. ChenMed brings light to the darkness.

19 Just want to wrap up with this final
20 point here. What we do matters in our
21 communities at large because when we treat our
22 senior patients and their health outcomes, it
23 benefits their families because so often our
24 patients are the caregivers, the grandmas or
25 the grandpas that are watching grandchildren so

1 their children, who are 75 percent of the time
2 single moms, can go and work their one or, many
3 times, two jobs.

4 So, if we can uphold the senior
5 population in these neighborhoods that we
6 serve, we actually don't just serve the health
7 of the patient, but we transform the health of
8 the community because these are the individuals
9 that are the pillars of the health of the
10 community.

11 So, let me just talk some data
12 because we like that. We talked about a 30 to
13 50 percent lower hospitalization rate. We do
14 the same for ER⁹ visits.

15 Our screening rates are much higher
16 than national averages, and that's where the
17 average is much higher.

18 We have care programs that have --
19 and we've published that we can reduce stroke
20 rates by 22 percent. We have reduced heart
21 failure admissions by over 70 percent.

22 We believe that our -- not believe,
23 we have data that supports that our patients

9 Emergency room

1 when they develop cancer, have a 50 percent
2 six-month mortality compared to patients who
3 are not ours prior to joining us with cancer.

4 So, pretty cool numbers, we believe,
5 and we're going through data right now, but not
6 only do our patients and -- many times we are
7 equalizing their outcomes between our Black and
8 our white patients and our duals and nondual
9 patients. We believe we're equalizing that.

10 And in many cases we are even
11 eclipsing the average Medicare recipient, and
12 even in higher-income outcomes, because they
13 are patient-focused and outcomes-focused.

14 Our patient satisfaction numbers are
15 in the 90s, as you can imagine, concierge
16 medicine for the lowest-income people, and the
17 upper income scoring in the 80s.

18 So, here are some simple
19 suggestions. Number 1, I believe we must push
20 global risk that's two-sided.

21 Partial cap does not work. People
22 will not change their behaviors. They will
23 wrap around things to get their outcomes.

24 Number 2, we must protect and
25 enhance risk-adjustment, not kill it. You have

1 to -- you got to take away the incentive to
2 pick a perfect population, and doctors can do
3 that. We've seen that in the past.

4 So, you need risk-adjustment.
5 Otherwise, people will not go and take care of
6 the sickest population, but how do you prevent
7 a gaining?

8 You have to rely on people who are
9 closest and most accountable for the care. So,
10 we believe that PCPs should be the ones who are
11 risk adjusting.

12 We do not believe that you can, you
13 know, hire third parties and wraparound
14 services and go to the home to just diagnose
15 people and not participate in actually
16 transforming their care, and we must put that
17 risk with primary care.

18 And we must come up with solutions
19 that can fundamentally change tech and how we
20 do tech, and we believe that health equity is
21 best solved locally, not across the board.

22 And that's it. Thank you very much
23 for your time.

24 VICE CHAIR HARDIN: Thank you so
25 much, Dr. Chen, for that very interesting

1 presentation. We are saving all questions from
2 the Committee until the end of all
3 presentations.

4 Next, I'm honored to announce we'll
5 be having a joint presentation from Dr. Palav
6 Babaria, Chief Quality Officer and Deputy
7 Director of Quality and Population Health
8 Management at the California Department of
9 Health Care Services; and Mr. Paul Leon,
10 Founder, CEO and President of the Illumination
11 Foundation.

12 Please go ahead.

13 DR. BABARIA: Thank you so much.

14 Hi, everyone. It's a pleasure to be
15 here with you today and to share some of what
16 we are doing in our California State Medicaid
17 Program, also known as Medi-Cal.

18 I am an internist by training and
19 have spent most of my career working in value-
20 based payments and clinical operations on the
21 health care delivery system side mostly in
22 California's safety net, and joined the
23 department a year ago to really lead our work
24 around value-based payment, quality, health
25 equity, and population health management,

1 especially given the tremendous changes
2 happening across our program right now through
3 the CalAIM¹⁰ initiative.

4 You can go to the next slide. So,
5 to provide a little bit of context, we're going
6 to kick off with what we are doing right now to
7 really think about whole-person care for our
8 members that really touches upon a lot of the
9 same themes that Dr. Chen touched upon thinking
10 about how do we provide integrated upstream
11 care that really gets at the root drivers of
12 our members' needs.

13 You can go to the next slide. So,
14 for those of you who are not enmeshed in the
15 California Medi-Cal landscape, we, the
16 California Department of Health Care Services,
17 launched CalAIM, which is really a multi-year
18 transformational initiative to fundamentally
19 change how our state Medicaid program operates
20 and achieve a few really critical goals.

21 We are a very large state. We have
22 58 different counties, very different
23 populations and regions across those counties,

10 California Advancing and Innovating Medi-Cal

1 and we have significant social drivers of
2 health that day in and day out impact the
3 outcomes of all of our members in the Medi-Cal
4 program.

5 CalAIM really seeks to identify and
6 manage member risk through this whole-person
7 care approach and really addressing the social
8 drivers of health as a key part of our Medi-Cal
9 program.

10 We also have a lot of variation
11 across the state. So, a lot of the initiatives
12 in CalAIM seek to provide a consistent and
13 seamless experience and standardize many of our
14 fundamental program components across the state
15 of California.

16 And then most importantly, all of
17 the initiatives in CalAIM are geared towards
18 improving quality outcomes, reducing health
19 disparities, and driving delivery system
20 transformation through value-based payments.

21 We can go to the next slide. So, a
22 little bit of background and context. The two
23 initiatives that I wanted to highlight that are
24 part of a much broader suite of initiatives
25 that comprise CalAIM are Enhanced Care

1 Management and Community Supports.

2 The issues that Enhanced Care
3 Management and Community Supports are designed
4 to address is that we know over half of all of
5 our Medi-Cal spending is attributable to 5
6 percent of enrollees with the highest-cost
7 needs.

8 We also know that our Medi-Cal
9 enrollees have often multiple complex health
10 and behavioral health conditions.

11 And we also know that across the
12 state, these enrollees have to engage in
13 multiple different delivery systems.

14 They access most of their physical
15 health through our managed care delivery
16 system. Our behavioral health system is carved
17 out and operated at the county level.

18 So, for anyone with severe mental
19 illness or substance use disorder needs, it is
20 an entirely different delivery system that may
21 or may not be effectively integrated and
22 coordinating with their physical health needs.

23 Dental is similarly a carve-out, and
24 then there are numerous local county-based
25 programs that provide care management and

1 county coordination -- care coordination as
2 well.

3 Go to the next slide. So, both
4 Enhanced Care Management and Community
5 Supports, which we are currently in the process
6 of scaling statewide, were really informed by
7 previous tests of change under, largely, our
8 previous Section 1115 waiver programs.

9 The Whole Person Care pilots and the
10 Health Homes Program pilots really looked at,
11 you know, how do we take these very complicated
12 high-utilizer individuals and create an
13 effective suite of wraparound services that
14 will change their health outcomes?

15 The initial evaluation, which is not
16 finalized yet, showed really remarkable results
17 in this domain.

18 So, from the beginning point of the
19 Whole Person Care pilot to our mid-year
20 evaluation, enrollees who reported being in
21 excellent or very good overall health increased
22 from eight percent to 22 percent. There were
23 more modest improvements in emotional health.

24 The number of enrollees ages 18 to
25 59 with controlled blood pressure went from 36

1 percent at baseline to 65 percent after
2 enrollment in this program. And there were
3 also modest increases in the number of
4 enrollees with controlled blood pressure rates.

5 The changes on total cost of care
6 and especially readmissions, ED¹¹ visits, and
7 hospitalizations were a little bit more mixed.

8 Not surprisingly, a lot of those
9 changes were delayed in seeing those outcomes
10 after enrollees were established in their care
11 management programs.

12 So, the experience from those pilots
13 that occurred in numerous different geographies
14 and populations across the state led to the
15 creation of Enhanced Care Management.

16 Enhanced Care Management is a new
17 Medi-Cal benefit and a contract -- or, sorry,
18 it is a new managed care contract requirement
19 that is available to all of our enrollees in
20 managed care who meet certain criteria.

21 And the care management is provided
22 through community providers, and they
23 essentially become the lead care manager who

11 Emergency department

1 will coordinate that member's needs across
2 delivery systems, across local social services
3 entities, housing entities, to really provide
4 the whole-person care not just for their health
5 care needs, but also linkage to addressing all
6 of their social drivers of health.

7 In addition, Community Supports are
8 currently optional services, but they are
9 strongly encouraged, and Medi-Cal plans have
10 been slowly scaling up the number of Community
11 Supports that they provide.

12 They are really focused on, you
13 know, providing, in lieu of services that we
14 know, can reduce the hospital length of stay,
15 prevent avoidable readmissions and
16 hospitalizations.

17 You can go to the next slide. So,
18 to just provide a little bit more detail, so
19 for ECM¹², this is really, as I mentioned,
20 designed to provide comprehensive wraparound
21 care management for any enrollees that have
22 complex needs and really navigate those
23 enrollees across all of the different delivery

12 Enhanced Care Management

1 systems that could be fragmented and very
2 challenging for our members to navigate, and
3 they are designed to address both the clinical
4 and nonclinical needs of these high-need
5 enrollees.

6 We can go to the next slide.
7 Community Supports are really services, as
8 mentioned, that are designed to be in lieu of
9 other types of health care utilization that is
10 often higher-cost with lower-value when we look
11 at the quality outcomes.

12 So, I'm not going to read all of
13 these, but these are the suite of Community
14 Supports that, in current state, are not
15 offered statewide, but each managed care plan
16 based off of local needs and capacity is
17 starting with a few of these and then looking
18 to scale over time.

19 We can go to the next slide. I
20 think I'm turning it over to Paul. So,
21 hopefully that brief overview of what the state
22 is doing around Enhanced Care Management and
23 Community Supports will provide the context
24 that is needed to understand what Paul and his
25 team have been doing at the local level, and

1 the impact that these programs have for our
2 Medi-Cal beneficiaries on the ground.

3 MR. LEON: Thank you, Palav.

4 I'm happy to be here. My name is
5 Paul Leon. I am a public health nurse by trade
6 and CEO of Illumination Foundation.

7 We are a grassroots nonprofit that -
8 -we're a provider in Southern California, Los
9 Angeles, Orange County, and Inland Empire.

10 So, back in 2007, straight out of
11 MBA school, we walked into -- actually it was a
12 class project -- walked into this shelter in
13 Orange County and realized that -- at this
14 shelter, there were about 200 children,
15 families, individuals with mental health,
16 substance abuse, and realized that we had to
17 take care of this population.

18 At that time, there were about six
19 to 7,000 rough sleepers, people that were
20 staying in the streets of Orange County.

21 As you know, Los Angeles now is the
22 epicenter for homeless and unstably housed.
23 So, we migrated up into LA.

24 We currently are the largest medical
25 respite recuperative care in the nation. We

1 have 408 beds. We get discharges directly from
2 the hospital, police, county, and we can settle
3 for it for now.

4 The Fullerton site up in the left is
5 our flagship site. It actually has a shelter
6 on the bottom, a medical respite. And on top,
7 services, primary care, dental, psychiatric,
8 housing navigation, and workforce.

9 All the services are on the top, and
10 on the bottom it's a navigation center and a
11 shelter. It also has -- it's a full-service
12 area that individuals could stay there.

13 Our newest site is UCLA. You'll see
14 on the bottom that it's actually a medical
15 respite that is within the hospital.

16 So, that is kind of the trend now
17 for medical respites to partner with a hospital
18 and place them either adjacent to the hospital
19 or in a facility near the hospital.

20 So, what we realized early on, we
21 started 15 years ago, is that not only did you
22 need a central location, which we call a hub,
23 and that's a medical respite, but also you
24 needed to discharge individuals from that
25 facility.

1 They're not quite ready to go to
2 another facility, so we actually transfer them
3 to micro-communities.

4 You can see there we have, I think,
5 about 241 different micro-communities. Some
6 that are mental health, substance abuse. A lot
7 more for seniors now and couples.

8 These are the micro-communities.
9 Again, 241 doors. They're in the community
10 adjacent to the medical respite.

11 So, this is our model, and it's
12 basically Street2Home. We have individuals
13 that are homeless, and now we're seeing a lot
14 more individuals that are just unstably housed.

15 They lost their housing and it --
16 from month to month, they're staying at
17 different places, couch surfing, going back
18 with their parents, going back with their kids,
19 either way.

20 So, this is the model that we
21 developed early on. It's the ability to take
22 somebody from the street to either a navigation
23 center, a family emergency center, and you'll
24 see medical respite, recuperative care is in
25 the center, and then into a micro-community and

1 permanent housing.

2 Prior to CalAIM, we figured out how
3 to fund this through city grants, through
4 different organizations and hospitals that
5 would pay for medical respite with charity
6 dollars.

7 And then, of course, when we're able
8 to get individuals into housing, HUD¹³ would
9 pick up, and we'd pay with it for vouchers.

10 So, that was our continuum of
11 payment until CalAIM came. And when CalAIM was
12 initiated, it now funds pretty much all this
13 process.

14 A little bit about the data and some
15 of the clients that we see. We do both
16 predictive and prescriptive analytics, but you
17 can see that the population, like Dr. Chen was
18 talking about, that we see are high-risk, high-
19 score risks that we use the HCC¹⁴ predictive
20 model from CMS.

21 And you can see that we have 245 of
22 these clients that we got the information from
23 our CalOptima, or CMO, that have 10 more -- 10

13 Housing and Urban Development

14 Hierarchical Condition Category

1 or more distinctive diagnoses. Most of our
2 clients have mental health plus medical health
3 that we're taking care of.

4 This is just another breakdown of
5 the scores that we're seeing. More of a visual
6 of clients that you can see run the whole gamut
7 of risk.

8 So, one of the things that we
9 started to really realize, and we did this
10 early on, but we didn't call them social
11 determinants of health.

12 We realized that it was not just the
13 medical things that they were coming to us for.
14 A lot of them was, you know, somebody would
15 come to us with a broken leg or a wound;
16 however, they had no transportation, they
17 couldn't pick up their medication, they
18 couldn't do follow-up with the hospital.

19 So, we really started to focus on
20 and do a lot of the AI¹⁵ work and really drilled
21 down so we could do prescriptive analytics and
22 really drill down on social determinants of
23 health, you know.

15 Artificial intelligence

1 And you'll see, I believe -- no,
2 it's the next slide, but one of the really
3 incredible benefits from medical respite, you
4 could see how many individuals weren't
5 connected to a primary care physician.

6 And now, you know, then they came
7 into our program, and we were able to connect
8 them to their primary care physician.

9 Obviously, the savings are immediate
10 when you can curb the, you know, the ED
11 utilization and hospitalization.

12 You can see right from the start we
13 were able to enter these patients into medical
14 respite and then provide most of the care on
15 site or by one of our local FQHCs¹⁶.

16 One of the things that we found out
17 when we started really analyzing the data -- we
18 have years of data, but we never really
19 scrubbed it -- is that we actually were taking
20 care of SPMI¹⁷ patients.

21 We had no idea that there was that
22 big a percentage of clients that were in
23 medical respite.

16 Federally Qualified Health Centers

17 Severe and persistent mental illness

1 Normally Beacon, our local provider,
2 was admitting the mental health diagnosis for
3 bipolar and schizophrenic, but within
4 recuperative care.

5 When we are with our clients and
6 really could get -- speak to them, they started
7 to trust us, we realized that they were really
8 multi-focal patients with mental health and
9 their medical diagnosis.

10 One of the things, again, that data
11 really showed us is the cost savings and
12 especially first year compared to the second
13 year.

14 And you can see that the obvious
15 things that you can do when we bring our
16 clients in, just basic teaching is going to
17 save money right away.

18 Things that -- transportation, basic
19 needs, and especially housing, which is a
20 component that CalAIM is starting to address,
21 but you can see that if you stick with the
22 social determinants of health, that the savings
23 sometimes will come the year after.

24 And, again, this is just one of the
25 graphics that we realized early on. This is

1 data from our CMO clients -- 1,266 clients.

2 Their actual cost to CalOptima is
3 almost \$26 million. It went down when they
4 became a medical respite.

5 And then afterwards went up quite a
6 bit because that's housing in there, but also
7 medications were increased. We were really
8 happy to see that. So, overall savings for one
9 year on 1,266 clients were \$17 million.

10 VICE CHAIR HARDIN: And, Dr.
11 Babaria, we need to wrap up in about two more
12 minutes.

13 MR. LEON: Okay. So -- and, again,
14 this is just some of the early projections for
15 CalAIM.

16 You can see that we've already
17 implemented a lot of the parts of CalAIM, and
18 it so far is really working well.

19 We're able to see and now be able to
20 get reimbursements for some of the things that
21 we're doing that we really couldn't do prior to
22 that. And again, these are monthly projections
23 for CalAIM.

24 And I'll just leave you with one
25 last item is that, you know, we had -- our last

1 client that came in had actually lived in a
2 cave for 12 years above LA. Was working,
3 living in a cave.

4 And we entered her into our medical
5 respite, and she has been there about six weeks
6 and is doing really well, but that's the kind
7 of clients that we're seeing with, you know, a
8 lot of unstable housing. So, thank you.

9 DR. BABARIA: Thanks, Paul.

10 And I would just say, you know, the
11 local trends and complexity that Paul's
12 describing is something that we've seen across
13 the state in numerous of these Community
14 Supports and Enhanced Care Management programs
15 that are serving our members.

16 So, hopefully that local context
17 provides a little glimpse into what we're
18 trying to accomplish.

19 The one thing I did want to plant a
20 seed with all of you is, as we've been doing
21 this work and really focusing on our complex,
22 high-utilizer individuals, it has become
23 abundantly clear that we also need to step back
24 and take a long view of health and wellness.

25 We can skip to the third slide.

1 There is information in here about how we're
2 contextualizing our value-based payment work
3 and all of these initiatives within our larger
4 population health management strategy, but I'm
5 going to pause us on this slide for a second.

6 So, as we've been looking at our
7 programs, I think, you know, as Dr. Chen
8 mentioned, prevention and upstream intervention
9 are not things that we naturally do well across
10 the health care delivery system or that, you
11 know, we physicians are particularly trained in
12 addressing.

