

**Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes**

June 8, 2022

9:30 a.m. – 1:50 p.m. EDT

**Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201**

Attendance

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members

Paul N. Casale, MD, MPH, PTAC Chair (Vice President, Population Health, NewYork-Presbyterian, Weill Cornell Medicine and Columbia University)

Lauran Hardin, MSN, FAAN, PTAC Vice Chair (Senior Advisor, Illumination Foundation and National Healthcare and Housing Advisors)

Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)

Lawrence R. Kosinski, MD, MBA (Founder and Chief Medical Officer, SonarMD, Inc.)

Joshua M. Liao, MD, MSc (Associate Professor, Medicine and Director, Value and Systems Science Lab, University of Washington School of Medicine)

Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)

Terry L. Mills Jr., MD, MMM (Senior Vice President and Chief Medical Officer, CommunityCare)

Angelo Sinopoli, MD (Chief Network Officer, UpStream)

Bruce Steinwald, MBA (President, Bruce Steinwald Consulting)*

Jennifer L. Wiler, MD, MBA (Chief Quality Officer Denver Metro, UCHealth, and Professor of Emergency Medicine, University of Colorado School of Medicine)

PTAC Members Not in Attendance

Soujanya Pulluru, MD (Vice President, Clinical Operations, Walmart Health Omnichannel Care, Walmart, Inc.)

Department of Health and Human Services (HHS) Guest Speakers

Elizabeth (Liz) Fowler, JD, PhD (Deputy Administrator, Centers for Medicare & Medicaid Services [CMS] and Director, Center for Medicare and Medicaid Innovation [CMMI])

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff

Lisa Shats, PTAC Designated Federal Officer

Victoria Aysola

Audrey McDowell

Steven Sheingold, PhD

****Via Webex Webinar***

List of Speakers, Public Commenters, and Handouts

1. Listening Session on Assessing Best Practices in Care Delivery for Population-Based TCOC Models (Part 3)

Chris Chen, MD, Chief Executive Officer, ChenMed*

Palav Babaria, MD, MHS, Chief Quality Officer and Deputy Director, Quality and Population Health Management, California Department of Health Care Services*

Paul Leon, RN, BSN, Founder, CEO and President, Illumination Foundation

Handouts

- Listening Session on PB-TCOC Models Day 2 Slides
- Listening Session Day 2 Presenters' Biographies
- Listening Session Day 2 Facilitation Questions

2. Panel Discussion on Assessing Best Practices in Care Delivery for Population-Based TCOC Models

Lee McGrath, MHSA, Executive Vice President, Healthcare Services, Premera Blue Cross (Payer Perspective)*

Gary Puckrein, PhD, President and Chief Executive Officer, National Minority Quality Forum (Patient Advocacy Perspective)*

Robert Saunders, PhD, Senior Research Director, Health Care Transformation, Duke-Margolis Center for Health Policy (Academic/Policy Research Perspective)*

Kristofer Smith, MD, MPP, Chief Clinical Officer, Prospero Health (Provider Perspective)*

Handouts

- Roundtable Panelists' Biographies
- Panel Discussion Guide

**Via Webex Webinar*

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available on the ASPE PTAC website located at:

<https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>].

The [ASPE PTAC website](#) also includes copies of the presentation slides and other handouts and a video recording of the June 8 PTAC public meeting.

Welcome

Lauran Hardin, PTAC Vice Chair, welcomed members of the public to day two of the June public meeting on population-based total cost of care (TCOC) models; and introduced Elizabeth (Liz) Fowler, Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS) and the Director of the Center for Medicare and Medicaid Innovation (CMMI; the Innovation Center).

Dr. Fowler stated that CMMI's vision is a health care system that achieves equitable outcomes through high-quality, affordable, patient-centered care. She added that CMMI appreciates the partnership and collaboration of PTAC to meet the goals that are embedded in the Innovation Center's vision. Dr. Fowler

continued by reiterating the five strategic objectives that CMMI issued in the Fall of 2020, and providing an update on the Innovation Center's efforts toward reaching these goals:

- CMMI's first objective involves driving accountable care – focusing on payment and performance incentives for specialty and primary care providers to coordinate delivery of high-value care and reduce duplicative, low-value care. She noted that CMMI has set an ambitious goal is to have all Medicare beneficiaries and most Medicaid beneficiaries in a care relationship with accountability for quality and TCOC by 2030. Dr. Fowler indicated that CMMI announced the transition of the Global and Professional Direct Contracting (GPDC) Model to a new Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model She noted that the ACO REACH Model lays a lot of the groundwork regarding CMMI's thinking about how to advance equity, and can be critical for achieving the Innovation Center's accountable care goals. She added that CMMI published an article in the *New England Journal of Medicine (NEJM)* in May on its vision for testing certain aspects of new Innovation Center ACO models that will inform the Medicare Shared Savings (MSSP) program. She also indicated that CMMI is working to design models to provide higher-quality, better coordinated care at the same or lower costs to Medicare beneficiaries.
- CMMI's second objective is advancing health equity. Dr. Fowler explained that CMMI is committed to embedding health equity into all aspects of its payment and service delivery models; and working to design models to increase participation among providers that care for underserved populations and close disparities in care and outcomes. CMMI held a roundtable in December 2021 on its health equity strategy; and in March 2022, Dr. Dora Hughes, the Chief Medical Officer of CMMI, published [an article in Health Affairs](#) that discussed CMMI's strategy on advancing health equity. Additionally, CMMI held a roundtable in March focused on safety net provider participation in CMMI models.
- CMMI's third objective is related to supporting innovation. CMMI is exploring what more the Innovation Center can do to support model participants that are looking for ways to improve care delivery – including through actionable data, learning collaboratives, and payment flexibilities.
- CMMI's fourth objective focuses on addressing affordability. In addition to addressing Medicare and Medicaid expenditures, CMMI also wants to ensure that its models have an impact on lowering patient's out-of-pocket expenses. CMMI is seeking strategies that target health care prices, affordability and reducing low-value and duplicative care. Going forward, CMMI is focusing on payment and performance incentives—especially in TCOC models— for primary and specialty care providers to coordinate delivery of high-quality care and reduce duplicative or low-value services.
- CMMI's fifth objective is partnering to achieve health care transformation. The goal relates to multi-payer alignment —finding ways of engaging commercial payers, and working closely with state Medicaid programs and other purchasers to ensure they are aligned and moving in the same direction. Dr. Fowler noted that alignment might not need to be as part of a single model, but could involve aspects of care where alignment makes the most sense, such as on quality metrics.

She also stated that the Innovation Center is actively engaging with stakeholders on how CMMI can better align with private payers, purchasers, and states; and enhance engagement with beneficiaries. CMMI is also seeking to improve transparency in its model design and implementation. Dr. Fowler also noted that CMS Administrator Chiquita Brooks-LaSure recently hosted a listening session on dementia care, which is an area of growing interest for CMMI.

Dr. Fowler concluded by thanking the Committee members and the presenters for their valued work and for their continued support for health care transformation.

Vice Chair Hardin thanked Dr. Fowler for her remarks and noted that a variety of experts presented during the first day of the Committee’s public meeting. Next, she provided a brief overview of the agenda for the second day of the public meeting and invited Committee members to introduce themselves and describe their experience with population-based payments or TCOC models.

Listening Session on Assessing Best Practices in Care Delivery for Population-Based TCOC Models (Part 3)

- Chris Chen, MD, Chief Executive Officer, ChenMed
- Palav Babaria, MD, MHS, Chief Quality Officer and Deputy Director, Quality and Population Health Management, California Department of Health Care Services
- Paul Leon, RN, BSN, Founder, CEO and President, Illumination Foundation

Vice Chair Hardin moderated the listening session with three subject matter experts who will comment on best practices in care delivery for population-based TCOC models based on their organization’s vision and experience. She noted that full biographies and presentations for presenters can be found on the [ASPE PTAC website](#).

Christopher Chen presented on his experiences as the CEO of ChenMed.

- Dr. Chen provided an overview of ChenMed, indicating that ChenMed has 5,000 employees. He also noted that by the end of 2022, ChenMed anticipates that it will be operating in around 130 medical centers across three brand names in 40 cities and 14 states.
- Dr. Chen stated that ChenMed works in a 100 percent global risk model and is fully accountable for TCOC. Dr. Chen noted that historically, ChenMed has operated with MA plans because MA’s flexibility is well-suited to its model of care and its population’s needs providing a risk-adjusted global capitation model. However, he indicated that ChenMed recently applied to participate in the ACO REACH Model.
- Dr. Chen stated that ChenMed serves low-income seniors with multiple chronic conditions. He noted that 40 percent of ChenMed’s patients are dually-eligible for Medicare and Medicaid, and 70 percent of its patients are racially or ethnically diverse. He stated that ChenMed patients often have five or more chronic conditions, and that ChenMed medical centers are located in the underserved neighborhoods where their patients live, and over 70 percent of its care team is comprised of women of color. Dr. Chen noted that ChenMed often cares for the 5 percent of Medicare patients who account for 45 to 50 percent of health care cost and the 15 percent of patients who account for 70 to 80 percent of health care costs.
- Dr. Chen indicated that there are three different types of primary health care, and suggested that ChenMed’s transformative primary care model can be spread to the broader U.S. population:
 - In traditional primary care, PCPs do not have accountability, are rushed to do some wellness visits are often rushed, and primarily focus on triaging patients to the right specialists to generate downstream volume. Dr. Chen stated that this kind of health care does not address the whole person, and it does not lower costs.
 - Advanced primary care involves varying degrees of financial accountability through taking capitation. However, Dr. Chen stated that this can lead to a focus on optimizing risk adjustment and minimizing the cost of specialty care. He noted that in some cases, this results in improved outcomes at lower costs. However, this model can lead to patient dissatisfaction, misalignment in goals between patients and payers, and incomplete success.
 - The third type of primary care, which Dr. Chen refers to as “transformative primary care,” has the same economic structure as the advanced primary care. However, transformative

primary care is a primary care physician (PCP)-centered model that utilizes a proactive and holistic care delivery model that fosters deep patient engagement care delivery, and facilitates that ability to accurately capture risk.

- Dr. Chen stated that Chen Med’s PCPs spend up to one year training on how to lead teams, influence patients, provide customer service, understand medical economics, and make sure they document to produce a comprehensive clinical picture rather than documenting solely for billing purposes. He indicated that ChenMed’s training of its PCPs includes a one-year fellowship that emphasizes three areas: addressing health holistically, focusing on prevention, and measuring improvement.
 - Instead of solving problems solely with medications, procedures, and clinical referrals, Dr. Chen noted that his PCPs are trained to recognize that health care use only accounts for about 20 percent of a patient’s health, while the other 80 percent of health involves addressing factors such as lifestyles, behaviors, social determinants of health (SDOH), and genetics “upstream.”
 - He emphasized the importance of training PCPs to focus on preventive care, noting that ChenMed believes that 90 percent of heart failure admissions are preventable.
 - Dr. Chen also noted ChenMed holds its PCPs accountable for improving a patient’s health across a spectrum of outcomes, with measurement being key to improvement.
- Dr. Chen described the organization’s care delivery model as “tak[ing] concierge medicine and put[ting] it on steroids.” He stated that ChenMed uses employed primary care staff, and each ChenMed PCP has a small patient panel (400 to 1 versus typically 600 to 1 for concierge care and 3,000 to one in the neighborhoods that the company serves). This allows each PCP to have a deep relationship with their patients, seeing them frequently to manage their complex diseases. He noted that the PCPs lead a care team of case managers, care coordinators, care promoters, and pharmacy services. He explained that ChenMed believes the most important element to the PCP and care team’s success is to earn the patient’s trust; and noted that the company focuses on helping patients to engage in open communication with their PCP (with PCPs seeing their patients once a month, at minimum, to manage their complex conditions; meeting their patients’ families; and providing their cell phone number to their patients).
- Additionally, Dr. Chen stated that ChenMed uses PCP-led care teams that include case managers, care coordinators, care promoters, and pharmacy services; and the organization also has all “tier 1” specialties on-site. ChenMed also has central analytics teams that they partner with patient to focus them toward more high-value specialists with better outcomes. Dr. Chen also indicated that ChenMed makes its PCPs accountable for an outcome of reducing hospitalizations by 50 percent.
-
- Dr. Chen also highlighted ChenMed’s investment in addressing health-related social needs (HRSNs). The company provides multiple opportunities to address HRSNs, including offering transportation through flexibility under MA; and offering on-site phlebotomy for laboratory services, medication dispensing, diabetic resources, cooking classes, and exercise classes.
- ChenMed also has its own electronic health records (EHR) system to support high-value care, and promote evidence-based medicine. Dr. Chen noted that ChenMed also puts a strong emphasis on its data analytics, with a focus on measuring outcomes. The organization partners with 300 to 400 data scientists and software engineers.
- Dr. Chen emphasized that ChenMed seeks to transform the health of older adults and ultimately the community at large; and eliminate gaps in outcomes between Black and white patients and between dual eligible beneficiaries and non-dual eligible beneficiaries. He stated that the company’s successes include a 30 to 50 percent lower hospitalization and emergency department

(ED) use, higher screen rates than the national average, a 22 percent reduction in rates of stroke, and a 70 percent reduction in heart failure admissions. . Dr. Chen also stated that ChenMed’s patient satisfaction numbers are in the 90th percentile among reporting providers.

- Dr. Chen suggested three several areas for improvements in health care that can be facilitated by payment model design and care delivery innovation. First, he suggested emphasizing global risk that is two-sided because partial capitation cannot successfully incentivize behavior change or improve outcomes. Second, he emphasized the importance of protecting and enhancing risk adjustment. He suggested that risk adjustment should aim to eliminate any incentive to “cherry pick” healthier populations by having PCPs involved in risk adjusting.. Third, he stated that PCPs need support to make the best use of technology. Fourth, he suggested that health equity is best solved locally.

Palav Babaria presented on what the California State Medicaid program, also known as Medi-Cal, has been doing through its new initiative, California Advancing and Innovating Medi-Cal (CalAIM).