13 I think one of our unique roles, as
14 a government payer, is that we really can step
15 back and take a longer view than sometimes our
16 health care delivery system or managed care
17 partners can.

18 So, when you think about our Medi-
19 Cal program, we cover over 14 million
20 individuals right now, or one in three
21 Californians.

22 But when you look at the younger
23 populations, we cover about half of all births
24 in the state of California and more than half
25 of the children residing in the state.

1 Then when we take our health equity
2 lens, almost three-quarters of all Latino and
3 Black children in the entire state of
4 California are covered by the Medi-Cal program.

5 And we know through extensive
6 literature, research, trends in our own
7 programs and our work on adverse childhood
8 experiences, screening, that what happens to
9 these children and pregnant individuals really
10 determines what their long-term health outcomes
11 are decades later.

12 (Interruption.)

13 DR. BABARIA: Sorry, is anyone else
14 hearing that background noise?

15 VICE CHAIR HARDIN: You may want to
16 mute, whoever just joined.

17 DR. BABARIA: So, I think, you know,
18 just want to underscore that when we think
19 about these complex populations and
20 individuals, if we really want to address the
21 number of high-utilizers and individuals with
22 poor health outcomes and multiple conditions
23 that are in our nation, we really have to look
24 upstream by decades, and government payers are
25 really in a unique position to take this long

1 view.

2 You can go to the next slide. This
3 just shows our Bold Goals initiative that we're
4 launching to really think about this upstream
5 intervention.

6 And we are, you know, rolling this
7 out through all of the levers that we have
8 across the Medi-Cal program, including in our
9 value-based payment programs.

10 We can go to the next slide. And I
11 think where we're really trying to double down
12 is, you know, like many of the folks have
13 talked about, how do we recenter primary care
14 and not just investing in primary care as it
15 exists today, but really integrating it with
16 upstream public health and social services
17 programs that we know work and have a return on
18 investment over the long run, you know,
19 especially home visiting.

20 First 5 Association have a number of
21 models that are really working in the state of
22 California.

23 In addition to that, we are
24 supporting investments in primary care
25 transformation and, with our managed care re-

1 procurement with new contracts going into
2 effect in 2024, are also mandating reporting on
3 the percent of spending on primary care as a
4 percentage of total spend at the health plan
5 level with the plan to set targets for that
6 spending in the future, as well as the
7 percentage of Alternative Payment Model
8 arrangements for our health plans.

9 So, I just encourage us to really,
10 you know, think about where can we put in that
11 long-term thinking and the long-term view so
12 that at some point in the future, we really are
13 curbing the number of individuals that we need
14 to enroll into programs like Paul's, as
15 effective as they are.

16 VICE CHAIR HARDIN: Thank you so
17 much, Dr. Babaria.

18 DR. BABARIA: Thank you. I'll turn
19 it over to questions.

20 VICE CHAIR HARDIN: And now at this
21 point, we have a few moments to open up the
22 floor for the Committee Members for discussion
23 and questions.

24 So, Dr. Chen, if you can also join,
25 and I see Bruce has his hand raised. Bruce.

1 MR. STEINWALD: My question is for
2 Dr. Chen.

3 Doctor, what proportion of the
4 entrance into that one-year fellowship that you
5 mentioned actually make it through to the end?

6 And would you say that there's a
7 selection process that limits the number of
8 primary care physicians who would thrive in
9 your kind of system, or do you think there is a
10 real upside to that?

11 DR. CHEN: What a fantastic
12 question.

13 It's only the number one thing that
14 we focus on as an organization. So, you know,
15 if our job is to take primary care doctors and
16 sort of de-program fee-for-service from them
17 and then re-train them in the ways that we just
18 discussed, you know, holistic care,
19 preventative care, learning how to win and
20 lead, not everybody can do that necessarily,
21 right?

22 So, we spend an enormous amount of
23 time, data, interviewing, to figure out who are
24 the primary care doctors that we believe can do
25 this kind of care.

1 Now, the good news is it's over 50
2 percent, we've discovered. The number of -- I
3 would say, in our population, over 95, 97
4 percent of doctors get through the training
5 program and do alright.

6 But then you're saying that's
7 because, Chris, you're doing a great job
8 selecting, and we think we can do a better job.

9 So, I'll give you an example. I was
10 on a panel once with a very prestigious
11 organization, leader of one of those, and they
12 were talking about their brand of the doctors
13 that they're looking for, you know, these
14 amazing pedigrees and all the things that we
15 talked about. And he's like, you know, we
16 don't hire these type of doctors.

17 And I said, can you do me a favor?
18 When you say "none of those doctors," can you
19 send them over to me? Because those actually
20 happen to be the profile of the doctor that I'm
21 looking for, and it's outrageously
22 counterintuitive.

23 So, doctors that can lead, doctors
24 that can think holistically and move upstream,
25 who can build relationships with their

1 patients, are very different than what
2 typically medical schools and residency
3 programs are looking for and even prestigious
4 organizations. It's just a very different
5 profile.

6 We actually psychologically profiled
7 our doctors. We spent five hours doing that.
8 We capture all this data as we're interviewing
9 them and determined what are the types of
10 doctors that can do this care.

11 I'll give you a couple pearls of
12 things that we look for that trump your
13 pedigree, that trump your, you know, your
14 scores and everything else.

15 Learning agility is absolutely
16 critical. The speed at which they can learn
17 because, remember, we're telling them all the
18 stuff that you've learned in the past may not
19 help you as much in this model in the future.
20 So, learning agility is one thing.

21 Second thing that has to go with
22 learning agility is humility. Humility in
23 different ways. Humility in, A, to learn
24 quickly, but humility also with the patient.

25 So, if there is this attitude that

1 some doctors have, right, where -- with
2 patients where they are, you know, I am the
3 authority and you are not, and you don't have
4 to listen to me and that's your problem, that,
5 unfortunately, doesn't work well when you're
6 building relationships with a patient, and
7 you're trying to get them to change their
8 lifestyle behaviors and trying to get you to
9 tell them the, you know, you have to convince
10 them to tell you when their son is stealing
11 their Social Security check so you can deal
12 with that, right? These are fundamental, real
13 issues, and so you can only do that with trust.

14 So, you're right on. I believe that
15 fee-for-service will be here to stay because I
16 do think there is some proportion of the
17 primary care work staff that is primarily
18 designed for that volume-based type of care and
19 not -- shouldn't be accountable for outcomes,
20 but the majority of primary care doctors out
21 there, I believe, can make that switch and
22 should make that switch. It's far more
23 validating.

24 We don't have a problem recruiting
25 docs, by the way. There's a huge shortage, and

1 we don't have that huge problem.

2 MR. STEINWALD: Thank you.

3 VICE CHAIR HARDIN: And then Lee
4 next, and I'd just like to give everyone --
5 we've got about five more minutes.

6 So, if you can make your question
7 succinct and answer succinct, there's a line of
8 people who'd like to ask.

9 Lee?

10 DR. MILLS: Thanks so much.

11 Dr. Chen, can you tell us more about
12 your model's involvement with specialists, how
13 you select them, how you contract with them,
14 how you work with them inside your total cost
15 of care-type arrangements --

16 DR. CHEN: Sure.

17 DR. MILLS: -- and philosophy.

18 DR. CHEN: You know, also, first of
19 all, we are not based in California. So, we do
20 not have the ability to create our own
21 delegated network.

22 So -- and we're in so many cities.
23 We're in 40 cities right now. So, we can't
24 hire specialists everywhere.

25 However, I can tell you there are

1 certain Tier 1 specialists -- obviously,
2 cardiology is one of them, endocrinology --
3 there's certain ones that are in our population
4 that are very common, and we will do our best
5 to hire Tier 1 specialists to come on site
6 either through a contract arrangement or
7 through direct employment.

8 We prefer direct employment so we
9 can go through that training process that we
10 discussed before and the selection process, but
11 then no matter what you do, you're going to
12 have to work downstream with the local sort of
13 ecosystem there.

14 And you go to the health plan
15 provider network, and then we start with that,
16 and we start looking at data.

17 We have Blue Button claims data, we
18 have health plan data, they can share some of
19 that with us, and we can look at some of their
20 patterns, and we've developed algorithms across
21 the board.

22 We have these central specialists
23 that sit in a corporate center that actually
24 develop algorithms that say, do our doctors
25 following evidence-based care? And you can

1 study that through claims data, believe it or
2 not.

3 That triangulates it, and then you
4 got to sit there, and then you got to go visit
5 those specialists and say, okay, are you the
6 kind of doctors that want to collaborate on
7 care, or do you just want us to send patients
8 to you, but you never want to have a
9 conversation, you don't want to collaborate,
10 you don't want to coordinate?

11 And if you're in the latter, sorry,
12 we don't want to work with you. If you're in
13 the former, and you want to be a partner with
14 us, and you're okay with us being the
15 quarterback of that care, then you're a great
16 partner, and we found the outcomes are the
17 best, and that's essentially what we're looking
18 for.

19 We do not beat them up for costs, by
20 the way. That's a unique thing. We do not
21 beat them up for their rates.

22 We prefer collaboration over rates
23 every day. You get better outcomes at a lower
24 cost.

25 VICE CHAIR HARDIN: And, Walter --

1 thank you.

2 Walter?

3 DR. LIN: Again, thank you for --
4 all the panelists for great presentations.
5 Very informative.

6 Question for Dr. Chen, and you've
7 kind of answered part of this with your answers
8 to Bruce and Lee's questions, but it sounds
9 like you have really engaged primary care
10 doctors that you select through a very rigorous
11 selection process.

12 They give out their cell phones,
13 they have small patient panels, but I'm
14 wondering what kind of levers that ChenMed has
15 post-training to really continue to engage and
16 influence the PCPs to produce such great
17 outcomes, 30 to 50 percent decrease in the ER
18 and hospitalization rates.

19 I suspect some are financial, but --
20 both financial and nonfinancial.

21 DR. CHEN: So, let me just handle
22 the financial piece because usually that's a
23 big part of people's questions. Yeah,
24 absolutely we compensate for outcomes and --
25 so, that's number one.

1 We do -- we give them, you know,
2 good compensation to begin with, and then we
3 give them tremendous upside based on their
4 outcomes.

5 Number two, we are an overly
6 transparent organization when it comes to those
7 outcomes. Everybody knows how everybody else
8 is doing.

9 So, you can imagine during the
10 selection process, humility is very important
11 because if you're not comfortable working
12 together and sharing data together and all
13 talking about it together, this is not the
14 place for you. So, we're outrageously
15 transparent across even markets and outcomes.

16 The doctor sitting next to you, you
17 know exactly how they're doing, you know how
18 you're doing, and you're learning from each
19 other.

20 So, it's not a shaming concept.
21 It's about -- it is a team type of aspect from
22 love, accountability, and passion.

23 Last, but not least, we allow
24 doctors to grow. Doctors, they get into their
25 job, and they're like this is -- I've reached

1 my ceiling. This is what I'm going to be
2 doing. I'm going to sit in a room and see
3 patients for the rest of my life. And we're
4 saying, maybe, but there's a tremendous
5 opportunity to grow and lead.

6 And so, we will -- we've developed a
7 development path for doctors to grow in our
8 organization in dramatic ways, and it's not
9 unusual for doctors to get promoted every one,
10 two years into new roles and new leadership
11 roles, either clinical leadership roles,
12 administrative leadership roles, teaching,
13 selections.

14 Remember, physicians are such a
15 fabric of our operating model, and we pair them
16 with business leaders. So, we need doctors to
17 get promoted. And so, they get that
18 opportunity.

19 And then they get recognized by
20 their peers and by other folks and, you know,
21 testify at Congress and whatnot. So, that
22 becomes exciting, too.

23 VICE CHAIR HARDIN: And, Angelo, I
24 saw you had your tent up.

25 DR. SINOPOLI: Yeah. Lee asked the

1 question I was going to ask, so --

2 VICE CHAIR HARDIN: Excellent.

3 DR. SINOPOLI: Good.

4 VICE CHAIR HARDIN: So, for Dr.
5 Babaria and Mr. Leon, can you speak to the
6 criteria for determining which patients are
7 appropriate for Community Supports and Enhanced
8 Care Management?

9 And also, what kind of crossover you
10 see with the senior populations when you think
11 about Medicare. If you could speak to those
12 two things?

13 DR. BABARIA: I'm happy to start us
14 off at the state level and then, Paul, you
15 probably have more details at the local level.

16 So, for Enhanced Care Management, we
17 have specific populations of focus that were
18 really informed by those Whole Person Care and
19 Health Homes pilots targeting individuals who
20 are homeless, have severe mental illness,
21 substance use disorders, you know, usually with
22 other criteria such as ED visits,
23 hospitalizations, or chronic conditions.

24 We are still working on our policy
25 and rolling out that benefit for justice-

1 involved populations, as well as children and
2 youth, and still finalizing the criteria, as
3 well as for long-term care and individuals
4 residing in the community, but who meet long-
5 term criteria of care. So, more to come in
6 that space in the year to come.

7 And then for Community Supports,
8 it's really, you know, anywhere -- based off
9 the recommendation of their provider, anywhere
10 where that benefit would thought to be
11 beneficial.

12 So, there's a broader application,
13 and we will be doing a thorough evaluation to
14 really assess the efficacy of that approach
15 and, you know, what the impact is on both
16 health outcomes and total cost of care.

17 MR. LEON: Yeah. And for us,
18 medical respite, they're referred to -- usually
19 by the hospitals now because with CalAIM, we
20 can self-refer, but many of the plans and
21 providers aren't really sure where their
22 clients are. And they give us a list each
23 month, and we go through and find their clients
24 with outreach.

25 And as far as seniors, it's the

1 fastest growing population of homeless and
2 unstably housed.

3 So, many of the plans, for example,
4 Kaiser, they want us to find, you know, maybe a
5 grandmother who's staying with two different
6 daughters and will just pop up in the ER.

7 And they won't really know where
8 their client is at or their patient, so we will
9 enroll them in ECM, and then make sure that we
10 can navigate their primary care physician.

11 DR. BABARIA: And I should just add
12 --

13 VICE CHAIR HARDIN: Go ahead. Go
14 ahead.

15 DR. BABARIA: I was just going to
16 say on the seniors' front, I definitely
17 underscore everything that Paul said that in
18 almost all of these categories, you know, we
19 are seeing the impact of all of these chronic
20 conditions, the housing crisis in California on
21 seniors.

22 And so, we have a separate
23 workstream specifically focused on duals in our
24 program, and that is absolutely where we see a
25 large burden of all of these issues.

1 VICE CHAIR HARDIN: Jennifer?

2 DR. WILER: Thank you for the
3 wonderful presentations. My question is for
4 Dr. Chen.

5 We heard yesterday about
6 participation in incentivizing providers,
7 physicians in particular, in programs and
8 outcomes.

9 What percentage of your physician's
10 total compensation is incentive comp?

11 DR. CHEN: So, you know, I mentioned
12 that we had multiple layers, right? So -- and
13 doctors have tremendous opportunity to grow.

14 So, we bring them in with a base
15 that is essentially highly competitive with,
16 you know, their market. That's usually the
17 starting point.

18 And then we usually put about an
19 additional 20 to 30 percent opportunity on top
20 of that. That's at the base PCP level.

21 As you start to, you know, if you
22 will, move up the ranks and demonstrate that
23 you are successful in this model, and you
24 continue to teach or even develop workflows
25 that -- or do research that helps us drive

1 towards, you know, better outcomes, what we
2 mostly flex in that environment is usually
3 based on outcomes, and it's going to be the
4 variable component.

5 So, you could have a doctor at one
6 point getting an additional, you know, 50
7 percent of their compensation could be entirely
8 variable and all the way to the very top, where
9 you have folks where perhaps even two-thirds of
10 their compensation is based on outcomes.

11 So, I hope that helps.

12 VICE CHAIR HARDIN: Thank you. One
13 final question for Dr. Babaria.

14 Can you speak very briefly to multi-
15 payer alignment that's happening with AHCP¹⁸ in
16 the state?

17 There's a lot of interest in the
18 group, but a brief answer, and then we'll go to
19 break.

20 DR. BABARIA: Absolutely.

21 So, at the state level, we have a
22 collaboration between Medi-Cal, which covers
23 about a third of our population; Covered

18 America's Health Care Plan

1 California, which is our incredibly robust
2 state health care exchange; and CalPERS¹⁹, which
3 is our sort of state employee and retirees
4 system -- benefits system.

5 So, collectively between us, we
6 cover upwards of 42 percent of the entire
7 population of the state.

8 So, us three state purchasers have
9 an ongoing strong relationship and
10 collaborative to align all of our measures
11 where possible, really, you know, support that
12 downstream Alternative Payment Model in a
13 coordinated fashion and are participating in
14 the HCP-LAN²⁰ state transformation collaborative
15 so that we can really scale some of those
16 efforts statewide with primary care practices.

17 VICE CHAIR HARDIN: Wonderful. We
18 want to thank you all very much for joining.
19 At this time we're going to take a short break
20 until 10:45 Eastern.

21 Please join us then. We have a
22 great lineup for our roundtable panel
23 discussion. Thank you so much.

19 California Public Employees' Retirement System
20 Health Care Payment Learning & Action Network

1 (Whereupon, the above-entitled
2 matter went off the record at 10:41 a.m. and
3 resumed at 10:49 a.m.)

4 * **Panel Discussion on Assessing Best**
5 **Practices in Care Delivery for**
6 **PB-TCOC Models**

7 CHAIR CASALE: I am excited to kick
8 off our panel. I ask our panelists to go ahead
9 and turn on video if you haven't already.

10 To further inform us about best
11 practices related to population-based total
12 cost of care models, we've invited esteemed
13 experts to represent several perspectives.
14 PTAC members, you'll have an opportunity to ask
15 our guests questions as well.

16 The full biographies of our
17 panelists can be found on the ASPE PTAC
18 website. So, I'll briefly introduce our guests
19 and their current organizations.

20 First, we have Lee McGrath who is
21 the Executive Vice President of Healthcare
22 Services for Premera Blue Cross.

23 Dr. Gary Puckrein joins us from the
24 National Minority Quality Forum, where he is
25 the President and Chief Medical Officer.