- Dr. Babaria explained how the California Department of Health Care Services implements CalAIM, a multi-year transformational initiative to fundamentally change how California’s Medicaid program operates. Dr. Babaria explained that the goal of CalAIM is to identify and manage member risk through a holistic care approach that addresses SDOH. She discussed the existence of variation in Medicaid program components and patient experience across California, and indicated that the initiatives of CalAIM are designed to provide a consistent patient experience and standardize program components across California Medicaid. She emphasized that ultimately, CalAIM hopes to improve quality outcomes, reduce health disparities, and drive health care delivery system transformation through value-based payment.
- She noted that over half of Medi-Cal’s spending is attributable to five percent of enrollees with the highest cost needs. Dr. Babaria explained that Medi-Cal’s behavioral health system and dental care are carved out and operated at the county level, while physical health care is provided through a different delivery system. She noted that many Medi-Cal enrollees have multiple complex health and behavioral conditions and must engage with providers that are part of multiple delivery systems, which may lead to care that is not integrated or coordinated.
- Dr. Babaria discussed the two initiatives in CalAIM, including Enhanced Care Management (ECM) and Community Supports, and noted that California is currently in the process of scaling ECM and Community Support initiatives statewide.
- Dr. Babaria stated that ECM emerged from the state’s Whole Person Care (WPC) and Health Homes Program (HHP) pilots that emphasized improving the health outcomes for complex patients through wraparound coordination services.
 - She indicated that there had been encouraging results from an initial evaluation of these pilots that showed that enrollees who reported being in excellent or very good overall health increased from 8 percent to 22 percent, as well as improvements in emotional health and blood pressure control. However, she noted that evaluation results associated with measures of cost, hospital readmissions, emergency department visits, and hospitalizations were mixed, since these improvements can take longer to achieve.
- Dr. Babaria explained that the experiences from the WPC and HHP pilot programs led to the creation of ECM, a new requirement for community providers to coordinate care to address members’ needs, including their HRSNs, across delivery systems. Additionally, she noted that community supports (i.e., housing supports, care transition navigation, food assistance) are currently optional services through Medi-Cal, but such supports are strongly encouraged. Dr.

Babaria noted that CalAIM focuses on providing services that can reduce hospital lengths of stay and prevent avoidable hospitalizations and readmissions.

- Dr. Babaria explained that ECM can especially support patients with complex needs and help these patients navigate across the different delivery systems. She provided examples of how community support can improve health outcomes while helping patients avoid the need for costly health care services. Each managed care plan is encouraged to use community supports that reflect the population's local needs.
- Next, Dr. Babaria introduced Paul Leon to discuss his work at the local level, including the impact that the care management and community support programs have for Medi-Cal beneficiaries.

Paul Leon presented on his experiences as the CEO of the Illumination Foundation.

- Mr. Leon noted that the Illumination Foundation is a grassroots nonprofit provider in Southern California that serves children, families, and individuals with mental health and substance abuse disorders. He indicated that the Illumination Foundation is the largest medical respite recuperative care provider in the nation. He noted that its central site in Fullerton, CA, has a homeless shelter, medical respite,¹ and services including primary care, dental, psychiatric, housing, and workforce navigation. Mr. Leon indicated that the organization's newest site at UCLA includes a medical respite located within a hospital, where individuals can be discharged to a transitional micro-community and, ultimately, to permanent housing.
- Mr. Leon indicated that the Illumination Foundation operates 241 micro-communities² for mental health, substance abuse, and seniors that are adjacent to the medical respite. He explained that the Illumination Foundation's model has the ability to take individuals who are enrolled in Medicaid from the street to a navigation center, family emergency center, or medical respite where they can recuperate and then be moved into micro-communities and permanent housing.
- Mr. Leon explained that the Illumination Foundation does both predictive and prescriptive analytics. He noted that its population includes patients with mental health issues. He indicated that the program realized how important it was to address HRSNs (including transportation) as part of overall care. Mr. Leon stated that his work with medical respite has made him realize how many individuals are not connected to a PCP. When the Illumination Foundation connects patients to a PCP, there are immediate savings due to reduced ED visits and hospitalizations. He explained that analyzing its data helped the Foundation realize that most of its patients in medical respite had a serious and persistent mental illness (SPMI). He noted that the analysis showed potential cost savings coming from addressing HRSNs by offering services such as transportation, assistance with basic needs, and housing.
- Mr. Leon stated that the program has been successful so far and noted that the Foundation has been able to receive reimbursements through CalAIM. He indicated that prior to CalAIM, the Foundation was funded through city grants, support from various organizations, and hospitals.

Dr. Babaria concluded by discussing how CalAIM's community support and care management programs can address the local trends and complexities that were noted by Mr. Leon.

- Dr. Babaria indicated that CalAIM's work focusing on complex patients has emphasized the importance of supporting prevention and upstream interventions related to health and wellness.

¹ Health care services for individuals experiencing homelessness who are too ill to recover from illness or injury on the street but are not sick enough to be admitted to a hospital.

² Homes in residential neighborhoods that have been renovated to serve as supporting housing for homeless individuals.

- She highlighted that the California Department of Health Care Services has a unique position as a government payer to take a longer-term view of health outcomes relative to health care delivery systems or managed care partners. Dr. Babaria explained that Medi-Cal covers 14 million individuals in California (one in three residents), and pays for half of all births in the state of California. Furthermore, Medi-Cal covers more than half of the children in California, and almost three-quarters of all Latino and Black children in the California. She reported that literature, research, trends in State programs show that what happens to children and pregnant women determines long-term health outcomes decades later.
- Dr. Babaria discussed CalAIM's initiative, that are seeking to provide upstream interventions involving primary care that it is integrated with effective upstream public health and social services programs. She noted that CalAIM also mandates reporting on primary care as a percentage of total spending to help set targets for spending in the future.

Vice Chair Hardin invited the Committee members to ask questions.

- Bruce Steinwald asked Dr. Chen about the proportion of entrants in ChenMed's one-year PCP fellowship that make it successfully to the end of the program. He inquired whether there was a selection process that limits the number of PCPs who would succeed in the program.
 - Dr. Chen emphasized that the fellowship is an important focus for the organization. He noted that ChenMed spends a significant amount of time interviewing candidates to determine the PCPs that can provide the care expected in its program. He reported ChenMed's conclusion that over 50 percent of PCPs meet this criterion, and almost all (95 to 97 percent) of PCPs succeed in their training program. He explained that ChenMed looks for physicians who can consider their patients holistically, proactively address potential health issues upstream, and build strong relationships with their patients. He noted that ChenMed examines the psychological profiles of applicants factors such as learning agility and humility. Dr. Chen also indicated that ChenMed does not have problems recruiting PCPs.
- Terry Mills asked Dr. Chen about ChenMed's involvement with specialists and how specialists work among its TCOC arrangements and philosophy.
 - Dr. Chen stated that ChenMed is not able to create its own dedicated network of specialists. He indicated that ChenMed hires tier-one specialists through a contract arrangement or by employing them directly, and it prefers direct employment so it can conduct its extensive training and implement a selection process. He explained that the organization looks for specialists that are interested in communicating with PCPs and working with ChenMed to coordinate care, rather than those simply looking for more referrals.
 - Dr. Chen explained that regardless of geography, ChenMed ensures that its specialists work with algorithms that encourage them to follow evidence-based care. He emphasized that ChenMed's PCPs collaborate on care with their specialists and focus on collaboration rather than on costs.
- Walter Lin asked Dr. Chen about the levers that ChenMed uses post-training to continue to engage PCPs and help them achieve successful outcomes. Dr. Lin inquired about the financial and non-financial incentives ChenMed offers to PCPs.
 - Dr. Chen stated that ChenMed compensates providers well and provides upside incentive payments based on outcomes. He stated that it is transparent around outcomes, so all PCPs know how other physicians perform. Dr. Chen also noted that ChenMed allows PCPs

to grow and lead in the organization. For example, PCPs are promoted frequently, and some transition into leadership roles.

- Vice Chair Hardin asked Dr. Babaria and Mr. Leon about the criteria for determining which patients are appropriate for Community Supports and ECM. Additionally, she asked about the crossover they see between senior populations and Medicare.
 - Dr. Babaria noted that CalAIM has specific populations of focus for ECM, including individuals who are homeless or have severe mental illness or substance use disorders; the criteria for identifying these patients include frequency of ED visits, hospitalizations, or the presence of chronic conditions. She explained that CalAIM is introducing new benefits addressing the needs specific to children and individuals who require long-term care. She explained that the community supports are identified based on provider recommendations. Dr. Babaria noted that CalAIM will evaluate the efficacy of this approach and its impact on health outcomes and TCOC.
 - Mr. Leon noted that usually, patients are referred by hospitals for medical respite. Since CalAIM allows patients to self-refer, many plans and providers are unsure where their clients are, so they provide a list to the Illumination Foundation on a monthly basis and the Illumination Foundation uses outreach to find their clients. He also noted that the fastest growing population in California is unhoused seniors and that the Illumination Foundation helps enroll the senior population in ECM, so they can navigate care along with their PCP.
 - Dr. Babaria agreed with Mr. Leon and highlighted the impact of the housing crisis in California on seniors living with multiple chronic conditions.
- Jennifer Wiler asked Dr. Chen about incentivizing providers, particularly physicians, for their programs and outcomes, including the percentage of physicians' total compensation that is tied to incentives.
 - Dr. Chen noted that ChenMed's base level starting salary for its PCPs is highly competitive in the market, and that ChenMed offers an additional 20 to 30 percent on top of the base salary to allow for future promotions and opportunities for advancement, based on the PCP's outcomes.
- Vice Chair Hardin asked Dr. Babaria to speak about multi-payer alignment happening in California.
 - Dr. Babaria confirmed that there is a collaboration at the state level between Medi-Cal, Covered California (the state health insurance exchange), and the California Public Employees' Retirement System (CalPERS). She noted that these three state-run health insurance programs cover 42 percent of the state of California. There is an ongoing, strong collaboration among these programs that promotes value-based care offers and opportunities to scale work with primary care practices statewide.

Panel Discussion on Assessing Best Practices in Care Delivery for Population-Based TCOC Models

- Lee McGrath, MHSA, Executive Vice President, Healthcare Services, Premera Blue Cross (Payer Perspective)
- Gary Puckrein, PhD, President and Chief Executive Officer, National Minority Quality Forum (Patient Advocacy Perspective)
- Robert Saunders, PhD, Senior Research Director, Health Care Transformation, Duke-Margolis Center for Health Policy (Academic/Policy Research Perspective)
- Kristofer Smith, MD, MPP, Chief Clinical Officer, Prospero Health (Provider Perspective)

Paul Casale, PTAC Chair, moderated the panel discussion of SMEs representing different perspectives on best practices in care delivery for population-based TCOC models. He introduced each panelist, noting that the full biography for each panelist can be found on the [ASPE PTAC website](#).

Chair Casale reiterated the CMMI goal of having every Medicare FFS beneficiary in a care relationship with accountability for quality and TCOC by 2030. He asked the panelists to discuss the potential for accountable care relationships and models to improve the quality of care and health outcomes while reducing TCOC. Chair Casale also asked the panelists to elaborate on what changes are needed to maximize the ability of models to achieve these objectives.

- Robert Saunders indicated that there are positive results from the recent expansion of TCOC models; however, the evidence may evolve and change over time. He noted that an ongoing challenge is engaging specialists in Alternative Payment Models (APMs). Although specialty care accounts for between 90 and 92 percent of total health care spending, many current TCOC models focus mainly on engaging PCPs. Dr. Saunders highlighted four strategies for engaging specialists in APMs: 1) networking or referral strategies employed by ACOs or TCOC organizations; 2) specialty-focused TCOC arrangements, such as end-stage renal disease (ESRD) seamless care organizations (ESCOs); 3) contracting strategies; and 4) virtual bundles. Despite the challenges, he emphasized the opportunity to integrate the specialist perspective into TCOC arrangements.
- Gary Puckrein described the National Minority Quality Forum's perspective that the health care system should mitigate patient risk (e.g., reduce hospitalizations, ED visits, disability, and mortality). He emphasized that APMs are not patient-centric models; they are financial models that distribute funds, and there is a lack of evidence supporting the assumption that these models improve patient outcomes. Dr. Puckrein recommended organizing the health care system around improving patient outcomes, especially when considering strategies for addressing health equity. He reiterated that he has not seen evidence that current models will improve quality in the short or long run.
- Lee McGrath agreed with Dr. Puckrein that current APMs are too focused on financial mechanisms. She highlighted three strategies for achieving the CMS mandate of having all Medicare beneficiaries in strong relationships with a PCP: 1) expanding access to primary care services; 2) investing in the data infrastructure to share clinical and claims information to enable PCPs to impact patient care in a meaningful way; and 3) broadening the definition of who delivers primary care, to improve patient outcomes.
- Kristofer Smith reflected that APMs struggle to identify the populations for whom they want to improve quality and reduce TCOC. He suggested that for certain populations, the focus should be on specific elements of quality (i.e., access, primary care measures). Dr. Smith noted that there are few data to support the concept of holding provider groups accountable for TCOC across entire populations. He emphasized that the data instead support holding entities accountable for quality and TCOC of a specific, high-cost patient population (e.g., frail elderly or ESRD patients). He also stated that there are subpopulations of high-cost patients that require different models of care to improve outcomes and reduce TCOC. Additionally, Dr. Smith indicated that 50 to 75 percent of Medicare patients are low-cost and low-utilization, and suggested that policy makers could think more broadly about quality in the remainder of the population.
- Larry Kosinski asked Dr. Saunders to describe whether models to date have put enough income at risk to incentivize the specialist population to participate in accountable care models. Dr. Kosinski

asked the panelists to clarify whether specialist engagement can be accomplished through management of the provider network, if not promoted through compensation.