1 We also have Dr. Robert Saunders.
2 He is the Senior Research Director of Health
3 Care Transformation at the Duke-Margolis Center
4 for Health Policy. So, welcome and thank you
5 for joining us.

6 To start off, the Innovation Center
7 at CMS has set the goal of having every
8 Medicare fee-for-service beneficiary in a care
9 relationship with accountability for quality
10 and total cost of care by 2030.

11 What do you see as the potential for
12 accountable care relationships and models to
13 improve quality of care and health outcomes
14 while reducing total cost of care?

15 What changes are needed to maximize
16 how these models can achieve these objectives?

17 First, I'll turn to Rob.

18 DR. SAUNDERS: Thanks, Paul, and I
19 appreciate the opportunity to be here today.

20 As Paul mentioned, I'm Rob Saunders
21 with the Margolis Center of Health Policy at
22 Duke, and we do a fair bit of research looking
23 at the facts of various payment and delivery
24 reforms.

25 You know, there's a couple of places

1 here where we've been focused on opportunities
2 to improve total cost of care models.

3 You know, there's clearly been some
4 movement over the last several years since
5 we've expanded the number of population-based
6 or total cost of care models, and we're
7 starting to see positive results in various
8 cases.

9 Although, I think the evidence is
10 not quite where we hope it will be yet, but,
11 you know, one of the big challenges that we're
12 seeing is really where do you engage
13 specialists in a number of these APMs²¹, you
14 know.

15 A lot of the total cost of care
16 models to date have really focused on primary
17 care, which is incredibly important, but
18 there's been less focus on the specialty
19 physicians or specialized care, which is at
20 least, you know, 90, 92, maybe a little bit
21 more percent, of total health care spending and
22 total health care in general.

23 And so, one of the challenges is

21 Alternative Payment Models

1 what we can do to better engage specialists in
2 these types of arrangements, you know.

3 Now, in research we're seeing a
4 variety of strategies take place. There's some
5 network referral strategies that individuals at
6 ACOs or total cost of care organizations are
7 using.

8 There's more specialized types of
9 total cost of care arrangements like, say, your
10 ESCOs²², for your end-stage renal disease,
11 there's some contracting strategies, maybe
12 virtual bundles. And then, of course, we all
13 want to end up in a care re-designed place as
14 well.

15 So, those are some places where I
16 think we're seeing some movement. There's not
17 a total silver bullet here yet, but I think
18 there's a lot of opportunity to integrate the
19 specialist perspective a bit more in these
20 types of total cost of care arrangements.

21 CHAIR CASALE: Thanks, Rob.

22 Next, I'll turn to Gary Puckrein.

23 DR. PUCKREIN: So, the National

22 ESRD (End-Stage Renal Disease) Seamless Care Organizations

1 Minority Quality Forum, we start from the place
2 that the health care system should be about
3 mitigating patient risk.

4 The real purpose of health care is
5 to reduce hospitalizations, emergency room
6 visits, disability, mortality for each patient,
7 and we see no Medicare beneficiary who is
8 coming in through the health care system with
9 any expectation that the system is going to
10 elevate their risk.

11 When we look at these models, these
12 models are not patient-centric. They're
13 financial models. They're just based on moving
14 money around.

15 And there's really no evidence,
16 actually, that over the long course of all of
17 these patient models -- of these financial
18 models that we see improvement in health
19 outcomes for beneficiaries.

20 And, you know, the operating
21 assumption is that if you pay a physician this
22 way or that way, are you necessarily going to
23 get good outcomes for patients?

24 I think the place we ought to begin
25 is with patient outcomes. So, model the system

1 and have the system focus on improving patient
2 outcomes.

3 Certainly when you're dealing with
4 equity, you've got to be able to focus down on
5 what's good for patients and have the system
6 organized around that.

7 I think if the system becomes
8 focused on patient outcomes, that will get the
9 results that we're looking for.

10 I don't see any evidence that any of
11 these patient models in the short run, or the
12 long run, are going to bring the kind of
13 quality that certainly patients expect to get
14 in the Medicare program.

15 CHAIR CASALE: Thank you. Next,
16 we'll turn to Lee McGrath.

17 MS. MCGRATH: Sure. Thanks so much,
18 Paul. I'm not sure where I'm esteemed, but I
19 appreciate the compliment early starting out
20 with that.

21 So, I'm going to take a different
22 type of approach. Although, Gary, I can't
23 begin to tell you how much I love the sentence
24 that the models are just about moving money
25 around, because that actually breaks my heart,

1 and I think you're right.

2 I think what we need to be
3 successful, because I actually really love CMS'
4 mandate around we want every Medicare
5 beneficiary to have a tight relationship with
6 primary care, I think what we need to be able
7 to do in order to make that work in a way that
8 actually focuses on patient outcomes and not
9 just moving the money around is access,
10 investment in infrastructure in order to
11 effectively move information back and forth
12 from wherever it sits, whether, you know, lab
13 outcomes or lab results sit in Labcorp, or
14 whether there's claim information sitting on
15 Premera's claim system, or whether there is
16 information from an emergency room when grandma
17 took their kids to Florida or Disneyland.

18 Wherever it sits, getting it in a
19 really useable, manageable position for the
20 primary care physician to then activate on
21 that, that takes an amazing amount of
22 investment and a different way to think about
23 how to impact care in a meaningful way.

24 So, that care becomes about
25 everything that happens in the patient's life

1 and not just when I'm standing and looking at
2 the patient saying, hey, why does your back
3 hurt, how can I help?

4 Then the other third piece, I think,
5 is the definition of "primary care." I'm not
6 sure that it's been really defined.

7 Are endocrinologists primary care?
8 Are cardiologists primary care? And how do we
9 think about that?

10 And then going through the things I
11 just talked about, access, infrastructure in
12 terms of data analytics, those are things that
13 will have to be contemplated as we think about,
14 I hope, broadening the definition of "primary
15 care" to meet the patient outcomes that we all
16 want.

17 So, that would be where I would
18 start from.

19 CHAIR CASALE: Great. Thanks so
20 much.

21 So, our fourth panelist has joined,
22 Dr. Kristofer Smith, Chief Clinical Officer
23 from Prospero Health.

24 So, Kris, if you turn your video on
25 if you're there and --

1 DR. SMITH: I am here. Can you hear
2 me?

3 CHAIR CASALE: Yes, we can. Yeah.
4 I'm hoping you heard the first question. I was
5 wondering if you had some thoughts around that
6 question on accountable care relationships and
7 changes needed to maximize these models.

8 DR. SMITH: Sure. So, you know, I
9 think there's a number of -- is this -- are we
10 talking -- I just want to make sure and I
11 apologize for being late to the Webex. It's
12 not the preferred video conferencing
13 application for my company.

14 Are we on Question 1 or Question 2?

15 CHAIR CASALE: Question 1. So, what
16 do you see as the potential for accountable
17 care relationships and models to improve
18 quality of care and health outcomes while
19 reducing total cost of care, and what changes
20 are needed to maximize how these models can
21 achieve these objectives?

22 DR. SMITH: Yeah. So, I did hear
23 some of the comments.

24 I do think that, you know, we're 10
25 years into this journey on models of care and

1 certainly, I've had the good fortune of
2 participating in them from both the side of
3 health care delivery systems, as well as for-
4 profit companies such as Prospero or Navajo.

5 I think where I see us continuing to
6 struggle as we think about these models is
7 often around what population are we trying to
8 improve quality and total cost of care.

9 And this is where I think we often
10 struggle a little bit because, as we've heard,
11 we want to put most beneficiaries into care
12 relationships for accountability for quality
13 and total cost of care.

14 I think that there are portions of
15 the population where we should be leaning in on
16 certain elements of quality, whether those are
17 measured by access, whether they're some of the
18 primary care measures that we all are held
19 accountable to, but I think there's not as much
20 data that we should be holding provider groups
21 accountable for total cost of care across
22 entire populations.

23 My experience working in this space
24 is that the reward and the data that would
25 support -- there are subpopulations of high-

1 cost patients that require different models of
2 care in order for us to achieve improvements in
3 total cost of care, and then there's a whole
4 tail of maybe 50 to 75 percent of the patients
5 where there's not actually a lot of cost to
6 break out of the system if you're talking about
7 utilization.

8 And so, I think we need to start to
9 really reframe the idea that we're going to
10 delegate total cost of care for entire
11 populations to provider entities or to for-
12 profit groups because I don't see that there's
13 a whole lot of compelling data around reducing
14 total cost of care in most of the populations,
15 yet there is the ability to reduce total cost
16 of care in certain, like, the frail, elderly,
17 end-stage renal patients.

18 And so, I would lean in more on
19 those for total cost of care, and I would think
20 more broadly about quality in the remainder of
21 the populations that aren't high-cost with a
22 lot of below-value care.

23 CHAIR CASALE: Great. Thanks, Kris.

24 And so before we move to the next
25 question, I want to open it up to PTAC members

1 for any follow-up questions.

2 Larry?

3 DR. KOSINSKI: Alright. I'd like to
4 ask Gary a question specifically about
5 specialist participation.

6 How do you have -- or have you
7 managed to put enough income at risk on the
8 specialist side for them to participate fully
9 in value-based care?

10 And if you're not doing it through
11 income, are you accomplishing it through
12 management of the network and bringing a larger
13 percentage of their workload into the value-
14 based care arrangement?

15 DR. PUCKREIN: I presume you're
16 directing that question really at Robert
17 because I think --

18 DR. KOSINSKI: Oh, I'm sorry. That
19 really went to Robert. I'm sorry.

20 DR. SAUNDERS: I'm happy to chat,
21 Larry. I know given your experience in thinking
22 through a number of Alternative Payment Models
23 really focused that specialist participation,
24 you understand the nuances that happen here.

25 What we're seeing out there in the

1 field is that it really varies to what extent
2 specialists have had their compensation
3 adjusted in terms of those total cost of care
4 arrangements.

5 I was on for a little bit of the
6 last panel where Chris Chen was talking about
7 some of the compensation changes that they were
8 making over at ChenMed, you know.

9 I think what we're seeing, writ
10 large, is that there have been very few places
11 that have changed compensation patterns even if
12 they're in a large health care system that,
13 say, has an ACO contract or some other type of
14 total cost of care arrangement, that actually
15 go forth and change compensation to their
16 specialists.

17 If they do, it's probably in the
18 percent range, and that's in the big systems,
19 you know.

20 I think if we're talking about a
21 smaller practice, you know, then we get into a
22 question of what level of their book business
23 or their level of their practice is actually
24 affected by that total cost of care
25 arrangement, and most of the time we're talking

1 about small numbers that we've seen in the
2 field with some notable exceptions, you know.

3 I think where you've been able to
4 get, say, a really focused arrangement for GI²³,
5 for instance, you know, and I know you're
6 familiar with this where you're able to have
7 something like an IBD²⁴ Medical Home and the
8 like that's really focused on one condition and
9 really get a practice engaged.

10 But for many of the general
11 specialists who receive a number of different
12 conditions, usually we haven't seen a huge
13 percentage of their compensation or the
14 practice revenue affected by these types of
15 total cost of care arrangements.

16 So, I think it's a mixed bag right
17 now, is the short answer.

18 CHAIR CASALE: Lee, I wonder if you
19 might have some comments about, again, this
20 topic of sort of engaging specialists within
21 total cost of care.

22 From your view, what are the
23 opportunities how best to think about how to

23 Gastrointestinal

24 Inflammatory bowel disease

1 engage them in these models?

2 MS. MCGRATH: I think the
3 opportunities are actually endless, and we have
4 to be creative in thinking about it, but I
5 can't keep underscoring what Gary mentioned.
6 It can't just be about moving money around.

7 So, we need to really make sure that
8 we're talking about access and quality and, you
9 know, infrastructure and reducing transaction
10 costs and figuring out how we can make systems
11 and specialists, or primary care, or whomever,
12 more efficient and make it easier to do their
13 jobs and remove the burden that has been put on
14 them.

15 So, we can keep talking about the
16 money, but I -- it makes me sad if we just keep
17 talking about the money. It should really be
18 about something more than that.

19 And, by the way, I get that
20 increasing access and infrastructure costs a
21 bunch of money, but that's actually where I
22 think our investment should lie as opposed to
23 just, you know, continuing to, you know, just
24 create contracts that, you know, measure
25 something against something, and then we pay

1 for it because I think we haven't seen all of,
2 you know, we've been in the value-based care
3 world now for a while, and we need to see a
4 greater change.

5 I think our customers, members,
6 patients, however the word we want to use,
7 expect a lot more from us.

8 CHAIR CASALE: Great. Thank you.

9 Josh?

10 DR. LIAO: Lee, thanks for those
11 comments, and I wonder, kind of thinking about
12 that and some other things that Gary and Rob
13 have mentioned, you know, if we kind of pull on
14 that thread of investment and that, you know,
15 it takes something to then do something and
16 increase access in other things we care about,
17 bring it back to the question, do we think
18 those are things that we might change or adjust
19 in total cost of care models or, in your view,
20 is that something that should be outside of
21 that?

22 I think that's relevant to us as a
23 Committee. The point is well-taken and for me,
24 at least, it's how would we incorporate that
25 into specific changes in these models or should

1 it be separate?

2 MS. MCGRATH: I don't know if it
3 should be separate or not. There's not a
4 conversation that I have with a provider today
5 as the person who's in charge of the provider
6 network here in Washington and Alaska that
7 doesn't involve how can I help with access, how
8 can I help, you know, reduce transaction costs,
9 you know, how can I help staff your facilities,
10 right, since there's a labor shortage.

11 So, I'm not sure, you know, whether
12 it's separate or not, but I will just say, for
13 example, at Premera, we are literally standing
14 up primary care.

15 There is not enough access in
16 Spokane, and it's a fantastic community. We
17 love Spokane. We can't let there not be enough
18 access.

19 And so, we just -- I mean, it was
20 exhausting and expensive, but we stood up
21 primary care, right? And we did that because
22 we love our communities, and we're standing up
23 primary care now throughout the state.

24 And, again, we're doing that
25 because, I mean, we just -- we love them. How

1 can we not just be yelling at other providers,
2 like, what are you -- like, that's -- no, let's
3 jointly figure out how to do this, and we put
4 our money where our mouth is, and we invested
5 in primary care.

6 DR. SAUNDERS: And I think just
7 building on what Lee says and underscoring
8 Lee's point and Gary's that, you know, it's
9 relatively easy to change the way we pay. It's
10 much, much harder to redesign care.

11 You know, our research also shows
12 that it takes several years. I mean, you know,
13 Step 1 in many of these arrangements is you're
14 just figuring out what are the details. Like,
15 in giving me a claims feed, how do I open this
16 file, you know?

17 Year 2, maybe you're trying to do a
18 thing. Year 3, hopefully you're seeing a
19 result, and that's, you know, folks who are
20 pretty well-resourced and have a good sense of
21 what to do.

22 I think to your question on up-front
23 capital, I think that's a big issue here, you
24 know.

25 We had early on, say, like, the ACO

1 investment model, like, which included some
2 level of up-front capital, you know, maybe a
3 hospital system or a health system may be able
4 to tap into capital reserves.

5 But to start an ACO, you know,
6 depends on which type of ACO, you know. We're
7 talking probably three-quarters of a mill, a
8 mill, to get the data infrastructure, to get
9 the people, to get the care coordinators, and
10 all of that is up-front.

11 And then on the Medicare side, you
12 do that, you then improve care, and then 18
13 months later you get the check that is your
14 reward.

15 You may or may not have the cash
16 flow to survive, especially if we're talking
17 about a petitioner to practice and still
18 working on cash accounting and trying to work
19 that way.

20 You know, I think we've seen actors
21 in the market help fill that gap a little bit,
22 your ACO enablers, your Elevates, your Privias,
23 your Agilons, who have been able to tap in and
24 provide some of that up-front capital, but I
25 think to Lee's point, there's still a big need

1 here.

2 And it's different, you know, the
3 up-front capital and that infrastructure
4 investment is different than the ongoing
5 incentive structure that we put in place.

6 And, you know, many practices don't
7 have the access to capital that allows them to
8 start putting those investments down and then
9 waiting, you know, two years, three, to see if
10 that investment pays off. They need, you know,
11 help up front.

12 So, I think we'll struggle having a
13 payment model that doesn't include something
14 that's thinking about where does that up-front
15 capital come from.

16 DR. SMITH: Yeah. Robert, if I could
17 follow up on that, you know, my career started
18 out in, you know, health systems.

19 And that was exactly our challenge,
20 was we had so many different models. Each of
21 them required -- I wish it was only half a
22 million to three-quarters of a million dollars
23 in start-up costs, right?

24 They often required enormous both
25 start-up costs, as well as subject matter

1 expertise that we didn't have.

2 And then we built that over time,
3 but each new model, you know, almost started
4 over with new capital requirements to meet the
5 needs of the model.

6 And so, what you're seeing now, I
7 think, is almost the privatization of fee-for-
8 service innovation in the marketplace right now
9 with most of the interesting investments coming
10 out of private equity and venture capital. I
11 don't know that we want that to be that way.

12 I think what's also not happening is
13 you're not seeing delivery systems really
14 transform themselves because they simply don't
15 have the working capital.

16 I mean, Lee, to -- I applaud you for
17 trying to find primary care doctors to put
18 across an entire state, but, you know, they're
19 just -- they don't exist in many of our states.

20 And we don't have the dollars to
21 invest in the salaries to pull people into
22 primary care who might have otherwise are now
23 going into hospital medicine or emergency
24 medicine.

25 So, the up-front costs if we are

1 comfortable with the privatization of Medicare
2 fee-for-service innovation, then we can
3 continue to make -- put forward demonstrations
4 at private equity companies like direct
5 contracting can fund, or we have to figure out
6 a different model for much bigger up-front
7 capital investment.

8 DR. PUCKREIN: So, let me return
9 this back to the patients for half a second.

10 So, if we look at Medicare fee-for-
11 service right now, about 24 percent of Medicare
12 beneficiaries in a fee-for-service program have
13 diabetes.

14 They have a 60 percent
15 hospitalization and ER visit, right? Sixty
16 percent of them are going to the hospital or
17 going to the ER every year.