- Dr. Saunders noted variation in how TCOC arrangements adjust specialist compensation. He emphasized that few organizations, including large health care systems involved in ACOs or other TCOC arrangements, have altered specialist compensation patterns. He suggested that for large health systems, the percentage of specialist compensation from value-based arrangements is small, and this would likely be even less in smaller practices depending on the proportion of the practice that is affected by the TCOC arrangement. He highlighted that focused TCOC arrangements, such as an inflammatory bowel disease (IBD) medical home for gastroenterology (GI) patients, include strong engagement from specialists. However, specialists that treat numerous conditions are not significantly affected by TCOC arrangements in terms of their compensation or practice revenue.
- Chair Casale asked Ms. McGrath to elaborate on engaging specialists in TCOC arrangements from the payer perspective.
 - Ms. McGrath emphasized that opportunities to engage specialists in TCOC arrangements exist; however, it is necessary to reduce the burden on PCPs and specialists. She reiterated Dr. Puckrein's comment on the importance of maintaining a patient-centered focus and noted that investments should be thoughtfully directed toward expanding access and improving data infrastructure to improve the patient experience.
- Joshua Liao asked the panelists to discuss how methods for expanding access and improving infrastructure can be incorporated into models, specifically whether they should be a component of the models or a separate initiative.
 - Ms. McGrath expressed uncertainty about whether such changes should be incorporated as an element of population-based TCOC models or implemented separately. She emphasized that providers are interested in expanding access, reducing transaction costs, and improving staffing. She noted that Premera Blue Cross is investing in primary care throughout Washington state.
 - Dr. Saunders stated that it is relatively easy to modify payment methodologies, but it is more difficult to redesign care delivery and it takes time to observe the impacts of care delivery innovations. He described how retrospective payments and the current incentive structure create demand for significant up-front capital to enter value-based care arrangements or to engage in care delivery innovations because the research demonstrates that results take time. Dr. Saunders added that large health or hospital systems may access capital reserves to support an up-front investment; but smaller entities, especially those operating through cash accounting, will not have access to the necessary capital. He noted that ACO facilitators (e.g., Aledade, Privea, Agilon) provide some of this up-front capital, but a significant need remains for additional funds. Dr. Saunders recommended that payment models consider sources for the up-front capital required to enter value-based care arrangements.
 - Dr. Smith agreed that up-front costs for APM participation are substantial and added that participation also requires significant expertise. Dr. Smith emphasized that each APM has unique requirements, leading to a constant need for additional capital and expertise as new models are implemented. He described the privatization of FFS innovation in the marketplace, where private equity and venture capital firms are leading investment. Dr.

Smith noted that large delivery systems are not participating in transformation because they do not have the required capital. He noted that investments are insufficient for increasing the primary care workforce. Overall, Dr. Smith discussed the need for identifying a different approach for supporting larger up-front investments.

- Dr. Puckrein stated that the health care system is failing to learn from prior performance. He noted as an example that 24 percent of Medicare FFS beneficiaries have diabetes, around 60 percent of whom experience a hospitalization or ED visit in a year, and that this statistic has remained steady over the last five years. Dr. Puckrein emphasized the importance of questioning why the system is not improving outcomes over time and discussing how to mitigate patient risk rather than financial risk.

Chair Casale asked the panelists to describe best practices to integrate efforts for screening and providing referrals for HRSNs into population-based TCOC models.

- Dr. Puckrein discussed the challenge of bringing social services (e.g., housing, transportation, food services) into the health care system. He agreed that social services are critical to health outcomes and that there should be some integration between health and social services. However, he recommended that the health care system remain focused on improving clinical performance before expanding social service partnerships.
- Dr. Smith noted the significant progress health care systems have already made to initiate SDOH screening. He described the ability of affordable health care staff (e.g., community health workers, medical assistants) to perform the screening. He also highlighted the proliferation of screening resources in the marketplace (e.g., NowPow, Aunt Bertha) and stated that such resources provide social service networks and contact information for community services. Dr. Smith noted that the standardization of Medicare's approach to SDOH screening has been helpful. He suggested that the SDOH screening infrastructure has created longer waiting lists for social support because the nationwide underinvestment in social service agencies limits their capacity to accept referrals.
- Ms. McGrath described Premera's investment in a team-based care management that focuses on building a meaningful connection between physicians and patients. She described how Premera supports holistic care through employment of social workers, pharmacists, case managers, and behavioral health specialists. Further, she noted that Premera works with community liaisons to build relationships with social services and community resources (i.e., affordable housing and food banks) to support patients beyond the clinical setting.
- Dr. Saunders agreed that the health system is encouraging SDOH screening. For example, the most recent Measure Applications Partnership (MAP) review included measures related to social needs; one of the measures was already proposed for Medicare hospital programs and would likely be proposed for physician programs as well. Dr. Saunders discussed two main challenges related to the incorporation of SDOH or HRSN screening and referrals.
 - Linking SDOH screening to referrals or activities that address social needs remains a major challenge. Dr. Saunders emphasized the need to send information related to the referral back to the referring clinician. He highlighted the opportunity to build on work like the North Carolina Healthy Opportunities Pilots, which engage providers in screening and use Medicaid funding to support services addressing an HRSN (e.g., housing support, transportation), and to develop data tools to facilitate referrals.
 - Dr. Saunders cautioned against the duplication of SDOH screening products that may lead to sustainability challenges and provider burnout. He indicated that informal surveys highlight the emergence of multiple SDOH screening tools that vary slightly from one another regarding design and coding outputs.

- Dr. Smith described how measuring SDOH improves risk stratification models. He referenced Dr. Puckrein’s example of Medicare beneficiaries with diabetes and noted that SDOH measurement enables provider organizations to identify which diabetic beneficiaries are more likely to be hospitalized. Dr. Smith discussed how claims data are homogenous and how laying in measurable, reportable SDOH allows providers to highlight patients that may require more support.
- Vice Chair Hardin asked the panelists to elaborate on what motivated their organizations to invest in social support services (e.g., social work, behavioral health, pharmacy, community liaisons) and any recommendations to generate more investment in building these resources.
 - Dr. Smith indicated that Prospero Health is investing in additional members of the care team who are experienced in managing social needs, such as social workers and community health liaisons. He clarified that Prospero Health is not investing directly in paying for services that address HRSNs (e.g., transportation, food) due to financial questions regarding the return on investment (ROI) and challenges of incorporating these services into a business plan. Dr. Smith indicated that some payers, especially in Medicaid, are considering studies of the ROI for these investments. Overall, he expressed hesitation that providers will invest in care delivery innovations where they directly provide or are responsible for paying for provision of these social services.
 - Ms. McGrath noted that patient retention would strengthen the business case for investing in social services. It takes time for social services to impact patient health, and patients may leave the health plan before the organization can realize the ROI gained by providing those services. Ms. McGrath noted that the focus should not be on money, but health care organizations must consider the financials to pay their employees and remain open.
 - Dr. Saunders explained that rules that determine appropriate payment vary by program (e.g., FFS Medicare compared with a MA plan). This makes it complicated for payers to directly compensate for social services. He also discussed the challenge of determining ROI for social service investments when the improvements in health outcomes or utilization patterns may not be realized for five to 15 years.
 - Dr. Saunders noted that the North Carolina Healthy Opportunities Pilots have a fee schedule that covers very specific social services. Direct payment for these services up front reduces the challenge of delayed ROI in terms of overall health care costs. Lastly, Dr. Saunders discussed the importance of answering uniformly whether the health care system should absorb social services or expand partnerships with social service agencies to mitigate the tension that is emerging as health care systems expand their role.
 - Dr. Puckrein suggested that the health system needs to be fundamentally reimagined to create incentives based on patient outcomes and to encourage competition between providers to improve these outcomes. He emphasized that current health care financing strategies are insufficient to support the ongoing improvements in medical technology and treatment, which will further exacerbate disparities moving forward.
- Angelo Sinopoli asked the panelists if their organizations have explored opportunities to partner with emergency medical services (EMS) for innovative transportation models.
 - Ms. McGrath confirmed that Premera explored this opportunity and currently uses helicopters and sea planes in its Alaska service area.
 - Dr. Smith explained that the organizations he has worked with engaged EMS to assist with unscheduled and acute visits, rather than transportation to scheduled appointments. For example, he described his work in designing a home-based model for complex patients that used EMS and paramedic staff to engage with patients at home when a longitudinal provider was unable to adjudicate the clinical complaint by a telephonic visit. He noted that response times were less than 30 minutes for frail elderly patients in downstate New York.