18 If you look at the hospitalization
19 rates and ER rates for the last five years,
20 they're completely flatlined by -- the number
21 of people who went to the hospital or the
22 emergency room last year was almost the same
23 number the year before.

24 And what that says to me, that's a
25 system that's not learning. It's not learning

1 one doggone thing about how to take care of
2 patients with diabetes.

3 We could talk about -- I mean, we
4 could go down the list of this, right? And the
5 point I'm making is that that's the
6 conversation that we're not having.

7 We're not saying to ourselves, why
8 is our system behaving like that? What do we
9 need to do in order to change that?

10 And what I'm suggesting is you got
11 to start with the numbers. You got to start
12 with the numbers of patients, right?

13 I understand the financial
14 investment, and I understand it costs and all
15 that, but the purpose of health care is to
16 mitigate patient risk, and all you're doing is
17 talking about mitigating financials.

18 And so, we're putting patients at
19 risk, and that is really a failed system
20 because it ain't health care if that's what the
21 system is doing.

22 CHAIR CASALE: Great. Thank you for
23 all those comments. I'm actually going to move
24 to Question 3 for our panelists.

25 I want to ask about addressing

1 health-related social needs in population-based
2 total cost of care models.

3 So, in your opinion, what are some
4 best practices for integrating screening and
5 referring to address social needs in total cost
6 of care models?

7 Gary, I'm going to start with you.

8 DR. PUCKREIN: That's a very tough
9 question because we are not succeeding
10 clinically.

11 And so, bringing social services
12 into this -- and I'm assuming that we're
13 talking about housing, transportation, food,
14 and all those kinds of things which are
15 obviously critical to health care, but is the
16 health care system really built to do that
17 right now and to add those on? Is that going
18 to really help the situation?

19 There's got to be some integration
20 obviously between social services and health
21 care, but, for the moment, I would pay
22 attention to what we're doing clinically to
23 make sure that we're operating at the top of
24 our license clinically and then obviously form
25 those partnerships with social services in

1 order to improve our outcomes with patients.

2 But I'm not sure -- even though I
3 deeply understand that social services are
4 critical, but I'm not sure if this health care
5 system is prepared to take that load on right
6 now.

7 CHAIR CASALE: Thank you. Kris, I'm
8 going to turn to you next about your opinion on
9 best practices for integrating screening and
10 referring to address social needs in these
11 models.

12 DR. SMITH: Sure. Thank you.

13 So, I actually think that we've come
14 a long way in terms of inclusion of screening
15 for social determinants into many of our health
16 care environments.

17 I think that, you know, we've also
18 learned that a variety of different folks, when
19 trained properly, can do it.

20 And you can actually use, whether we
21 call them community health workers or even
22 medical assistants, you can use staff that are
23 relatively affordable to collect the
24 information.

25 And I think that we also have seen

1 in the marketplace the proliferation of some
2 solutions, whether they're things like NowPow
3 or Aunt Bertha, which are providing the sort of
4 network, so to speak, and contact information
5 for all these social services.

6 So, I think we're actually pretty
7 far along in Medicare with their
8 standardization of the social determinants
9 screening has really helped, but I'm with Gary.

10 I think that all that we've done now
11 through building all that infrastructure and
12 learning has created longer waiting lists in
13 our social service agencies.

14 And our experience is we incorporate
15 social determinant screening for all of our
16 populations, and we are making referrals, but
17 the referral isn't being acted on any faster.

18 And what we're -- I appreciate the
19 refocus on social determinants and I appreciate
20 how they do -- are determinant of patient
21 outcomes, but, as a country, we have so
22 underinvested in those entities that are
23 capturing the referrals.

24 I don't think we're -- we are not
25 making the progress we hoped, and I don't think

1 we are going to, because these social service
2 agencies don't have the capacity to take the
3 referrals.

4 CHAIR CASALE: Great. Thanks for
5 those comments.

6 Lee?

7 MS. MCGRATH: I agree with all of
8 that, and I think I'll just -- I'll take the
9 approach of what we're doing at Premera. How's
10 that?

11 So, in with the primary care that
12 we're investing, and we actually created a
13 team-based way to manage the patient -- and
14 "manage" is such an insurance word, so I
15 hesitate to use it, but really to provide love
16 to the patient and create a magical moment, as
17 we refer to it, between the patient and the
18 physician, as well as the team that is supposed
19 to give a big, giant hug to that patient.

20 So, we've employed social workers
21 and pharmacists and case managers and
22 behavioral health specialists, and we have, you
23 know, invested heavily in community liaisons to
24 understand, you know, where affordable housing
25 might be or food banks, and trying to create

1 that relationship to the good people in the
2 areas that we've invested in primary care to be
3 able to provide that loving hug to the patient
4 once they leave the four walls of the clinic.

5 So, that's how we view making sure
6 that our patients, our members, are getting
7 what we think they signed up for when they
8 signed up for Premera insurance and what
9 they've signed up for -- or what they just
10 deserve, right?

11 So, that is, you know, how Premera
12 has taken that approach and invested heavily
13 in.

14 CHAIR CASALE: Great. Thank you.
15 Appreciate that.

16 Rob, any comments on this?

17 DR. SAUNDERS: I think, you know,
18 building on what others have said that there's
19 been a fair bit of activity on the screening
20 side, and I think we're getting better at
21 encouraging screening for social drivers of
22 health, you know.

23 This year, for instance, there were
24 a few measures that were put forward in the
25 Measure Applications Partnership review, and I

1 think we're already seeing at least one of
2 those proposed for some of the Medicare
3 hospital programs.

4 And the Measure Applications
5 Partnership, you know, is probably going to --
6 recommended those -- some for the physician
7 programs as well, you know.

8 I think as also building on others,
9 the struggle is often linking the screening to
10 the referral or the acting on the identified
11 social need, and that tends to be where the
12 challenge takes place.

13 Some examples of things we can work
14 on or build on would be like North Carolina's
15 Healthy Opportunities pilots which are doing
16 screening, but also have funding -- in this
17 case, Medicaid funding -- to help with the
18 actual referred service on housing, nutrition,
19 transportation, interpersonal violence, and
20 also set up data tools to help with the
21 referrals so that there's a sense of not only
22 the referral to the community-based
23 organization, but, you know, information and
24 feedback back to the referring clinician to
25 say, and here is what happened, you know, with

1 that case, you know.

2 We were able to meet that need, or
3 we also found that there were other social
4 needs, or we've been able to work with the
5 patient in the following ways.

6 I think without that infrastructure
7 to help with the connection between the
8 screening clinician or the screener, whether
9 that's a community health worker and the like,
10 and the community-based organization, we're
11 going to have a little bit of a struggle and
12 may have some problems in actually making
13 things happen.

14 The other thing that I think is
15 worth flagging here is we're starting to see a
16 little bit of cacophony happening in the social
17 drivers of health screening space, you know.

18 We've done some just informal sort
19 of surveys and, you know, finding that, you
20 know, individual systems are finding, you know,
21 three, four, five different variants of the
22 screening tools, each of which have different
23 ways of asking the question, each of which have
24 different ways that they are, you know, looking
25 for answers, each of which are also coding the

1 answers a little bit differently.

2 And we may be repeating the
3 cacophony we have with quality measures and the
4 social drivers of health, and then it's a
5 really good thing that we're seeing so much
6 attention paid on social drivers of health.

7 That is a good thing, but I would
8 hate to repeat the challenges that we have and
9 the burnout and burden that we have with
10 quality measures on social drivers of health
11 which aren't going to help with the long-time
12 sustainability encouraging greater connections
13 between the health care system and the social
14 care space.

15 DR. SMITH: If I could just follow
16 up your comment, I just want to -- I want to
17 find a silver lining to the social determinants
18 because I think, you know, the one place where,
19 as we have, in our programs have gotten better
20 at measuring social determinants in a way that
21 can feed into our risk stratification models, I
22 will say that the one area that we have, Gary,
23 to your point about managing the medical, is
24 we're getting better at using the social
25 determinants to help us to identify who, you

1 know, which diabetic patient, to your earlier
2 comment, is more likely to be the one
3 hospitalized because from just a claims
4 standpoint without the social determinants,
5 they look rather homogenous.

6 And once we start to layer that in,
7 we've had some good success in highlighting
8 folks who need more help that we wouldn't have
9 been able to do without attention to
10 measurable, reportable social determinants.

11 CHAIR CASALE: Thank you.
12 Appreciate all those comments. I'm going to
13 open it now to PTAC members.

14 Any follow-up questions before we
15 move to the next question?

16 Lauran?

17 VICE CHAIR HARDIN: Just a quick
18 question.

19 So, universally across the country,
20 there's an issue of screening and referral to
21 nowhere.

22 And I'm curious for each of you,
23 I've heard some innovative practices you're
24 investing in in your systems.

25 What motivated you to put the

1 investment in actually building some of those
2 services, and what recommendations might you
3 make as we look at total cost of care to
4 generate more investment and actually investing
5 and building those resources?

6 DR. SMITH: Can you just clarify
7 which resources? You mean you would like us to
8 build the actual receivers of the referrals or
9 --

10 VICE CHAIR HARDIN: Yes.

11 DR. SMITH: -- the infrastructure to
12 capture the information?

13 VICE CHAIR HARDIN: So, when we
14 think about health-related social needs, things
15 like transportation and housing and food
16 security.

17 Universally across the country,
18 there is an issue with referral to nowhere, but
19 I've heard in you describing some of your
20 models you're building some of those things in.

21 You're investing in care management,
22 social work, behavior health, pharmacy, the
23 community liaisons.

24 What motivated you to do that? And
25 then how -- what advice would you give to

1 others for investing in that?

2 DR. SMITH: I can try.

3 Lee, do you want to go first on that
4 or --

5 MS. MCGRATH: No. Please, go ahead.

6 DR. SMITH: Yeah. So, I mean, much
7 like Lee, you know, we, in our programs, are
8 investing in other members of the care team.

9 Whether they're social workers,
10 community liaisons, community health workers,
11 you know, we're definitely trying to surround
12 the patients with more individuals who have
13 skills, whether it's around managing things
14 like social isolation, depression.

15 But where we're not investing is
16 we're not investing in, like, paying for
17 transportation on the care delivery side.

18 And the reason we're not, in many
19 ways, our food, you know, we're not buying food
20 for folks, is because it's hard to build a
21 business plan around that.

22 And in former life, we did that, and
23 everybody was very excited because it makes for
24 a good press release.

25 And then after about two years,

1 someone looks at my budget and says, why are
2 you paying for all this food? What's the ROI²⁵
3 on that food? And it's very challenging to
4 build a business plan around some of those
5 services.

6 And so, that's why I am a little bit
7 jaundiced that you'll get the delivery side to
8 be able to make those investments.

9 On the payer side, I have definitely
10 worked with forward-thinking payers,
11 particularly in the Medicaid space, who will
12 partner with us on studying what the return is
13 for these investments, but I think it's very
14 hard to see if providers will lean into that
15 space and make those investments.

16 MS. MCGRATH: That's a really good
17 answer. So, for Premera, I mean, it was, you
18 know, our employer groups were like, our
19 patients aren't getting in to see care, you
20 know.

21 Our employer groups hire us, right,
22 to help and do that. Like, a Premera ID card
23 should get you places, right? And so, we had

25 Return on investment

1 to answer that.

2 I think the business case -- how do
3 I say this? So, the best way to solve the
4 business plan is if we hold -- if our patients
5 stayed with us, if our members stayed with us
6 for a very, very long time, the business case
7 proved out.

8 If they only stayed with us for six
9 months, it doesn't. And that is a -- that's
10 something we have to fix and have to really
11 think about because if someone holds onto a
12 Premera ID card, for example, for 80 years,
13 business case works great.

14 If they stay with us for six months,
15 the business case for providing food or
16 transportation is really tough.

17 And somehow, you know, I literally
18 am -- like, it can't be about money. It really
19 can't. And yet, you know, we have to, you
20 know, still pay our employees. So, we have to
21 figure that out.

22 We're committed to figuring that out
23 at Premera. Truly, we've invested hundreds of
24 millions of dollars into primary care and teams
25 to surround that primary care.

1 And we've invested a ton in
2 providers that are just not owned by Premera,
3 to be super clear, in Seattle, in Washington
4 and Alaska, but, you know, it's really hard.

5 CHAIR CASALE: Thank you.

6 DR. SAUNDERS: I'm sorry.

7 CHAIR CASALE: Go ahead, Rob.

8 DR. SAUNDERS: I was just going to
9 say I would build on those two comments just to
10 say in our surveys and talks with delivery
11 systems and payers, I think we're hearing
12 similar feedback across the board.

13 I mean, one point here would be
14 there's a lot of technical nuance here and what
15 you can use different dollars for.

16 And if you are using traditional
17 Medicare dollars, there's a set of
18 restrictions. If you're using traditional
19 Medicaid dollars, here's your restrictions.

20 Medicare Advantage has a little bit
21 more flexibility in certain areas, but not
22 others, and, you know, being able to navigate
23 that technical nuance is incredibly important
24 and incredibly challenging.

25 I think the second piece here is --

1 and, Lee, I know you hit on this a little bit,
2 is that there's different -- I hate to use the
3 word "return on investment," but there's
4 different returns depending on what services
5 are provided and, at the end of the day, folks
6 have to think about long-term sustainability.

7 And, you know, in some cases if you
8 were targeting, say, food, to use Gary's
9 example, to a diabetic patient who may be
10 housing insecure and, therefore, have less
11 access to, you know, fresh foods and probably
12 doesn't have a refrigeration, let's say, for
13 their insulin, you know, that -- you may see
14 your changes in care utilization within a year,
15 you know.

16 Some longer-term changes, Lee, as
17 you mentioned, may take, you know, five, 10, 15
18 years until you actually see changes in health
19 outcomes and changes in utilization patterns
20 and just -- I think a lot of folks are still
21 figuring out what are those specific care
22 delivery services that can take place and show
23 changes in a short amount of time.

24 That's a big issue with North
25 Carolina's Healthy Opportunities pilots and

1 Medicaid, is that they're not funding every
2 service in transportation, nutrition, housing,
3 interpersonal violence, but have a fee schedule
4 of here are very specific services that they
5 are funding with the theory being that they may
6 see returns and changes in a short period of
7 time.

8 And I think the final question here,
9 which is an existential one, is if you want to
10 see something done in the most expensive way
11 possible, you have the health care system be in
12 charge of it.

13 And we don't want to have, you know,
14 the health care system take over social
15 services. We have a well-functioning -- or at
16 least a well-defined social service system, and
17 the question may be more a partnership as
18 opposed to health care trying to absorb all
19 those services and do them in-house, but there
20 is a little bit of tension here as we think
21 about social determinants of health screening
22 and meeting those needs that we don't just have
23 the health care system absorb and overtake
24 social service systems.

25 DR. PUCKREIN: I would make the

1 argument that we've come to the point where we
2 have to start reimagining our health care
3 system.

4 It has to be fundamentally -- and
5 I've been saying this, obviously -- focused
6 around patients.

7 I think if the health care system is
8 incentivized, if the incentive is around
9 patient outcomes so that everyone is working
10 competitively to improve patient outcomes, I
11 think a lot of these issues would get
12 addressed.

13 I think about it, you know, cable
14 companies, they fight over membership tooth and
15 nail, right? And we want health care plans to
16 fight over membership tooth and nail.

17 And I think the way you get them to
18 do that is to really focus on patient outcomes
19 to make the system really focus in on patients.

20 And unless we do that, we're just
21 talking money all the time, and in a year,
22 you're going to find out that you can't afford
23 to provide food and housing and all these other
24 things and, indeed, sometimes we can't even
25 afford to provide care, you know.

1 So, I think we're really at that
2 moment particularly given the medical
3 revolution that's around us.

4 The science is exploding, and the
5 health care financing system is not competing.
6 It's not supporting that.

7 And so, we have to make that shift
8 if we're going to get the full benefit of the
9 medical revolution that's going on because the
10 challenge is only going to get greater because
11 the new technologies are going to cost, and the
12 disparities around them are going to increase.

13 And the only way forward, I would
14 argue, is really to center this conversation
15 around patients and make everybody in the
16 system think about evidence-based patient
17 outcomes.

18 CHAIR CASALE: Great. Thank you.

19 Angelo?

20 DR. SINOPOLI: Yeah. This is Angelo
21 Sinopoli, and this question might be directed
22 more toward Kris and Lee.

23 Have you explored the opportunities

1 in your communities to partner with EMS²⁶ for
2 transportation and innovative transport models
3 that can benefit the patients there in your
4 communities?

5 MS. MCGRATH: Yes. Yes, we have
6 explored it. We have explored it. And to tell
7 you the truth, we do a ton in Alaska with
8 helicopters and have invested a lot in those
9 tiny little sea planes that make me really
10 scared and nervous, and it makes no Alaskan
11 scared or nervous.

12 And we've invested a lot into being
13 able to provide transportation in super rural,
14 very cold, snowy places in particular.

15 DR. SMITH: Yeah. So, in a number
16 of different stops in my journey of building
17 complex programs, we've used EMS not as much
18 for transportation to, say, like an
19 appointment. We've used EMS mostly for our
20 help with unscheduled visits and acute visits.

21 So, patients call, we can't get a --
22 I've built mostly home-based models for complex
23 patients.

26 Emergency medical services

1 And so, mostly we use EMS and
2 paramedic staff to get out to patients' homes
3 because we can't get to them with their usual
4 longitudinal provider.

5 And I will say that, you know, when
6 we did work with this in downstate New York
7 around some programs for the frail/elderly, we
8 were able to partner with EMS programs.

9 We got a response time down to under
10 30 minutes for patients where we couldn't
11 adjudicate the clinical complaint over the
12 phone.

13 I will tell you when you get that
14 response time down to 30 minutes, boy, you can
15 really -- you can really impact total cost of
16 care because all of a sudden everyone calls all
17 the time looking for help because they know
18 they'll get help in a timely manner.

19 So, that's where I think there's
20 tremendous, tremendous opportunity to innovate
21 and partnership with our EMS colleagues
22 provided we can provide the right oversight and
23 supervision.