Dr. Smith emphasized that this type of transportation partnership can significantly impact TCOC. He argued that patients will engage with the system regularly when they are assured that they will receive care in a timely manner. He felt that there is tremendous opportunity to innovate in partnership with EMS colleagues under the correct oversight and supervision.

Dr. Wiler asked the panelists if they are aware of health care organizations or programs that consider member retention as a quality measure, and if they favor using member retention as a quality measure.

- Dr. Smith explained that Prospero Health uses “controllable discharge” as a performance measure, which is viewed as an early warning sign that the organization is not providing the desired services. Dr. Smith noted he is in favor of using member retention as a quality measure.
- Ms. McGrath noted that Premera Blue Cross uses employer and member retention as a source of feedback for the insurance organization and agreed that providers could be incentivized for retaining patients. She explained that insurance premiums also affect member retention. Ms. McGrath emphasized that premium calculations are complicated, especially due to the retention challenges caused by the high levels of resignation observed during the COVID-19 public health emergency (PHE). Ms. McGrath also highlighted the importance of feedback loops and understanding success signals for all of those involved in value-based care. These inputs enable each actor to become successful within their own organization and to translate that success into downstream benefits for patients and communities.

Chair Casale summarized the ongoing discussions of trade-offs when designing population-based TCOC models, including the trade-off between maximizing provider choice for beneficiaries and providing flexibility for accountable entities to manage costs by narrowing provider networks. He asked panelists to describe best practices for balancing this potential trade-off.

- Dr. Saunders discussed how the trade-off differs based on each patient’s insurance. For example, FFS Medicare beneficiaries have a wide range of provider choices, while MA beneficiaries have a relatively narrower network, and commercial insurers offer an even tighter network. He acknowledged that some organizations, including ACOs, are using referral strategies by identifying high-value providers or skilled nursing facility (SNF) services nearby and providing referral suggestions at the individual clinician level. Dr. Saunders also highlighted the benefits of care delivery partnerships that emerged during COVID-19 (e.g., engaging with SNFs on infection control and testing). Such partnerships did not have to be financial relationships, but they were effective at improving patient care and managing patients across care settings. He noted that there is potential to focus on these partnerships and improve referral recommendations without restructuring TCOC rules to improve how care is delivered.
- Dr. Puckrein favored maximizing beneficiaries’ provider choice because this will foster competition among providers. He expressed that competition would encourage providers to improve clinical performance.
- Dr. Smith agreed that APMs should maintain a patient’s ability to exit the model, but he encouraged new Medicare and CMMI models to consider attribution methodologies that stabilize a model’s patient population. He noted that a consistent 20 to 30 percent of turnover in a model’s population limits the ability of the accountable entity to improve quality and reduce TCOC.

Chair Casale asked the panelists to elaborate on specific trade-offs between including more structure regarding specialist engagement in population-based TCOC models and allowing more flexibility for accountable entities to determine organically how to incentivize specialists.

- Dr. Smith highlighted that the data support investing in medical homes and primary care services. He described his support for developing ACOs around primary care networks, rather than subspecialty ACOs, that can determine contracting relationships with more specialized services (e.g., subspecialist providers, subacute rehabilitation facilities, hospitals). Dr. Smith explained that the ability of primary care networks to negotiate financial terms moves all providers toward value-based outcomes as patients will seek these improvements from all providers.
- Dr. Puckrein agreed that it is a good idea to allow ACOs to determine how to incentivize specialist engagement because these organizations are focused on finding partners to help improve patient outcomes. He added that the ACOs should report patient outcomes to document and ensure improvement.
- Ms. McGrath asked whether Chair Casale is referencing a shift of investments from primary care to specialty providers.
 - Chair Casale clarified that this question is focused around whether specialty models (e.g., Bundled Payments for Care Improvement [BPCI] Initiative) should be continued, potentially as nested models, or if policy makers should focus on larger TCOC models and allow specialist coordination to happen more organically.
 - Ms. McGrath emphasized the need to address three fundamental issues of health care: affordability, access, and fragmentation of care. She expressed hesitancy that creating more models would address these issues. Ms. McGrath suggested that investing in data sharing infrastructure is a key solution to these issues, especially in a competitive environment. She emphasized the large role that payers have in promoting information sharing and the responsibility of CMS to share additional information.
 - Dr. Puckrein reiterated the importance of CMS and CMMI working to help increase data sharing as a tool for improving patient care.
 - Dr. Smith expressed concerns about nesting models because such models introduce significant uncertainty for providers, both in determining how to mitigate risk and in anticipating patient attribution. He emphasized that providers with slim profit margins are not going to use complex modeling to determine whether assuming population risk with carve-outs is beneficial to them.
- Dr. Saunders highlighted three topics related to specialist engagement in population-based TCOC models. Overall, he stated that specialists should feel involved; however, the pathway for this involvement will likely vary and needs to be further developed.
 - He noted that specialists often feel that TCOC arrangements are not appropriate for them. Furthermore, many providers in ACOs are unaware that they are an ACO provider or feel that being an ACO provider does not affect their care.
 - Dr. Saunders noted that a single solution for engaging specialists in value-based care may not exist. He discussed how specific populations (e.g., ESRD, IBD) lend themselves well to a specialty-focused payment arrangement where a specialist will treat the condition and coordinate most of the patient's care; in other situations, a broader TCOC arrangement may be appropriate.
 - Dr. Saunders highlighted Dr. Smith's comment about nesting and discussed the technical challenges of implementing nested payment models within ACOS. He said that ACOs understand risk, but may not see an advantage in assuming the additional risk associated with managing the cost of care delivered within a specific nested bundle when they are already assuming risk for other services contributing to TCOC for a patient.

Chair Casale asked the panelists to share any final insights regarding population-based TCOC models that could inform PTAC's discussion of these models.

- Dr. Puckrein emphasized his desire to reimagine the health care system to focus on the patient. He stated that CMMI plays a large role in supporting this vision and helping create a system that cares for a diverse population. Dr. Puckrein expressed his sense that the current system is not designed to address a diverse population or health disparities.
- Dr. Smith repeated that there is a lack of compelling evidence on the benefits of delegating responsibility for reducing TCOC at the population level because the majority of Medicare and Medicaid beneficiaries are relatively healthy with little opportunity for TCOC reductions. He recommended identifying specific, high-cost populations where TCOC can be reduced because policy makers believe that low-value care is being delivered.
- Dr. Saunders highlighted three topics related to PTAC’s further consideration of population-based TCOC models.
 - He emphasized the opportunity to leverage TCOC and accountable care arrangements to improve health equity through thoughtful design and implementation of these arrangements.
 - Relatedly, Dr. Saunders discussed the need to engage safety net providers in TCOC and accountable care arrangements. He noted that traditionally, these providers have not been engaged due to technical challenges but that involving them is critical for reaching large proportions of the U.S. population, especially those living in historically underserved areas.
 - Dr. Saunders encouraged further discussion of primary care and specialty collaboration in TCOC arrangements.
- Ms. McGrath encouraged policy makers and organizational leadership to “lead without fear” and be bold. She emphasized that this is an important time for decision-makers to listen to and respond to the demands of patients.

Public Comment Period

No public comments were provided.

Committee Discussion

Chair Casale invited the Committee members to discuss what they have learned from both days of presentations, the roundtable discussion, and the background materials. He noted that PTAC will submit a report to the Secretary of HHS after the series of theme-based discussions on population-based TCOC models concludes in September. Chair Casale indicated that the goal of the discussion was to begin developing comments and recommendations that will inform the portion of the report to the Secretary on care delivery best practices and innovations, as well as the September theme-based discussion on payment methodologies.

- Jay Feldstein stated that the theme of integrating specialty care into TCOC models was a key topic of discussion during the public meeting and emphasized that specialist integration and accountability would need to be addressed to develop successful models. He suggested that the physician most responsible for individuals’ care and costs should be the accountable party, and in many cases, specialists may be the best-suited to manage care.
- Dr. Kosinski recalled the discussion of “cascading accountability” and emphasized the fluidity between primary care and specialty care, noting that depending on the context, specialists can function as PCPs, and PCPs can function as specialists. For example, a specialist caring for a patient with a chronic disease may also be providing primary care for that patient, while an internist managing a patient with multiple complex conditions may be providing the care of multiple

specialists. He emphasized the necessity to move beyond the specific, prescriptive definitions of primary and specialty care to focus on providing holistic patient care. Dr. Kosinski stated that developing an effective population-based TCOC model would require multiple layers of accountability. He discussed how engaging specialty providers requires tighter networks and larger numbers of patients within specialty groups, a critical look at the bundled services that are nested inside TCOC models, and additional information on providing care management support.

- Chair Casale noted that developing cascading accountability would also necessitate a cultural shift among specialists to recognize collective accountability. He noted that it would be important for providers to work together to move beyond a compartmentalized understanding of responsibilities for primary care versus specialty care providers.
- Dr. Liao commented on key concerns regarding engaging specialists. He noted that it is necessary to understand the ongoing curves of population health and associated care if the curve is monotonic and ongoing or fluctuating episodically. Dr. Liao highlighted the need to understand how specialists impact the patterns of care. He also suggested that the individual contacting the patient is not as important as the fact that necessary care is being provided. Dr. Liao noted that he felt models should find a way to incorporate both primary and sub-specialty care, despite potential technical issues associated with cost assignment and cost accounting. He emphasized that the focus should be on providing care, rather than focusing on which provider last touched the patient.
- Dr. Mills emphasized the need for standardized data to successfully affect access, affordability, and fragmentation. He suggested that developing a standardized national framework for data analysis could be a leadership opportunity for CMMI. Dr. Mills suggested three key aspects of the data framework, including standardizing the nomenclature associated with source data, increasing accessibility of CMS data and encouraging its standardized use, and requiring coordination and data sharing within a national, established framework. He emphasized the need for timely access to quality and utilization data so that organizations and providers can make proactive decisions in response to that information.
- Dr. Lin recalled Dr. Smith's comments about the complexity of nesting models, noting that responsibility should be assigned to a single organization or provider and cannot be spread across multiple providers with complicated carve-outs and nesting schemes. He suggested that when accountability is spread across multiple entities, no one entity assumes responsibility. Dr. Lin also emphasized the role of PCPs in reducing costs and coordinating patients' care among multiple specialists, noting the increased importance of specialist referrals with increased accountability for the PCP. He suggested assigning accountability to a single base entity, with the goal of ensuring that one physician would be held accountable for a patient's care.
 - Chair Casale commented that Dr. Smith's description of nesting sounded closer to a description of carve-outs models. He discussed the importance of specifying the appropriate level of accountability for different types of care, noting that Dana Safran, a presenter during the June 7 public meeting, emphasized the difficulty of assigning patient quality outcomes to individual providers.
- Dr. Wiler emphasized that access to meaningful, actionable health data can be an important lever for improving health disparities. She noted that a complete switch to ACO-type models would likely not foster patient-centered care on its own. However, she emphasized that accountable entities, regardless of whether they are PCPs or specialists, must be accountable for all aspects of a patient's care. She suggested that payment models be agnostic to who owns accountability, but she

emphasized the importance of specifying a single accountable owner or entity to avoid creating inefficiencies, poor outcomes, and higher costs. Dr. Wiler discussed the importance of encouraging payment models to develop incentives to support partnerships between accountable entities and other providers and organizations, and to support the cost associated with these partnerships so that the relationships are seen as important and offering value.

- Mr. Steinwald highlighted how research has demonstrated the value of robust primary care in improving health outcomes and reducing costs. He noted that the structure of medical education and the medical job market discourages primary care. However, he acknowledged that looking at these issues is likely beyond the scope of PTAC. Mr. Steinwald expressed support for expanding the role of the PCP and emphasized the importance of managing the relationship between primary care and specialty care.
- Dr. Liao agreed with the collective vision and values related to expanding primary care, but he noted that, across organizations and models, primary care had many different definitions. He highlighted the importance of deciding whether TCOC models should allow more flexibility or if they should be more structured. He emphasized the importance of determining where variation across model design is desired. He also shared that additional work is needed to determine how models can best address patient-centeredness, as well as technical issues associated with model design and implementation including necessary number of lives that need to be covered by an accountable entity, attribution of patients to accountable providers, and effective approaches to nesting and carve-outs. Finally, he emphasized the importance of considering a useful definition of primary and specialty care that reflects the value of maintaining flexibility in model design and implementation.
- Dr. Sinopoli emphasized the importance of primary care transformation and suggested that specialists serve on the primary care team rather than try to fill the PCP role. He noted that having specialists function as PCPs could be a disservice to patients and suggested that specialists be incentivized to focus on their responsibilities and work as part of the care team. Dr. Sinopoli highlighted the need to continue addressing SDOH by collaborating with non-health care agencies and organizations.
- Vice Chair Hardin discussed the importance of integrating data on social needs into EHRs. This will support efforts to address social needs and to understand patient context. Vice Chair Hardin highlighted the theme of employing integrated care management teams, noting the value of integrating social workers, nurse case managers, community health workers, and pharmacists to allow providers to focus on serving patients. She noted that the shift away from FFS payments enables new flexibility in the provision of care, which can increase efficiency and may lead to more ambulatory care utilization. Vice Chair Hardin remarked on the value of providing care where individuals live, noting the importance of directly engaging with patients to extend resources and build relationships. She emphasized the importance of investing in resources beyond HRSN screening, highlighting potential Medicaid payment models that provide payment for social services and innovation in California, building on multi-payer collaboration to address housing needs.
- Dr. Mills discussed the importance of simplifying social needs screenings to prevent confusion and enable data collaboration. He suggested that CMMI leadership should consider developing a single set of standardized questions and definitions to screen for SDOH and HRSNs.