24 CHAIR CASALE: Thank you.

25 Jennifer?

1 DR. WILER: Thank you for a very
2 interesting discussion.

3 There was a comment made about the
4 business case and the cycle time to actualize
5 the investment in care and to see that outcome
6 and, Gary, you made some really important
7 comments about being -- trying to constantly
8 focus on being patient-centered.

9 I'm curious. Have any of you heard
10 of programs where retention of members or
11 looking at recidivism rates from programs is
12 considered a quality measure?

13 And if not, would you be open to
14 that as a measure that we endorse?

15 DR. SMITH: One of our key
16 performance measures is what we call
17 "controllable discharges" from our services,
18 because we view it as an early warning sign
19 that we're not providing something that
20 patients want.

21 And if the patients and families do
22 not believe that we're providing something of
23 value, they won't call us. If they don't call
24 us, we can't help them when they're having a
25 deterioration.

1 So, we use controllable discharges
2 or unexpected discharges as a key measure of
3 our performance. So, I would be in favor of
4 that.

5 CHAIR CASALE: Any other thoughts
6 from panel members? If not, we can move to
7 Question 4.

8 So, in our discussions over the last
9 two days, we've highlighted the trade-offs when
10 designing total cost of care models.

11 One of those trade-offs potentially
12 is between maximizing beneficiary choice of
13 providers and providing flexibility for
14 accountable entities in managing costs they're
15 able to control.

16 So, as you -- in thinking about that
17 trade-off, was interested in your thoughts on
18 how to balance that particular trade-off of
19 beneficiary or patient choice and flexibility
20 of the accountable entity to manage costs that
21 they can control.

22 Lee, I'm going to start with you.

23 MS. MCGRATH: Yeah. I think the
24 question that was just previously asked about
25 retention feeds in here, right?

1 And Gary actually -- what are the
2 feedback loops? I really love that word and
3 that concept.

4 So, we get retention as an insurance
5 carrier, right, from employer groups and from
6 individuals who buy our insurance on the
7 exchange, and that's our feedback loop.

8 And I love the retention idea of
9 incentivizing providers to hold onto patients.
10 I think that's fantastic.

11 But, you know, we don't -- we also
12 have to make sure our premiums -- our feedback
13 loop is affordable premiums.

14 And when we don't standardize, we
15 run the risk of increasing costs and increasing
16 premiums.

17 And so, all of those pieces are in
18 the mix as how we think about -- how we think
19 about value-based care, how we think about
20 partnering with providers, how we think about
21 our own provider entity, and how we think about
22 what we deliver consistently to the employer
23 groups and to the individuals who buy our
24 insurance on the exchange.

25 And I think it's important to

1 understand everybody's feedback loops and
2 everybody's -- Kris was mentioning his signals
3 that he uses of success.

4 Our signal is truly, does the
5 employer stay with us? And, by the way, just
6 to super overcomplicate this, the fact that --
7 I forget what it's called. What happened
8 during COVID? The great resignation or
9 whatever.

10 We saw an amazing change in -- yes,
11 we retained the employer group, but the
12 employees were moving so fast and, therefore,
13 waiting for premium becomes more complicated,
14 therefore, retention rates at the employee
15 level become more complicated just because
16 people were quitting or resigning or moving.

17 And so, all of those feedback loops
18 are things that we spend a lot of time at an
19 insurance carrier thinking about.

20 And one of my favorite things that,
21 I think, has happened in value-based care in
22 the last 10, 15 years, is we -- each side has
23 learned about each other in a different way.

24 And so, hopefully I am providing
25 that perspective of how we think about things

1 so that when an insurance carrier and a
2 provider sit down to duke it out over what
3 makes sense, everybody understands what -- the
4 feedback loops that each side is using in order
5 to be successful within their own organization,
6 then ultimately to the patients, members, and
7 community.

8 CHAIR CASALE: Great. Thanks, Lee.

9 Rob, I'm going to turn to you next
10 with this question of, you know, Medicare fee-
11 for-service, you know.

12 You can choose any provider, but
13 when you're in these accountable entities,
14 what's the trade-off in terms of maximizing
15 that choice versus flexibility for the
16 accountable entity to manage cost?

17 DR. SAUNDERS: Thanks, Paul. And
18 you're right. The trade-off here differs
19 depending on the type of insurance, you know.

20 Medicare fee-for-service, where
21 you've got full choice, is different than
22 Medicare Advantage, which may have some -- or
23 likely have somewhat of a network, and then
24 commercial insurance which would have a much
25 tighter network.

1 You know, I think we've seen a few
2 different strategies done out there in the
3 field, you know.

4 If we're thinking about ACOs, they
5 may be looking at referral strategies, or
6 they're starting to look at who are the
7 specialists nearby who are providing the high-
8 value care, and how do we get that information
9 into the hands of the referring clinician, as
10 well as into the patient to talk those things
11 through at the time of referral?

12 And that effect alone can have -- or
13 that type of action alone can have a decent-
14 sized effect in changing where folks are going.

15 You know, there are always
16 countervailing forces if someone is trying to
17 come up with a SNF²⁷ network, let's say, and
18 only encouraging folks to be half an hour or an
19 hour away, and folks want to stay local because
20 that's where the kids are, that's where their
21 caregivers are, you know, we're going to see
22 pushback.

23 But being able to provide some level

27 Skilled nursing facility

1 of just nudges and suggestions and support at
2 the individual clinician level and, as Gary's
3 reminded us, to help patients as well as
4 they're thinking about their choices, can be
5 useful.

6 I think one thing we saw during
7 COVID, which was interesting and we didn't
8 expect, was the number of partnership
9 strategies that were pretty effective here.

10 So, for instance, we saw a number of
11 ACOs working, let's say, with local SNFs on
12 infection control or testing or treatment
13 paradigms, which didn't even necessarily have
14 financial relationships, it was just a straight
15 care delivery partnership, and that those can
16 be pretty effective in both improving care, but
17 also in managing patients in different
18 settings.

19 And so, I think there's some
20 opportunity here even if we're not talking
21 about, you know, changing the way that we're
22 structuring the total cost of care arrangement,
23 but providing better focus on those
24 partnerships, referrals to make a difference in
25 how care is delivered.

1 DR. PUCKREIN: I would just say that
2 I think about this as competition, and we need
3 to have competition in the health care system.

4 Too much of it now is centered
5 around, I'm sorry, CMF, but you're taking
6 attention away from the beneficiary and not
7 forcing the competition to be around the
8 beneficiary so that the beneficiary is making
9 the decision about where they're getting their
10 health care, who's delivering it.

11 Competition is good here. It's a
12 good thing, and it will force everyone to
13 operate at the top of their license, but you're
14 not allowing that to happen. You're
15 interfering too much in the marketplace, to be
16 blunt about it.

17 And so, my strongest recommendation
18 is to get some competition into the system, to
19 figure that one out, because I think everyone
20 will operate in the patient's top interest once
21 they are competing for their attention.

22 CHAIR CASALE: Thanks for those
23 comments.

24 Kris, I don't know if -- do you have
25 any particular comments around this trade-off

1 of sort of beneficiary choice or, you know,
2 narrow networks versus full networks, versus
3 flexibility for the accountable entities to
4 manage costs?

5 DR. SMITH: Yeah. I mean, I agree
6 with many of the comments. I think the only
7 thing that I would add is as we think about
8 different models that are coming out of
9 Medicare and CMMI, anchoring on -- allowing
10 patients to choose to move out of a
11 demonstration or out of a practice, I think,
12 obviously has to be maintained, but the
13 algorithms by which you attribute patients to
14 practices and to programs needs to err on the
15 side of stability in the population.

16 Because, as Lee was saying, if you
17 have -- if you have 20 to 30 percent churn in
18 your population, the likelihood that that's
19 going to dampen your ability to improve quality
20 and total cost of care, I think, is pretty
21 well-established in literature and in our lived
22 experience.

23 So, I would say that that is
24 something that has to be top of mind as we're
25 developing new models of care.

1 CHAIR CASALE: Thank you. I'm going
2 to open it up to PTAC Committee members. Any
3 questions? If not, I'm going to turn to
4 Question 5.

5 We spend a lot of time as a
6 Committee thinking about specialty care within
7 total cost of care models.

8 And, you know, there's a lot of
9 conversation -- I think we've talked about this
10 a little bit about whether there is the benefit
11 of having sort of a structure regarding the
12 accountable entity.

13 So, indeed, you know, should there
14 be sort of specialty models that are sort of
15 clear for the specialist to then engage in the
16 total cost of care model versus having
17 flexibility for the accountable entity to sort
18 of organically determine how to incentivize
19 providers.

20 And, Gary, I'm sorry to be talking
21 about money. It's part of what we're trying to
22 think about when we think about -- we're not
23 ignoring quality and outcomes, but we'd be
24 interested in thoughts around this.

25 Kris, maybe I'll start with you on

1 this as you think about the role of the
2 specialists to engage them or incentivize them.

3 DR. SMITH: Um-hm.

4 CHAIR CASALE: The trade-offs
5 between providing sort of a structured model
6 for them to participate in versus having them
7 in a total cost of care model, and then the
8 accountable entity sort of more organically
9 incentivizes the specialist.

10 DR. SMITH: Sure. So, just, you
11 know, in terms of my bias, I'm an internist,
12 and so I believe that, you know, the data
13 supports that we want patients to have medical
14 homes.

15 And I think that a lot of the work
16 that your group is doing, that we've been doing
17 over the last 10 years, part of what it should
18 be trying to do is reinvigorate primary care
19 such that 10 years from now, we can see that
20 these investments led to a larger primary care
21 workforce, for example.

22 And so, I'm not a big fan of having
23 sort of subspecialty ACOs. I would think that
24 we would want ACOs that are built around
25 primary care networks, and that those primary

1 care networks be allowed to determine how they
2 want to contract and what the relationship they
3 want to be with, whether it's the subspecialty
4 providers, whether it's the subacute rehab
5 facilities, even the hospitals.

6 And I think in my lived experiences,
7 as some of these models have delegated the
8 ability to negotiate financial terms with,
9 let's say, laggards, all of a sudden these
10 entities who are trying to stay out of total
11 cost of care models like hospitals are all of a
12 sudden now trying to fix readmissions because
13 they see that the ambulatory network around
14 them is demanding that and that the ambulatory
15 network, unlike the insurance company, they can
16 actually move patients.

17 And so, they can work to move a
18 patient to one hospital two miles down the
19 street compared to the other hospital who's not
20 willing to work on these value-based incentive
21 models.

22 CHAIR CASALE: Great. Thanks.

23 Gary, thoughts on this?

24 DR. PUCKREIN: I actually like the
25 idea of leaving the power with the ACOs.

1 Obviously, to me, it's -- they're focused on
2 patient outcomes, and I think of them as
3 finding partners to help them get the best
4 possible outcome for the patients.

5 I think if we're forcing everyone
6 into various systems, you're going to lose that
7 attention on the patient.

8 At the end of the day, the buck has
9 got to stop somewhere. And so, I would leave
10 it with the ACOs and -- but obviously they've
11 got to report on outcomes. You've got to have
12 that sense that they're making improvements for
13 patients.

14 CHAIR CASALE: Thank you.

15 Lee, any thoughts on this?

16 MS. MCGRATH: I mean, I'd be
17 actually really curious what the underlying
18 piece of the conversation or the question is.

19 Is it we should be pushing more
20 money to specialists?

21 CHAIR CASALE: No. It's more about
22 do we need to create specialty models that need
23 to be either nested, carved, you know, sort of
24 nested within a total cost of care, or do you
25 allow the total cost of care entity to sort of

1 work with the specialist and sort of
2 organically develop what the incentives should
3 be?

4 MS. MCGRATH: So, right now we
5 incentivize primary cares who are thinking the
6 insurance carrier should take the money from
7 the primary care and move it to the specialist?

8 Is that what the question is?

9 CHAIR CASALE: It's really more
10 about how -- collaboration between primary care
11 and so really not so much -- I don't want to
12 overemphasize the money piece. It's more
13 about, in reality, it's currently the
14 specialists have not -- even within Medicare
15 ACOs, the specialists have not been
16 particularly engaged within those models.

17 And there's a lot of conversation
18 that CMMI has had around, you know, they have
19 quite a few specialty models currently in the
20 BPCI²⁸ program, et cetera.

21 And the question is, do they need to
22 continue some of those models, is that helpful,
23 or is it better to sort of focus on the larger

28 Bundled Payments for Care Improvement

1 total cost of care model?

2 MS. MCGRATH: You know, I think the
3 three fundamental things that are wrong with
4 health care that we all need to address are
5 affordability, access, and fragmentation of
6 care.

7 And I don't know if creating more
8 models and more ways to move money around will
9 address affordability, access, and
10 fragmentation of care, and I'd rather talk
11 about what can address affordability, access,
12 and fragmentation of care.

13 So, you know, fragmentation of care
14 and affordability and access, I think, can be
15 addressed a lot by investing in sharing
16 information and data, and I think the payer
17 role in sharing data is significant.

18 I think the responsibility for CMS
19 to share additional information is significant.
20 And I think the ask for physicians, even if
21 they're not within the same system, is sharing
22 information.

23 So, Gary's point about increasing
24 competition, well, they also need to share
25 information back and forth because if the

1 competitors aren't sharing information, you
2 have access, affordability, and fragmentation
3 of care problems.

4 And so, I think those are the things
5 that need to be discussed, and that's where I
6 would head in terms of the conversation.

7 CHAIR CASALE: Great. Thanks, Lee.

8 DR. SMITH: Wait. Can I just follow
9 that?

10 CHAIR CASALE: Oh.

11 DR. SMITH: Can I follow up for one
12 quick second?

13 CHAIR CASALE: Sure.

14 MS. MCGRATH: Sure. Go for it,
15 Kris.

16 DR. SMITH: You said something,
17 Paul, you used the word "nesting."

18 MS. MCGRATH: Um-hm.

19 DR. SMITH: And I would like -- I'm
20 curious to see what other panelists -- nesting
21 is a disaster. And it's a disaster because it
22 introduces such uncertainty.

23 And again we're getting to money,
24 but in terms of planning, if you are a provider
25 and you want to take population risks, but you

1 may have X, Y, and Z carved out, but you won't
2 know until 18 months after you've entered, you
3 create such uncertainty around the modeling and
4 patient attribution that if I'm a provider who
5 is on a 1 percent profit margin, I have no
6 interest in figuring out whether that
7 complexity is going to hurt me or help me.

8 CHAIR CASALE: Great.

9 DR. PUCKREIN: I just want to --

10 CHAIR CASALE: Go ahead, Gary.

11 DR. PUCKREIN: -- pick up on
12 something Lee said about data.

13 CMMI could play a very big role in
14 freeing up data because they're not going to
15 get great health care until the data is moving
16 around.

17 And so, if I was seated at CMMI and
18 I was really thinking about innovating, I would
19 be thinking about how to break down these data
20 walls so that we can share information across
21 the system, and I think it would be a dramatic
22 change of the kind of care that patients will
23 receive.

24 CHAIR CASALE: Thank you, Gary.

25 Rob, I know you've done a lot of

1 thinking around this. I know you alluded to
2 some of this in your opening question/remarks.

3 Any other additional thoughts around
4 this?

5 DR. SAUNDERS: Just a few thoughts
6 building on what Kris, Gary, and Lee have said
7 already. I mean, I think three thoughts here.

8 One, you know, if we look at and
9 talk to specialists now, they don't really feel
10 like a lot of these total cost of care models
11 are for them. That can be just a total lack of
12 awareness.

13 If you ask folks who are in an
14 organization that is an ACO, you know, did you
15 know that you're part of an ACO, and senior
16 clinicians, senior attendings down to trainees
17 will look in confusion at you if they even know
18 what that word means, let alone feeling like
19 that represents them and their care. So, I
20 mean, I think there is clearly a need for more
21 focus on engaging specialists.

22 It's hard to see that there will be
23 one solution given the different types of
24 specialists and subspecialists we have in play
25 right now.

1 In some cases that may -- it may
2 make a lot of sense to pick a particular
3 population and have a model that is very
4 focused for them, you know.

5 ESRD²⁹, younger inflammatory bowel
6 disease come to mind where you've got, you
7 know, a condition that is managed by a
8 specialist, and that specialist is in charge of
9 most of that person's care and would be
10 expected to manage that.

11 In other cases, you could see more
12 of a case of having a total cost of care
13 arrangement and then thinking about where there
14 are opportunities to pull folks in.

15 I think the third point here is
16 really the technical -- and Kris noted this,
17 you know, some of the challenges we've had to
18 date in nesting, say, bundles within ACOs, have
19 been challenging from a technical perspective,
20 they're challenging from an implementation
21 perspective.

22 The ACOs would note that they are
23 taking a lot of the risk here of, you know, is

29 End-stage renal disease

1 the bundle doing well? Then they don't really
2 see any advantages to that.

3 And so, it makes it difficult to
4 plan. It makes it difficult for them to
5 succeed in their role.

6 And so, where there may be
7 opportunities to, say, move that nesting
8 approach or that sort of coordination approach
9 to, say, like CMMI or to other -- whoever the
10 care is in this case so that they're bearing,
11 say, some of that actuarial risk, as opposed to
12 the ACO having to think about, alright, if I'm
13 to stay in this type of ortho bundle, I'm going
14 to be, you know, harmed if that goes well
15 because I don't get to see that type of return.

16 So, the short story here is I think
17 we've got to do something here more on
18 specialty payment reform to make sure the
19 specialists feel involved.

20 There will probably be some
21 diversity, and the technical pieces are
22 nontrivial, and we're probably going to need to
23 see a lot more improvement there.

24 CHAIR CASALE: Great. So, I'm going
25 to just move to the final question for our

1 panelists and appreciate all the discussion.

2 So, for each of you, just interested
3 in hearing any final thoughts or insights you'd
4 like to share as PTAC thinks further about
5 population-based total cost of care models.

6 Gary, I'm going to start with you.

7 DR. PUCKREIN: I think we have a
8 great moment here where we can do a lot for the
9 future of health care.

10 I don't think that value assessment
11 models have proven themselves. Actually, we've
12 been doing this since 2005, by my recollection,
13 and they haven't really worked.

14 And so, I think the moment has come
15 now for reimagining, and I think that imagining
16 has to be around the patient.