- Chair Casale agreed that this is an area of opportunity for CMMI to advance SDOH measurement.
- Dr. Liao noted the differences between flexible payment structures that allow physicians to provide necessary resources to patients and more restrictive payment structures. He suggested that it is harder to hold physicians accountable for patient outcomes broadly under more restrictive payment structures, because they may not have the resources to affect more than a relatively small portion of patient outcomes. Dr. Liao reflected on the urgency of increasing alignment between physicians' ability to address outcomes and payment structure. This may be achieved either by building appropriate levels of flexibility in payment structure, outcomes for which physicians are responsible, or a combination of these two approaches.
- Chair Casale commented that CMMI should consider which partnerships are needed to develop effective SDOH screening and data collection tools.
- Dr. Wiler discussed how many models employ patient-driven, high-touch strategies. She suggested that encouraging care teams to focus on interacting with patients in beneficial ways will ultimately improve patient health.
 - Chair Casale noted the value of proactive patient touches and emphasized that active engagement among providers can increase provider confidence that information is being shared across the care team, thus reducing fragmentation.
 - Dr. Kosinski pointed out that providers do not have incentives under FFS to engage with patients proactively and referenced prior discussions regarding the need for value-based payments address this by providing resources in a timely way that encourages proactive patient engagement. He suggested recommending adjustments to the FFS system, such as changing Chronic Care Management (CCM) and Primary Care Management (PCM) code billing, which could bridge the FFS system with value-based care initiatives.
 - Chair Casale suggested that CMMI might be able to expand waivers to eliminate copays for some high-touch services in TCOC models. They are doing this in the ACO REACH model.
- Dr. Liao emphasized the need to consider patient needs separately from TCOC. He noted that focusing exclusively on cost may not support the goal of addressing patient needs. He noted that while some models of primary care are very successful in the current system, models and approaches need to bring primary and specialty care together to effectively analyze the joint issues of total cost and health care needs.
- Chair Casale discussed the issue of including pharmaceutical spending, particularly Part D spending, in TCOC models. He noted that current models often include Part B spending on medication but not Part D. Chair Casale described how in his experience with the Oncology Care Model (OCM), the availability of new expensive medications would hurt the organization's performance against benchmarks.
 - Dr. Kosinski further emphasized the importance of including all pharmaceutical costs in TCOC calculations. He suggested that it is important to include both Part B and Part D medication spending in TCOC due to the potential for shifting between self-administered versus physician-administered therapies.
 - Dr. Liao noted that the significant costs and issues associated with Part B medication spending in existing models will only increase when Part D is included in TCOC calculations.

He further noted that deciding how to incorporate all pharmaceutical costs in TCOC should occur as a precursor to specialist integration in TCOC models.

- Dr. Wiler emphasized the need to develop specific definitions of quality and suggested that process measures can be used as surrogates for desired outcomes, as outcomes improvement often requires a longer time horizon to realize, and it is difficult to delay incentive payment until outcomes improvements can be established. She noted that while process measures are not widely used, care models being adopted by innovators often create their own performance measures and structures. This experience may inform future, broader scale models. Dr. Wiler suggested that the ratio of primary care touches to specialist touches could serve as one surrogate indicator of how effectively patients are being engaged.
- Dr. Mills questioned whether movement toward TCOC models would be incremental or if the desired innovations require a sudden shift to the next stage of development. He noted that both ChenMed and Prospero did not move incrementally but fully transformed their models. Dr. Mills suggested that moving forward, models might no longer be able engage in incremental change, but might need to shift clearly to the next model created by distilling past successes and new ideas.
 - Chair Casale questioned whether entities would voluntarily move to more advanced models or if the movements need to be mandated.
 - Dr. Mills implied that some entities would voluntarily move, and others may not move until they are required to through mandate.
- Dr. Lin noted that the insights shared during the public meeting made him hopeful for future health care models, emphasizing that the Committee heard from a number of organizations that are using population-based TCOC models to great success.
- Dr. Liao emphasized the importance of considering whether and how some groups of patients are specifically selected into some models but not others, noting that many issues could be impacted by this selection. He noted that there was significant discussion around different trade-offs related to model design and suggested that PTAC should move from identifying trade-offs to making recommendations.
- Chair Casale noted that data and performance metrics are foundational to developing effective models, but that accessing quality data continues to be a challenge. He suggested continuing to recommend that CMMI support the development of data infrastructure to support the success of potential participants in future population-based TCOC models.
- Dr. Wiler highlighted the valuable innovations discussed during the meeting, noting that the presentations have allowed the Committee to understand what ideal care models might look like and what they would need to succeed. She suggested that the next step is sharing information on these promising strategies and increasing their uptake. Dr. Wiler emphasized the importance of and need for data infrastructure, suggesting that it would be an ideal federal- or state-level investment. She highlighted her view that programs cannot be voluntary and need include the health care safety net. However, she also noted that providers will object to taking on full financial risk for patient outcomes and costs. She suggested that future efforts need to incentivize improving access to well-coordinated care to help expand the spread and adoption of payment innovation
- Mr. Steinwald noted that the concept of “moving money around” can be an important technique for achieving objectives and incentivizing innovative care delivery approaches.
- Chair Casale asked if ASPE staff had any additional questions for the Committee.

- Audrey McDowell noted that Debbie Zimmerman, a presenter during the June 7 public meeting, suggested that TCOC models should focus on managing the costs of high-risk patients, but also invest in services that focus on low-risk patients. On the other hand, she noted that one of the panelists suggested that if reducing TCOC is a more important priority than improving quality, then models should focus on high-cost populations where a TCOC reduction is possible. Ms. McDowell asked the Committee members if they thought models should be focused on managing chronically ill, higher-cost patients, or if they should be focused on making investments in patients who are currently lower-risk patients to prevent the development of higher costs later.
 - Dr. Sinopoli emphasized the importance of paying attention to and identifying lower-risk patients that may become higher-risk. He noted that earlier interventions improve outcomes in rising risk, preventing the worsening of conditions and limiting future utilization.
 - Chair Casale observed previous high-cost patients may not be future high-cost patients, emphasizing the importance of continually evaluating risk and addressing the needs of patients as their risk levels rise.
 - Dr. Kosinski referred to Dr. Zimmerman’s listening session presentation, noting the importance of early investments in care for low-risk individuals. He highlighted how maintaining effective care prior to a patient being high-risk can help avoid higher-cost, higher-risk deterioration.
 - Dr. Liao expressed his view that models should address both low-risk and high-risk patients. He emphasized the importance of using appropriate quality measures and benchmarks for low-risk populations, noting that it could be difficult to measure improvement for these patients and understand the effects of early intervention. He emphasized the importance of providing needed services to move individuals away from rising risk while being sure not to provide unnecessary care.

Closing Remarks

Dr. Casale closed the public meeting by thanking participants and attendees. He reminded stakeholders that the Request for Input (RFI) was posted on the ASPE PTAC website, and responses received by July 20 would help inform PTAC’s September public meeting.

The public meeting adjourned at 1:50 p.m. EDT.

Approved and certified by:

//Lisa Shats//

9/2/2022

Lisa Shats, Designated Federal Officer
Physician-Focused Payment Model Technical
Advisory Committee

Date

//Paul Casale//

9/2/2022

Paul N. Casale, MD, MPH, Chair
Physician-Focused Payment Model Technical
Advisory Committee

Date