17 And I think CMMI has a great
18 opportunity here to break down all kinds of
19 walls and help put together a health care
20 system that has to now take care of a diverse
21 population.

22 We haven't even gotten to the issue
23 of diversity and inequities and all that. And
24 all of that has to be addressed, and I don't
25 think the current system is really designed to

1 take on those kinds of challenges.

2 CHAIR CASALE: Thank you. Kris?

3 DR. SMITH: Thanks. You know, my
4 final thoughts are just going back to my
5 initial thoughts, which is I think there's a
6 lot more evidence around certain large
7 populations of patients who need alternate
8 models of care and that many of the people who
9 are insured through Medicare or Medicaid who
10 are relatively healthy do reasonably well on
11 the current system.

12 And so, I would continue to ask that
13 you consider -- if total cost of care is the
14 top priority versus quality, then you have to
15 find populations where total cost of care can
16 be -- total cost of care reductions can be
17 achieved because we believe that there is low-
18 value care being delivered to those cohorts.

19 There is not compelling evidence
20 that for much of the cohorts that we're trying
21 to delegate at a population level, that there's
22 a whole lot of total cost to strip out of their
23 medical expense.

24 CHAIR CASALE: Thank you. Rob?

25 DR. SAUNDERS: Yeah. I think I have

1 three thoughts. Echoing Gary, I wish we would
2 have talked a little bit more about health
3 equity.

4 There's a lot -- and we've been
5 writing a lot about this recently. There's a
6 lot of opportunity to leverage these types of
7 total cost of care and accountable care
8 arrangements to improve health equity, but they
9 have to be thoughtfully designed, and they also
10 need to be thoughtfully implemented.

11 So, I think that is one place where
12 we can push a bit more, but related, but
13 different, there's also a tension here in how
14 we've been engaging the safety net in these
15 types of total cost of care arrangements.

16 They've largely been left out for a
17 wide variety of technical reasons. But if we
18 would like these types of total cost of care
19 arrangements to reach a large portion of the
20 U.S. population, especially those who are
21 living in more traditionally vulnerable areas,
22 involving the safety net is incredibly
23 important.

24 And finally just to go back on the
25 primary care specialist collaboration point,

1 there is a lot of potential here, and I think
2 at this particular moment, there's a lot of
3 questions technically about how that can be
4 done in a total cost of care arrangement.

5 But anything we can do at this
6 particular moment to help with that type of
7 collaboration would be welcomed.

8 CHAIR CASALE: Great. Thank you.

9 Lee?

10 MS. MCGRATH: Since we have about 30
11 seconds because I took a hard stop at 9:00, I
12 guess I'll just leave folks with something that
13 I tell my team all the time. We've got to lead
14 without fear and only the bold survive.

15 And I think it's our time to really
16 answer what every single person in America is
17 screaming and yelling at us about, and we need
18 to listen, and we need to lead without fear,
19 and we need to be super bold here.

20 CHAIR CASALE: Great. Great way to
21 end. Thank you, Lee.

22 So, on behalf of the Committee and
23 our audience, I would like to thank each of our
24 panelists for their insights today. We're
25 grateful that you have been generous in sharing

1 your expertise.

2 So, at this time we have a break
3 until 12:45 Eastern Time. Please join us then.
4 We will begin with our public comment period
5 followed by our final Committee discussion to
6 wrap up the meeting.

7 (Whereupon, the above-entitled
8 matter went off the record at 12:00 p.m. and
9 resumed at 12:46 p.m.)

10 * **Public Comment Period**

11 CHAIR CASALE: Welcome back. We're
12 going to move into the public comment period.
13 We don't currently have anyone signed up to
14 give a public comment; however, I'm going to
15 pause -- check with the host before we move on.

16 Are there any folks who want to
17 contribute?

18 (Pause.)

19 CHAIR CASALE: Okay. Great. So,
20 hearing no public commenters, that will be the
21 end of the public comments, and we'll move
22 right into Committee discussion.

23 * **Committee Discussion**

24 So, the Committee Members and I are
25 going to discuss what we've learned yesterday

1 and today from our guest presenters, the
2 roundtable discussion, the background
3 materials.

4 As you know, this two-day meeting is
5 Part 2 in our three-meeting series on
6 population-based total cost of care models.

7 After all three meetings in the
8 series are complete, we will submit a report to
9 the Secretary of HHS.

10 So, the report will include our
11 findings from the March, June, and September
12 team-based discussions.

13 While it's fresh in our mind, we
14 want to discuss what we learned yesterday and
15 today. Lots of information to sift through.

16 So, Committee Members, please check
17 the pocket of your meeting binder for a
18 document of potential topics for our
19 deliberation.

20 Our goal is to begin developing
21 comments and recommendations that will inform
22 the portion of our report to the Secretary on
23 care delivery, best practices, and innovations,
24 and to pave the way for our September
25 discussion of payment methodologies to

1 encourage what we've identified at this public
2 meeting.

3 As you make comments or ask
4 questions, please remember to flip your name
5 placard up. So, I'm going to open it up now to
6 the Committee Members, and we'll get started.

7 So, Jay?

8 DR. FELDSTEIN: Thanks, Paul.

9 One of the things that stood out
10 through every session, and it generated a lot
11 of questions by the Committee, is how do we
12 integrate specialty care and specialty cost
13 into a total cost of care model?

14 And when I struggled with this back
15 in my insurance days, and I think we all
16 struggle with it today, and that is if you
17 believe that whoever is responsible for the
18 care is responsible for the cost, then that
19 should be the accountable party.

20 And, in many circumstances, for many
21 conditions, the specialist is the best person
22 suited to get the best patient outcome. So,
23 somehow we've got to figure it out.

24 We can't just say, you know, oh -
25 we keep putting it in the parking lot because

1 it's so difficult to deal with, but we really
2 do need to figure it out if these plans and
3 models are going to be successful.

4 CHAIR CASALE: Yeah. I appreciate
5 that comment. Other thoughts particularly on
6 that topic?

7 I know we've asked several of the
8 panelists around this around, you know, how to
9 either incentivize specialists, engage
10 specialists.

11 And to your point, Jay, there are
12 certainly, you know, thinking about best
13 outcomes and how specialists can engage in the
14 cost of care model.

15 So, Larry, I'll start with you.

16 DR. KOSINSKI: Well, the term that
17 you used early in the meeting on yesterday,
18 "cascading accountability," you know, forget
19 primary care, specialty care.

20 We've designated those definitions,
21 but they're fluid in many respects because a
22 specialist following someone with a serious
23 chronic disease has to be providing primary
24 care for that illness to that patient.

25 And likewise, the internist, who's

1 managing multiple complex conditions, who may
2 be experienced, is delving into the specialty
3 world in multiple specialties at the same time.

4 So, I push back on this definition
5 of primary and specialty care, and I keep
6 coming back to what is total care for the
7 patient depending on what the illness is.

8 And we know from what we've heard
9 over the last couple days that the frontline
10 work has to be proactive, and it has to have a
11 lot -- whatever touches are necessary for that
12 person's illness, that person's SDOH³⁰ status,
13 whatever number of touches are necessary, those
14 touches have to be made.

15 And whether they're made by a
16 primary care doctor or a specialty physician or
17 a nurse practitioner or a PA³¹, whoever is
18 performing this, or even an unlicensed person,
19 we have to define the touches to the patient.

20 And then if we want to be able to
21 pass responsibility for cost onto a population-
22 based total cost of care model, we have to be
23 able to envision the layers of accountability

30 Social determinants of health

31 Physician assistant

1 that have to be created there.

2 So, I heard a lot over the last two
3 days about frontline work. I'm starting to get
4 comfortable on what that frontline proactive
5 primary care work should be.

6 I didn't hear enough on the
7 specialty side, but what I think I gathered out
8 is we either need to use tighter networks so
9 that the number of patients a specific
10 specialty group is seeing has enough critical
11 mass for them to change their practices, and
12 either it's the number of patients they're
13 seeing or it's a financial driver, but in order
14 to get into that specialty space, we're going
15 to have to look very distinctly at what are
16 bundled -- what type of services they provide
17 are bundled because they're low-variability,
18 they're high-volume, they get bundled, but that
19 gets nested inside this total cost of care, and
20 then what conditions they're managing, and how
21 do we provide the care management support
22 there.

23 It's obviously very complicated, but
24 those are my takeaways from the two days.

25 CHAIR CASALE: Yeah, that's great.

1 Very helpful.

2 Yeah, as I think about cascading
3 accountability and the comments you made, you
4 know, I think it also requires sort of a
5 culture change even amongst the specialists.

6 And again, I'm speaking as a
7 specialist where even on the quality side, you
8 know, so depression screening, I hear endlessly
9 specialists saying, well, I'm not accountable,
10 I don't do that, but really it's the collective
11 accountability, and you're sort of within that
12 cascade of accountability.

13 For us to move all of this forward,
14 it can't be the bucket of this is primary care,
15 this is specialty care. It needs to be -- we
16 need to think how we can do this sort of more
17 collectively.

18 Josh?

19 DR. LIAO: Yeah, I agree with those
20 comments, and I was just going to say, you
21 know, to me, lots of good things to noodle on
22 for me over the last few days.

23 I think I returned to a few things
24 with regards to engaging specialists. One is,
25 do we think populations -- their care is just

1 ongoing in a kind of monotonic ongoing way, or
2 are there kind of curves where there are
3 episodes that come up and down? That's one.

4 The second is, in some of those
5 episodes, the kind of patterns of care, do we
6 think specialists play a key role in that?

7 And then the third is, do we want to
8 go by who's touching versus that's the phase of
9 care where more people are needed?

10 I tend to favor the latter. And the
11 reason is even in the primary care setting, we
12 were hearing even some of that outreach is not
13 traditionally the primary care physician
14 anymore, right? It's other team members. Some
15 are licensed, some are not. So, I think the
16 who's touching is not as important.

17 Thinking back to the idea of
18 centering on patients, it's when that patient
19 needs something to be able to define that
20 moment and then ask the question, is a
21 subspecialist a key player in that?

22 And so, listen, lots of, I think,
23 technical work needs to go into it, but, you
24 know, I do think about this idea of nesting,
25 and I think about nesting in that way.

1 And personally, I think, you know,
2 we want to be careful on avoiding kind of the
3 tail wagging the proverbial dog a little bit
4 because, you know, some of the comments about,
5 you know, well, it takes incentive away, the
6 margins are small, 18 months is retrospective.
7 That's true.

8 I just want to call out that in
9 total cost of care models that engage primary
10 care docs, that's what they're dealing with
11 already. We've been dealing with that for a
12 long time.

13 And so, those are issues to address,
14 but the main issue is should we find a way to
15 bring primary and subspecialty care together
16 for those parts of the care that need both.

17 And personally I think the answer is
18 yes, and I think those technical things can be
19 worked through and need to be worked through.

20 Things like cost accounting and who
21 gets assigned what cost, we need to work
22 through that, but I take the optimistic view
23 that we should do it.

24 And until we do that, I think things
25 like nesting or other ways of doing it that

1 acknowledge that -- those parts of the care
2 that need those team members, not who touched
3 them last is important to me.

4 CHAIR CASALE: Yeah, that's great.

5 Lee?

6 DR. MILLS: I think something that I
7 heard throughout multiple talks, and I think
8 many of the members around the table have
9 commented on, we've had robust discussion on,
10 is just about the centrality of the data that's
11 required to impact access, affordability, and
12 fragmentation.

13 And having an essentially all-
14 source, normalized, timely, updated, you know,
15 no one EMR is good enough, no one or even three
16 payers is good enough, it's got to be all
17 sources all the time, which can only be done on
18 a big standardized national framework, which is
19 already coming together.

20 So, I think this is a huge
21 leadership opportunity for CMMI in three
22 different parts. One would be to, you know,
23 proceed with bold policymaking and set the
24 standards for how that all-source data should
25 be, you know, what the nomenclature is, how it

1 should be standardized, normalized, and set
2 some bounds to that.

3 The other would be to change the --
4 essentially change CMMI's actual paradigm
5 around data, that data is a siloed treasured
6 resource to be protected and closeted to it's a
7 health data utility that must be ever present
8 and flow through everything we do, or it's
9 never going to be effective.

10 And lastly, to essentially move
11 forward and to start requiring data
12 participation with the national framework
13 that's established that is receiving all this
14 data and normalizing it and then feeding the
15 parts that need the data to make a difference.

16 To just an earlier point, yeah, we
17 have to get comfortable with -- we can't have
18 an 18-month period where that data, that
19 lifeblood, is linking to metrics that are
20 defining quality and utilization.

21 We've just got to get comfortable
22 that we're not going to be able to act on it 18
23 and 24 months later when 99.9 percent of all
24 the data is known.

25 Typically you've got about 94 to 96

1 percent of the claim run out within six months,
2 and that's pretty much the -- in my mind, the
3 outside of when any provider or patient group
4 can react to data and make changes in response
5 to it. Past that it's a dead issue, and it's
6 too late.

7 CHAIR CASALE: Thank you. Walter?

8 DR. LIN: So, I just wanted to
9 circle back around to the whole discussion
10 around kind of how the specialist fits into the
11 total cost of care.

12 A couple thoughts. You know, I
13 think one of the standout lines to me from our
14 two-day session this week was when Dr. Smith
15 said, "nesting is a disaster," and, you know,
16 it harkens back to kind of old business school
17 principle.

18 If everyone's accountable for
19 something, then no one is really accountable
20 for something, right?

21 And so, I think as we think about
22 total cost of care, it's crucial to assign
23 accountability to a single organization, a
24 single -- ideally a single provider who can
25 make a difference at the front line, but it

1 can't be, in my mind, at least, multiple
2 providers with complicated carve-outs and
3 nesting schemes. And so, that's just one
4 thought.

5 Another thought I wanted to share
6 was I think there's good evidence in the
7 literature that primary care is one of those
8 few areas in health care where increasing the
9 spend in that area actually decreased total
10 cost, right? And so, I think that's also
11 important to keep in mind.

12 And in my own practice and how I --
13 in my experience with others as well, who
14 better to make the decision of how to use
15 specialists and which specialist to use than
16 the primary care doctor who is supposed to be
17 coordinating the patient's care among multiple
18 specialists?

19 And that -- the weight of that,
20 those referrals and the use of those specialist
21 will, I think, even be more important if we
22 give more accountability, both financially and
23 quality-wise to the primary care physician.

24 So, you know, I'm an internist. So,
25 I'm clearly biased in this arena, but I do

1 think that sometimes we overcomplicate things,
2 and we just need to figure out the kind of base
3 entity or the base unit of health care in which
4 to assign accountability and then have that
5 person just be truly accountable for the
6 patient's care.

7 CHAIR CASALE: Thanks, Walter, for
8 those comments.

9 And, Bruce, I do see your hand up.
10 I'm just going to make a comment, and then I'm
11 going to turn to Jen before you.

12 Just two comments. I'm not sure
13 when Dr. Smith was referring to nesting, it
14 sounded like he was describing carve-outs more
15 than nesting.

16 It was like you're taking money out
17 of the total cost of care as opposed to the way
18 I think about nesting as still within the total
19 cost of care model, but then there's a piece of
20 it that's sort of within specialty care.

21 And I think the other piece, I
22 think, that deserves further conversation is
23 around what is the right level of
24 accountability?

25 I know I asked Dana Safran yesterday

1 on the quality side, you know. When you think
2 about patient outcomes, it's very difficult to
3 assign that to a single provider.

4 Similarly around all this, what is
5 the right level for accountability as we think
6 through this?

7 So, Jen, I'll turn to you.

8 DR. WILER: I want to agree with Lee
9 that I think one of the biggest opportunities
10 that we have as a nation is to recognize access
11 to meaningful, actionable data related to
12 health is the great equalizer to help improve
13 what are current disparities.

14 And I agree with Walter that what
15 I've heard over the last two days affirms that
16 if we focus on the patient and patient-centered
17 care, and we heard lots of great applications
18 of transformation and care delivery models that
19 are making a difference in terms of patient
20 care outcomes, focusing on an Accountable Care
21 Organization might be too big of a swath.

22 And that really getting down to the
23 base units, as you've described, around an
24 accountable entity, could be a provider,
25 primary care or specialist, but that entity has

1 to own everything. And we heard that over and
2 over.

3 So, yes, maybe in heart failure, a
4 cardiologist is the right person to own total
5 care for a patient who is in a certain phase of
6 disease progression, but then they have to own
7 all their diabetic care and when they have a
8 stroke, their rehabilitation, and fill in the
9 blank, fill in the blank.

10 I think our payment models should be
11 agnostic to ownership, but have a principle to
12 prioritize that there needs to be an owner.
13 Because if not, there will be inefficiencies,
14 and ultimately that leads to poor outcomes and
15 higher cost.

16 And so, clearly by creating
17 accountable entities, we heard strategies
18 around by builder partner, and that's my last
19 comment.

20 And that's those incentives to then
21 partner with that accountable provider group or
22 entity need to be compelling enough to want to
23 create a relationship.

24 And so, I do think we need to go
25 deeper and think about, you know, payment

1 models that recognize that that relationship is
2 both important and needs to be valued, and
3 there's a cost associated with paying for those
4 relationships.

5 CHAIR CASALE: Yeah, that's great.
6 Thanks, Jen.

7 Bruce, I'm going to turn to you.

8 MR. STEINWALD: Okay. Thank you.

9 I want to agree with both Walter and
10 Jen. Beginning with Walter, he alluded to
11 there's decades of research that shows that
12 communities that have robust primary care are
13 much better off in terms of patient outcomes
14 and costs --

15 CHAIR CASALE: Sorry, Bruce. You're
16 a little soft. If you can just get a little
17 close -- yeah, thanks. Sorry to interrupt.

18 MR. STEINWALD: Okay. Decades of
19 research have shown that communities with
20 robust primary care are much better off in
21 terms of outcomes and cost per capita than
22 other communities. And that's not even
23 transposed to primary care, of the kinds we're
24 talking about now. Just as a footnote
25 that's probably beyond our scope, the way that

1 we select for physicians in this country
2 discourages primary care, and Medicare adds to
3 that discouragement by the way they subsidize
4 medical education that's both hospital- and
5 specialty-oriented.

6 And if we think we need more primary
7 care, and I agree that we do, it should be to
8 transform to sort of Level 3 kind of primary
9 care that Dr. Chen mentioned that makes the
10 primary care physician the quarterback, but
11 extends the concept of primary care to be much
12 more than just what the primary care physician
13 does.

14 And I'm in favor of that, but how we
15 get there obviously is a problem. I do think
16 that the organic way, I think as you called it,
17 Paul, of dealing with the relationship between
18 primary care and specialty care is probably the
19 way to go.

20 CHAIR CASALE: Great. Thank you,
21 Bruce. Appreciate the comments.

22 Josh?

23 DR. LIAO: I appreciate the comments
24 that were made. I want to kind of respond to a
25 few of them, and I think this is actually

1 really important for us as a Committee and
2 probably as a collective us as a country to
3 grapple with.

4 As a general internist who has also
5 practiced primary care, I think I -- I think --
6 I don't want to speak for anybody else, but I
7 think I believe in the same vision and, like,
8 the values that we're working towards.

9 I also try to filter through the
10 fact that we've heard from some very good
11 exemplar organizations that even across them
12 primary care has meant different things.

13 And then I think about how even some
14 presenters have talked about having a hard time
15 finding primary care clinicians in key parts of
16 certain states.

17 And so, as we think about scale,
18 right, and things that might be done through
19 this, it -- I kind of oscillate between that,
20 like, what it could be in the best case, but
21 then what might be a way to engage primary care
22 more broadly speaking.

23 And so, I think just to echo a few
24 comments, I think how we get from here, given
25 that variation is, too, where we want to be is

1 important.

2 And are we solving for the exemplar,
3 or are we solving for the norm, and how might
4 models look different if we did that?

5 And so, you know, maybe it's a
6 semantic issue around carve-outs versus
7 nesting, but I do think -- I think the issues
8 that we're talking about with sample size,
9 attribution, all the things that have been
10 brought up, do you take too much of that
11 financial skin out of the game, what's patient-
12 centered?

13 Those are -- I think, to me, it
14 comes back to something that was in Question 4,
15 I think, which was do we want flexibility, or
16 do we want more structure?

17 And, to me, TCOC models as we
18 understand them now, short of bigger changes
19 like defining new costs, feel more flexible.

20 So, if we believe that the changes
21 need to happen, then I think we should grapple
22 with things like nesting or carve-outs or
23 dynamic ways of defining primary and
24 subspecialty care.

25 All are on the table, from my view,

1 but to then, I think, articulate early on all
2 the problems with that, are we then suggesting
3 in some ways something closer to what we have
4 today? And that's an open question.

5 CHAIR CASALE: Great. Thanks, Josh.
6 Angelo?

7 DR. SINOPOLI: Yeah, thank you. So,
8 I just wanted to make the comment that I think
9 this is one of the best meetings that I've
10 attended since I've been on the Committee.

11 And so, I just want to congratulate
12 everybody that was involved and all of our
13 great speakers today.

14 I think we agreed on a lot. And I
15 think that we agreed a lot around primary care
16 and what primary care needs to be resourced
17 with, how they need to function in really
18 creating a true transformation within primary
19 care.

20 I think we need to have a little
21 more discussion in regards to the specifics of
22 what some of those are.

23 I do agree -- I was a pulmonary
24 critical care doc, and I functioned somewhat as
25 a primary care physician for a lot of patients

1 with various pulmonary issues, but prefer the
2 idea that the specialists are part of the
3 primary care team and not necessarily the
4 primary care doctor, because even in my
5 practice, there were a lot of things that I
6 didn't know about and wasn't covering.

7 And so, to try to function as a
8 specialist and consider yourself as the primary
9 care doctor and not part of the team, I think,
10 does give a disservice to the patient.

11 And so, we've got to figure out what
12 that looks like and how to incentivize the
13 specialist to be primarily responsible for what
14 they're responsible for, but to be part of that
15 team.

16 I do agree that data is huge, and
17 we've got to solve that problem because chiefly
18 early entrance into this just don't have the
19 data to be able to make the right decisions.

20 And then the last comment I want to
21 make is there were some discussions about us
22 not being ready for or not paying attention to
23 the social issues, social determinants,
24 accountable community-type issues that affect
25 our patients, and I don't think we can just put

1 that on the back burner.

2 I think that, you know, the
3 organizations that I've seen that have really
4 addressed those see such a benefit from it that
5 we've got to figure that out, and I think
6 that's got to be put back on the front burner.

7 I don't think that the MLR³² can
8 cover all the cost of all the social issues.
9 And so, we can't rely on the medical models to
10 fix all that, so we've got to have some
11 collaboration somehow with other agencies to
12 help us solve those problems, but it's critical
13 to get the outcomes we're going to need going
14 forward. So, thank you.

15 CHAIR CASALE: Great. Thanks,
16 Angelo. Great comments.

17 Lauran?

18 VICE CHAIR HARDIN: So, I agree with
19 Angelo. I think this has been one of the most
20 stimulating meetings and interesting in my
21 history over the last two years.

22 So, I think I reflect a lot on
23 health-related social needs in these models,

32 Medical loss ratio

1 and these are the themes that I definitely
2 heard.

3 So, across the innovations utilizing
4 data not only to understand the population, but
5 to case find across systems and to build a
6 comprehensive, deep patient story across EMRs
7 is critical for integrating social needs, but
8 also really deeply understanding what was
9 actually happening with the patient.

10 And then the theme of integrated
11 teams, so bringing in social work, nursing,
12 case management, community health workers,
13 pharmacists, really building an integrated team
14 and everyone operating to the top of their
15 license, and then people spending their time
16 only doing what mattered most from their
17 discipline.

18 So, for example, in hospice and
19 palliative care when the model shifted, and it
20 was no longer fee-for-service, it didn't need
21 to be the physician that had the direction of
22 care conversation because there's no longer
23 payment attached to it. It wasn't a billable
24 event.

25 So, then things shifted, and people

1 started to learn, well, what was 101-version
2 that many people could do to a standard of care
3 and what required the highest level of
4 education and experience to do.

5 And that's how we sort out the
6 delivery of our care, and that's how we carry
7 it together and get more done in the visit that
8 we have in the office and across systems as
9 well.

10 I heard a theme of really starting
11 to think about care where people live. So,
12 definitely the primary care is the center, but
13 outside of that office visit, how do we
14 effectively and appropriately reach people,
15 extend our services in the place where they
16 spend the most time and really deeply invest in
17 relationship and trust building, which is where
18 many of these models talked about actually
19 seeing movement in outcomes.

20 The challenge came up around --
21 there's been a lot of movement with health-
22 related social needs screening, but we're
23 navigating to nowhere.

24 The lack of investment in those
25 services, we could find out a lot about what's

1 going on with people, but if there is no one to
2 refer to in that community, there's really an
3 imperative for us to look at that on a broader
4 level and some ways of partnering and sharing
5 to develop that. Also, seeing new payment
6 models under Medicaid that are starting to pay
7 for that.

8 So, we heard some really exciting
9 innovation from California where there is now
10 payment for housing, there's payment for
11 housing navigation, really Enhanced Care
12 Management for the most complex and vulnerable
13 populations.

14 And then what's happening from that
15 is integration of health care and social
16 services in community-based systems.

17 So, we heard of a housing and health
18 care integrated system. We're seeing
19 community-based collaboratives take on some of
20 these social needs, including starting to blend
21 and braid city funds, county funds, other
22 sources of dollars that extend the table and
23 the opportunities for really addressing social
24 needs.

25 And then finally under the

1 California approach, we also heard about payer
2 collaboration that's emerging from that and how
3 they're incentivizing that, again, to generate
4 collective dollars to really deeply address
5 health-related social needs.

6 So, a lot of rich material for
7 future dialog.

8 CHAIR CASALE: Thanks, Luran, for
9 those comments.

10 Lee?

11 DR. MILLS: Yeah. So, I was going
12 to pick up a thread that we heard several
13 different times most eloquently today that just
14 as we turn our attention, and it becomes one of
15 the CMMI focuses on, you know, diversity,
16 equity, inclusion, and social determinants of
17 health and looking beyond the 20 percent that
18 actual health care impacts, we need to take on
19 this issue of rapidly diversifying social needs
20 screening methods and prevent -- I love the
21 phrase "prevent the cacophony from occurring
22 that we've seen in the quality space," and that
23 is very, very real. And it's going to happen
24 unless we take proactive steps, and CMMI can
25 lead the way to prevent that.

1 And I would propose that just like I
2 am not convinced there has to be seven
3 different standardized definitions of what a
4 breast cancer screen quality metric looks like,
5 there doesn't have to be five different ways
6 and five different ways to ask the question to
7 screen for a given social determinant. We just
8 need a way.

9 If we have seven ways, it's going to
10 distract everybody's time and attention to
11 arguing which is the best and how to compare
12 them, and one dataset doesn't talk to another
13 dataset and can't be normalized.

14 And that is simply distracting us
15 from receiving the information and engaging
16 with the actual need that our patients have.
17 And so, I think that is another opportunity for
18 bold policy leadership that CMMI can step into.

19 CHAIR CASALE: Yeah. I think great
20 comments and, you know, it's so far down,
21 though, the quality. We're trying to come back
22 to it, but now we're at -- as you're saying,
23 we're just at the beginning of this whole
24 measurement at SDOH.

25 It's a real opportunity to sort of

1 have CMMI sort of take the lead on how to move
2 that forward in a rational way.

3 Josh?

4 DR. LIAO: Yeah. I just want to
5 maybe take Lee's point and kind of zoom out on
6 it a little bit and say that I think one of the
7 things I've heard from -- over the last few
8 days from a few of our speakers is this idea
9 that they are the financial -- it's not about
10 moving dollars, but the dollars are structured
11 in such a way where they have the ability to
12 buy an AC or to walk to the back and grab a
13 nebulizer and give it to a patient.

14 And I think there's a harmony
15 between what they're able to do and then the
16 big dot patient-centered outcomes are being
17 held accountable to.

18 Contrast that, I think, now under
19 other payment structures where there's much
20 more restriction, right?

21 I just want to raise as something
22 for us to consider, is that holding clinicians,
23 primary care, subspecialty care, different
24 teams, different clusters of clinicians,
25 accountable for those ultimate patient outcomes

1 when we don't have the ability to, like, affect
2 them.

3 It may be 20 percent, you can
4 quibble about the numbers, but the 100 percent
5 outcomes when we are affecting 20 percent and
6 not a resource to do that, I think, is not a
7 bridge to a productive place.

8 And so, I just -- to me, it raises
9 an urgency to address one of those things to
10 get us into better alignment.

11 Either we begin to look more like
12 the flexibilities, or we think about the
13 outcomes or maybe something that's a
14 combination of those.

15 CHAIR CASALE: Yeah, that's great.
16 And I think I was thinking about, Angelo, your
17 comment about the MLR, and, you know, so we
18 need partners on this.

19 You know, to the point about just
20 SDOH in general and where to collect the data
21 and how to implement and -- you really need to
22 think more broadly around, you know, who those
23 partners should be to really help with all of
24 this.

25 And I'm not sure all of those -- who

1 all those should be, but really I think CMMI
2 needs to think about that now, not only just
3 the screening, but then -- in moving -- who
4 else in addition to this sort of health -- the
5 traditional health care system that can help
6 with this work.

7 DR. WILER: Totally agree with
8 Josh's comments and just wanted to resurface
9 something else that we heard in that many of
10 these successful models have proactive outreach
11 and actually high touch, ultimately high
12 utilization.

13 And so, back to what's currently,
14 you know, considered to be within scope and out
15 of scope, we've created models that incentivize
16 higher patient panels and face-to-face
17 interactions often that are patient-driven.

18 And what we heard today is flipping
19 that model -- or over the last two days,
20 flipping that model on its head and actually
21 having care teams direct the interactions in a
22 way that benefits patients.

23 So, there's got to be ways to incent
24 that kind of activity that ultimately improves
25 health.

1 CHAIR CASALE: Yeah, I couldn't
2 agree more. And I was thinking about that, you
3 know, again thinking back to my own practice
4 days as a specialist, you know, when you see
5 the patient, you know, you know in the
6 traditional model, you're not sure when they're
7 going to get back to see the primary care
8 doctor. Is the information going to get back
9 to the primary care doctor?

10 And then even if I have a
11 recommendation that they see, like, a different
12 specialist, well, should I just make that
13 referral myself because I'm not sure if, you
14 know, my recommendation is going to get back?

15 So, to your point, all these
16 proactive touches will, at least in my view,
17 raise the confidence within the sort of team
18 that, in fact, that information -- it always
19 goes back to the information, is going to get
20 back to primary care who can then decide, yeah,
21 that's an appropriate referral to someone else
22 and reduce the fragmentation, et cetera.

23 DR. KOSINSKI: Well, Jennifer
24 prompted something for me to remember. And
25 that is that there really is very little way to

1 pay for proactive care in the current fee-for-
2 service model.

3 And we heard from multiple speakers.
4 Fee-for-service is not going away. We're going
5 to have to live with this some way in the
6 future.

7 We also heard that payments need to
8 be timely, that value-based payments need to be
9 timely. They can't wait for an 18-month
10 reconciliation period. I live in this space
11 all the time.

12 We've talked about maybe not
13 focusing on venture-backed entities. Well, the
14 only reason I am able to provide up-front money
15 to providers is because of the financial
16 backing we have.

17 So, it begs the question that we
18 discussed yesterday on the chronic care
19 management codes, the principal care management
20 codes.

21 Should we be recommending some
22 adjustments to the current fee-for-service
23 system that will allow us to bridge into the
24 value-based care system more efficiently and
25 effectively? Is there something we can do now

1 that can do that?

2 I realize that raises legislative
3 issues that are beyond the purview of our
4 Committee, but if they're listening to what
5 we're saying, maybe we need to make some
6 adjustments to the fee-for -- or recommend
7 changes to the fee-for-service system that
8 allow us to make this transmission.

9 CHAIR CASALE: Yeah. And along
10 those lines, I mean, CMMI has said, you know,
11 they have the ability to do the waivers just
12 like they're doing for ACO REACH, to waive, you
13 know, the copays on the patients.

14 So, they could think about how more
15 broadly to do some more of these waivers if
16 you're in, you know, some kind of total cost of
17 care model.

18 Josh?

19 DR. LIAO: I think connected to
20 prior comments, but another theme that we heard
21 yesterday and then, I think, kind of indirectly
22 said today, and we've been talking about, I
23 think, in all the things that I've been hearing
24 that I just want to surface is that, you know,
25 cost doesn't equal need.

1 And relevant to total cost of care,
2 I think if what we're talking about is
3 identified need either through just our
4 clinical encounters, through screening, through
5 data capture, through hopefully more timely
6 data and shared data, I think if we're thinking
7 about that, one of the questions I posed to one
8 of the -- to the panel was around should that
9 be brought into TCOC models? Should it be
10 outside? Should it be collaborative as we've
11 seen in some states?

12 I don't know. But if we're talking
13 about need mediated through higher touches and
14 a broader aperture about how we're thinking
15 about it, then I think pegging these models as
16 the cost must come down, we may run into a
17 challenge there.

18 On the other side, I think one of
19 the speakers today said, you know, there are
20 probably certain populations where there is
21 cost to be taken out of the system. And so, I
22 think work to be -- to look at that is very
23 useful.

24 I think, in that, my suspicion is
25 that we'll find there will be some collection

1 of primary and subspecialty care, which is why
2 I think this issue of how do we engage in this
3 is so important, so we can actually identify
4 those areas to then take a cost come down
5 approach to TCOC models versus a needs-based
6 approach.

7 And just very quickly here, you
8 know, Larry's comment about, you know, the
9 financial ability to operate, to me, is a bit
10 of a potentially pragmatic one.

11 We may wish for a different, you
12 know, current state, but where we are now,
13 that's an ability to deliver the care we
14 believe is right.

15 In that same way, just going back to
16 the point of primary care, I think we've heard
17 visions of what primary care can be and should
18 be, and it is in certain settings, but the
19 pragmatism is that until we get there, I would
20 love to see models and approaches that, again,
21 bring primary and subspecialty care together so
22 we can do that business of is there really
23 total cost to remove here, or is it more of a
24 needs thing where we need investment? And
25 those, to me, are very different.

1 CHAIR CASALE: Great. Thank you.
2 Thanks for those comments.

3 You know, under the topic of
4 unintended consequences -- I always like to
5 talk about unintended consequences, so -- but
6 one of the topics listed under this -- and,
7 Jay, you've brought this up a few times -- is
8 around pharmacy, which generally is not part
9 of, you know, total cost of care for some of
10 the models and whether really Part D should be
11 part of total cost of care.

12 We know the private payers often
13 focus on, you know, medication adherence, et
14 cetera, and in that world, the current model is
15 often, you know, they include some of the Part
16 B medication, but not the Part D.

17 And so, as we think about total cost
18 of care, where does that sort of the
19 pharmaceutical spend sit, and should it be?

20 And to counter that, I'll just tell
21 you from my experience both when we bid in the
22 Oncology Care Model and when we were in the
23 ESRD ACO, over time there were certain
24 medicines that became available where all of a
25 sudden the costs went up astronomically, and

1 then all of a sudden our -- didn't look very
2 good against our benchmark.

3 So, you know, there's not a perfect
4 answer, but just, in general, should pharmacy
5 be something we should be thinking about or,
6 you know, sort of having some recommendations
7 to CMMI as they're thinking through total cost
8 of care?

9 So, any thoughts on that?

10 DR. KOSINSKI: We should at least be
11 including the drugs that are in the medical
12 cost because the shifting of cost between Part
13 B and Part D that occurs with specialty pharma,
14 I don't know how you wrestle with total cost of
15 care unless you either have that totally out,
16 which doesn't make sense since it's 40 percent
17 of the cost of care, or you have to at least
18 have those specialty drugs in that really blow
19 up the cost on the Part D side and on the Part
20 B side.

21 I don't know how we talk about total
22 cost of care without at least including that.

23 CHAIR CASALE: Any other thoughts on
24 that?

25 DR. LIAO: Yeah. I think, yeah, I

1 agree with that point broadly. I would just
2 say even before we get there, in current models
3 that look at A and B, I think many
4 organizations that have been in these models
5 have seen that Part B medication spending is
6 significant.

7 What's interesting to me is you
8 double click and zoom in on that a little bit,
9 and the question is to what extent, again, not
10 to belabor the point, do primary/subspecialty
11 care work together?

12 That exemplifies the point of the
13 engagement, right, whether, again, we're all in
14 it together, or it's in a sequence carved out.

15 I don't want to get into the
16 semantics, but even in Part B over five-plus
17 years of ACOs, I think we can see that issue
18 come to play.

19 I think the moment we then wrap D
20 in, this issue is just only going to be
21 magnified. So, to me, it's like a precondition
22 to really think through this specialist piece.

23 CHAIR CASALE: Great. Thanks. So,
24 again, I know I brought up the pharmacy on the
25 unintended consequences.

1 Any other thoughts on any particular
2 unintended consequences that come to mind as we
3 think around total cost of care models?

4 Yeah, Jen.

5 DR. WILER: I know we talked about
6 this briefly yesterday, but just to circle back
7 to it, I don't know if it's an unintended
8 consequence as much as don't forget to include.
9 And that's back to what's high-quality care.

10 We all know value is quality to
11 cost, and we've focused all of our conversation
12 on cost and will do so in the fall, but being
13 explicit about what is the definition of
14 quality for a given patient population is
15 really important.

16 And we heard today that, you know,
17 there's not a sustainable business model to do
18 currently nonrevenue-generating activities to
19 actualize what we think are high-quality
20 outcomes because it just takes that long in
21 terms of evolution of health, maintenance of
22 health or prevention of deterioration.

23 And so, we need to start thinking
24 about process measures that accountable groups,
25 i.e., providers, can own and be incented to do

1 that we know are good surrogates for achieving
2 the outcomes that we want.

3 And currently what I have heard in
4 these conversations is that they -- that those
5 are not in place, but these innovative care
6 models are creating them within their own space
7 and trying to create internal incentives that
8 we could learn from.

9 And I think there were quite a few
10 that were described, including one that, you
11 know, again I think this ratio of primary care
12 touches to specialist touches is a surrogate
13 marker for engagement.

14 And to your point, Paul, of
15 including -- ensuring conversation essentially
16 between the patient and the care team was an
17 interesting idea.

18 So, I think focusing more on, you
19 know, what's the definition of "quality" would
20 be a really valuable conversation.

21 CHAIR CASALE: Thanks, Jennifer.

22 Lee?

23 DR. MILLS: Yeah. Just a
24 philosophical underpinning that I've heard
25 refrains of here that I think bear more noodle

1 time and us thinking about and discussing it at
2 a future meeting, which is this question of are
3 we going to incrementalize our way to the
4 glorious new future? And I propose the answer
5 is no.

6 And what I mean is when you think
7 about -- first of all, if you're going to
8 incrementalize it, we would have done it in the
9 last 20 years of pilots and trials, right? We
10 would have already gotten there.

11 But partly the science of -- the
12 science of change and performance improvement
13 says at some point along an S curve, further
14 input of resources doesn't increase
15 improvement. You have to jump to the next
16 higher S curve, right?

17 We heard several good examples by
18 ChenMed and Prospero and others earlier
19 yesterday. They did not incrementalize their
20 way to their current state. They just changed
21 their model and took a leap.

22 I think that that's a really
23 important concept, and I'm not sure I've made
24 up my own mind really where we are, but it's
25 consistent with the, you know, the path forward

1 where we're not going to have a pilot model for
2 every disease state.

3 It looks like the future is fewer
4 models, and they're more standardized and more
5 broadly applied, perhaps in some areas not
6 optional. That feels like leaping to the next
7 S curve.

8 And so, I think as we keep wrestling
9 with what this is about, I'm not sure, you
10 know, more codes to transfer value, and a
11 fundamental fee-for-service concept is going to
12 get us where we need to go.

13 We need to try to distill what has
14 worked and whatever models we can think of and
15 try to say, well, here's at least the skeleton
16 of what the future model might look like. And
17 it's up to people with, of course, you know,
18 the Secretary's encouragement to jump to that
19 future in some fashion.

20 CHAIR CASALE: Yeah, I think that --
21 I appreciate those remarks. Really helps my
22 thinking and then also begs the question, you
23 know, to make -- do people voluntarily leap, or
24 do they need to sort of get them pushed, you
25 know, sort of mandatorily leaped, figuratively?

1 DR. MILLS: Yes, they do.

2 (Laughter.)

3 CHAIR CASALE: Walter?

4 DR. LIN: I wanted my last comment
5 for this public meeting to be one of hope, you
6 know. As one of the newest members of the
7 Committee, I thought we were taking on a
8 tremendous undertaking by trying to tackle the
9 whole opportunity of population-based total
10 cost of care, you know.

11 There's so much work that's been
12 done by many, many people and institutions, but
13 one thing that leaves me really hopeful as we
14 end our session, is that we heard from a number
15 of organizations over the past two days that
16 are already doing this, and doing this well,
17 and doing this with a financially viable model
18 that also is hitting the quality metrics and
19 having high net promoter scores and low patient
20 disenrollment.

21 So, I think there are models out
22 there that we can continue to learn from, and
23 we hope to continue this conversation in
24 September.

25 CHAIR CASALE: Just to be clear,

1 that doesn't need to be your last comment
2 because, you know, we can still -- we have time
3 to continue our conversation, but thank you for
4 those comments. That's very helpful.

5 Josh?

6 DR. LIAO: Gosh, I almost wish I
7 made my comment before that comment of hope.
8 You know, I think I had a thought about
9 unintended consequences, but I'll kind of loop
10 in what I heard from Lee, which I agree with,
11 which is that, you know, we're talking about
12 populations.

13 Kind of the thing that lives on the
14 back-end behind populations is how you select
15 those populations.

16 And they keep -- the thing that
17 keeps me up at night potentially, as someone
18 who applies scholarship and evaluation to this
19 and who helps lead things locally at my
20 institution, is that issue of selection at the
21 patient level, but also at the clinician level,
22 at the group level.

23 I think probably all of us have seen
24 at least snapshots of that happening. And so,
25 I was trying to think through all the important

1 things I've heard around this table and how
2 many could be punctured by issues of selection,
3 and I think probably all of them.

4 So, I just wanted to add that to the
5 record, but say that I think the other theme --
6 and I was actually counting it on our questions
7 for our listening panel today -- was that the
8 number of times the word "trade-offs" came into
9 -- we brought up.

10 And so, I guess at some point, we
11 need to trade and go. And monitor, yes, and be
12 careful, yes, but I think if we keep propping
13 up trade-offs and saying there are trade-offs,
14 there's an inertia to that.

15 And so, with respect to do we -- do
16 they jump in on their own, do we nudge them in
17 to jumping in, these are things we'll get into,
18 I think, at the next session, but I would love
19 to see us, as a Committee, move to from
20 identifying those trade-offs to actually
21 saying, in this trade-off, here's the put,
22 here's the take, this is our recommendation
23 because we think this is bold, and at least
24 that would be my hope.

25 CHAIR CASALE: Yeah, that's great.

1 You know, I think we spend a lot of time
2 talking about data, performance metrics, and
3 that data piece keeps coming back in the
4 comments that many of you've made of really
5 being foundational and really to move all of
6 this.

7 And some of the models that we heard
8 from is -- some of the presenters also
9 emphasize that, you know, for their models to
10 work, they really need timely data.

11 And for many places, this continues
12 to be a challenge, you know, just either they
13 don't have the financial wherewithal or don't
14 have access to the data sources to really move
15 this forward.

16 And I think again this is something
17 -- we talked about emphasizing to CMMI to think
18 through how they can really help support this
19 to really -- if we're going to really continue
20 to push, as you said, Lee, not so
21 incrementally, but to really, you know, it's
22 hard to sort of push or make people do things
23 if you don't have the tools for them to be
24 successful, and I think that data piece is just
25 a critical underpinning.

1 So, again, how you sequence things,
2 that, I think, as we communicate to the
3 Secretary and to CMMI, I think, really needs to
4 be emphasized.

5 Jen.

6 DR. WILER: Walter, I'm going to
7 pick up on your theme of hope. I think over
8 the last couple of days, and actually if I
9 think over the last year or so as we've been
10 doing these theme-based discussions and having
11 the opportunity to talk to leaders across the
12 country who are just doing phenomenal things,
13 you know, really they're our early adopters.

14 Despite our current system, there is
15 a lot of really impressive innovation that's
16 going on, and I am encouraged by the fact that,
17 you know, these previous models and programs
18 have sparked innovation that has helped us to
19 understand what an ideal care model might look
20 like or what does it need.

21 And, you know, really we need to
22 move now to uptake and then diffusion. And so,
23 that's a jump from Curve A to Curve B that, you
24 know, I think, Lee, that you were talking
25 about.

1 And, you know, just to summarize
2 some of those things, again, totally agree.
3 Data infrastructure is a utility. It's got to
4 be ubiquitous.

5 We've heard that over and over. It
6 cannot be underscored how important that is.
7 And that that's real cost, real money, and real
8 expertise.

9 And so, that seems like that would
10 be an ideal investment from a federal or a
11 state level. Although we heard even at the
12 state level, because of where patients seek
13 care, that a single-state strategy is probably
14 unlikely to be successful.

15 I think we've also heard that these
16 programs cannot be voluntary because right now
17 with how the incentives are aligned, it -- even
18 though there's been a conscious focus to not
19 allow cherry-picking, it still will happen.

20 And fortunately, right now, it seems
21 to be the opportunity is in chronic care
22 management of some of our most frail and
23 elderly patients, which is a good thing, but at
24 other times, the incentive might be for a
25 different population.

1 So, the safety net -- so, these
2 programs need to not be voluntary, and they
3 have to include our safety net patients and
4 program partnerships, but we cannot expect, as
5 was described before by Josh, these programs to
6 be implemented with all risk being put on the
7 backs of providers.

8 It is unfair, and it's unrealistic,
9 and they will balk and you -- we need them to
10 participate in a meaningful way because when
11 they are leading decisions and care teams, we
12 get great outcomes. And that's actually what
13 we want to try to achieve.

14 And so, I think what we heard with
15 our last panel of really thinking about how to
16 incent closing the gap in areas that we know
17 are the biggest barriers, access in
18 coordination are potentially ways for us to be
19 thinking about how to go from these wonderful
20 pilots of innovation that show that it can be
21 done to creating this, you know, uptake in
22 diffusion.

23 I think that's where CMMI has a real
24 opportunity, so I agree with your optimism.

25 CHAIR CASALE: Thank you.

1 Bruce?

2 MR. STEINWALD: Can you hear me
3 okay?

4 CHAIR CASALE: Yes.

5 MR. STEINWALD: For just a couple of
6 minutes, I'd like to defend the concept of
7 moving money around, which somehow seemed to be
8 cast in a negative during much of the
9 discussion.

10 You know, historically in Medicare,
11 moving the money around often meant trying to
12 move money within the fee-for-service system,
13 which maybe had some limited success in
14 supporting primary care, but I would say very
15 limited.

16 But if we're now talking about
17 moving money -- and someone did say, maybe it
18 was Lee, there is an incentive to move to a
19 different mode of practice, a transform mode
20 where there's a team approach to care and --
21 that needs to be attractive.

22 And there certainly can be
23 attractions other than monetary, but certainly
24 there has to be monetary.

25 At the same time, there can be --

1 many people think there are, and there's lots
2 of evidence, that staying within the fee-for-
3 service system has mounting unattractive
4 features, many of which are navigating, you
5 know, adjudication, things like that, that can
6 be relieved from the physician who practices in
7 a different setting.

8 And so, the notion that moving money
9 around is somehow distasteful, I think, is
10 incorrect.

11 I think we need to think about how
12 to accomplish an objective through moving money
13 around and also through other mechanisms that
14 go along with it.

15 CHAIR CASALE: Thanks, Bruce. We
16 appreciate the perspective of the economist.
17 You do have to think about money. It's
18 important.

19 Before we close, any final comments
20 from any of our Committee members? Great
21 discussion, great feedback.

22 Audrey, I'm going to turn to you to
23 see if you either have other questions or
24 clarifying points you want from the Committee
25 or -- let us know.

1 MS. MCDOWELL: Thank you.

2 So, first I would like to ask if the
3 other ASPE staff have any points that you guys
4 might want to make. Lisa? Steve?

5 Okay. So, I just had one follow-up
6 question regarding one of the issues that I
7 think Chinni had raised during the PCDT³³
8 presentation yesterday as one of the things
9 that maybe you were trying to think about.

10 And I think you've touched on it a
11 little bit, but there's still, at least from my
12 hearing, I still had a question.

13 When we began the theme-based
14 discussion yesterday, Debbie Zimmerman had kind
15 of talked about the need for, as part of total
16 population-based total cost of care models,
17 looking at managing to achieve lower cost for
18 high-risk patients, as well as making a
19 significant increase in investment and services
20 for lower-risk patients so that both of those
21 needed to happen at the same time.

22 Today we heard one of our panelists
23 say that if total cost of care is the top

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1 priority rather than quality, then there's a
2 need to focus on the populations where we
3 believe that we can achieve total cost of care
4 reduction.

5 So, I'm wondering if you guys have
6 come to a point of thinking about, you know,
7 should the focus within these models be more so
8 on the higher-cost patients, you know,
9 chronically ill, higher-cost patients versus on
10 kind of what was referred to as that broader
11 tail that maybe they have lower cost right now,
12 you know, and the prevention of that, and then
13 how do you, I guess, in September, how do you
14 manage the cost associated with whichever
15 strategy?

16 CHAIR CASALE: Angelo?

17 DR. SINOPOLI: Yeah. I think we
18 have to spend some time discussing that tail
19 and particularly that group, the rising risk
20 group, and identifying -- and there is some
21 ability to identify who's going to be increased
22 -- who's going to need increased resources
23 going forward, you know.

1 As a pulmonologist, COPD³⁴ gets
2 worse, and you can't change that
3 pathophysiology. They're going to get worse,
4 and they're going to start utilizing and
5 needing hospitalization, et cetera. And the
6 earlier you intervene in those things, the
7 better.

8 So, you're not going to prevent
9 everything, but I think we have to pay
10 attention to those rising risk patients and fix
11 what we can and mediate what we can't fix.

12 CHAIR CASALE: Yeah, I would agree
13 with that. I mean, and I think - I'll get to
14 everybody else -- , and I think maybe, Larry,
15 you said this, you know, a patient who cost a
16 lot last year isn't necessarily the one that's
17 going to cost next year.

18 And so, you know, you really need to
19 think about the whole population, particularly
20 the rising risk, as you alluded to.

21 Larry?

22 DR. KOSINSKI: I jotted down that I
23 was impressed with Dr. Zimmerman's Slide 4. I

34 Chronic obstructive pulmonary disease

1 mean, I think that really tells the story. And
2 if you're looking at it from a population point
3 of view, you got to invest.

4 You got to invest in the early care,
5 and those people may have low risk now, and if
6 her curve is accurate, then you're avoiding the
7 higher-cost, higher-risk deterioration later.

8 I know in our population of
9 inflammatory bowel disease, someone could have
10 a totally -- it can vary from year to year to
11 year.

12 So, unlike illnesses like COPD that
13 once they reach clinical significance, they're
14 going to continue to deteriorate, there are
15 many illnesses that have periodicity to them
16 that -- and we heard from our actuary that, you
17 know, like the stock market says, past
18 performance doesn't predict future performance.

19 So, I think I would lean more
20 towards Dr. Zimmerman's approach.

21 CHAIR CASALE: Josh?

22 DR. LIAO: Audrey, thanks for
23 bringing this up. To me, there's at least two
24 distinct issues here.

25 The first is in managing

1 populations, do you focus on the tail, or do
2 you focus on kind of the bell, like, the middle
3 of the distribution? I think it's a both end.

4 My sense is early on, maybe there
5 are people in the tail that can help, but
6 you're going to want to move people across the
7 population. At least ostensibly that's the
8 goal.

9 I think in recognizing that, though,
10 because just like in the clinical context when
11 you give them medication, often you get the
12 biggest effect of the people who have the least
13 well-controlled disease.

14 If you intervene early, how would
15 you measure that improvement in someone before
16 they've gotten, you know, out of that range?

17 I think that speaks to the
18 importance of quality measures in that. So, I
19 like the idea of taking a broader approach. It
20 may be staged, I think, a focus on quality.

21 The second issue to me is what to do
22 with the tail. And for the reasons that Paul
23 and Larry have mentioned, I think it's not one
24 group that never changes, but I go back to my
25 comment about cost not being need.

1 If we think that they are in the
2 tail of that curve because there's something
3 that we can do less of because they don't need
4 it, it's overuse, it's potentially unwarranted,
5 then I think those models should push us to
6 that.

7 I think if it's a need, and they
8 actually need more services, different
9 services, right, to move them out of that tail,
10 which I think everybody probably wants, then I
11 think the traditional TCOC approach of doing
12 less is probably not the right thing.

13 Now, we're talking about investment
14 within these models, adjacent to these models
15 in a collaborative way, again, I don't know,
16 but that's how I think about that.

17 CHAIR CASALE: Great. Thanks, Josh.
18 Audrey, any other clarification?

19 MS. MCDOWELL: No. Thank you.

20 * **Closing Remarks**

21 CHAIR CASALE: Okay. Great.

22 So, I want to thank everyone for
23 participating today, our expert presenters and
24 panelists, my PTAC colleagues, and those
25 listening in. We explored many different

1 facets of population-based total cost of care
2 models.

3 Special thanks to my colleagues on
4 PTAC. A lot of information packed into these
5 two days, and I appreciate your active
6 participation and thoughtful comments.

7 We'll continue to gather information
8 on our themes through a Request for Input,
9 which is posted on the ASPE PTAC website. You
10 can offer your input on our questions by July
11 20th.

12 Now that we have explored relevant
13 care delivery innovations, the next step is to
14 dive into the financial incentives to encourage
15 these, which we will do at our September public
16 meeting. I hope to see you all then.

17 * **Adjourn**

18 The meeting is adjourned. Thank
19 you.

20 (Whereupon, at 1:50 o'clock p.m. the
21 meeting was adjourned.)

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: 09-20-22

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.



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