

PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL
ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

+ + + + +

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

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TUESDAY, JUNE 7, 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 IN PARTIAL 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
STEVEN SHEINGOLD, PhD, ASPE

*Present via Webex

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

9:32 a.m.

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2
3 * CHAIR CASALE: Good morning, and
4 welcome to the meeting of the Physician Focused
5 Payment Model Technical Advisory Committee,
6 known as PTAC. I am Paul Casale, the Chair of
7 PTAC. So I think I speak for all the Committee
8 members that we're very excited to be here in
9 person after being away for more than two
10 years.

11 Most of our Committee members are
12 here in the Great Hall of the Humphrey Building
13 in D.C., after many virtual public meetings,
14 and we look forward to a time when we can
15 welcome members of the public to join us in
16 person as well.

17 * **Welcome and Overview - Population-**
18 **Based Total Cost of Care (PB-TCOC)**
19 **Models: Assessing Best Practices in**
20 **Care Delivery for PB-TCOC Models**

21 As you know, PTAC has been looking
22 across its portfolio to explore themes that
23 have emerged from proposals received from the
24 public.

25 In March, we were excited to kick

1 off a three-meeting series of theme-based
2 discussions on population-based total cost of
3 care models. The public meeting focused on
4 definitions, issues, and opportunities related
5 to developing and implementing these models.
6 Today and tomorrow, we will focus on care
7 delivery model design.

8 PTAC will hear about lessons learned
9 from the public and subject matter experts,
10 including stakeholders who have previously
11 submitted proposals to PTAC that included
12 relevant elements. We've developed an agenda
13 to explore topics including what strategies
14 have helped entities be successful in bearing
15 financial risk while managing care for
16 different patient populations; incorporating
17 specialty care innovations into total cost of
18 care models; measuring performance and
19 evaluating these models; integrating episode-
20 based or condition-specific models within a
21 population-based model while reducing
22 complexity; and meaningfully addressing equity.

23 That's just a sample of what we hope
24 to cover at this meeting. In September, we
25 anticipate addressing the payment

1 considerations and financial incentives that
2 would encourage care delivery practices
3 discussed today in total cost of care models.
4 So if we don't cover a topic that's important
5 to you today or tomorrow, you're likely to hear
6 about it in September.

7 You can also read our environmental
8 scan and supplemental online material, which is
9 part of our background materials for this
10 series. After the September meeting, PTAC will
11 issue a report to the Secretary of HHS¹, with
12 the Committee's comments and recommendations on
13 these topics.

14 Today, we have multiple presenters
15 ready to describe their vision and experiences
16 related to assessing best practices in care
17 delivery for population-based total cost of
18 care models. Then the Committee will discuss
19 what we've learned before adjourning for the
20 day.

21 Tomorrow morning, we begin with
22 opening remarks from Liz Fowler, the Deputy
23 Administrator of CMS² and the Director of the

1 Health and Human Services

2 Centers for Medicare & Medicaid Services

1 Innovation Center. We will also hear from many
2 more experts from a variety of perspectives.
3 We'll then have a public comment period.
4 Public comments will be limited to three
5 minutes each.

6 If you'd like to give an oral public
7 comment tomorrow but have not registered to do
8 so, please email ptacregistration@norc.org.
9 Then the Committee will have a discussion to
10 shape our comments that will be included in the
11 report of the Secretary of HHS that we will
12 issue after the series.

13 Taken together, the prep work, the
14 presentations and discussions, and the public
15 comments are aimed at informing PTAC about the
16 latest knowledge from the field regarding the
17 development of population-based total cost of
18 care models in the context of APMs³ and
19 physician-focused payment models. I'll note
20 that as always, the Committee is ready to
21 receive proposals from the public on a rolling
22 basis.

23 We offer two proposal submission

3 Alternative Payment Models

1 tracks for submitters to provide flexibility,
2 depending on the level of detail that is
3 available about their payment methodology. You
4 can find information about how to submit a
5 proposal online.

6 * **PTAC Member Introductions**

7 So at this time, I would like for
8 the PTAC members to please introduce
9 themselves.

10 Please share your name and
11 organization. If you'd like, feel free to
12 share a brief word about any experience you
13 have with population-based payment or total
14 cost of care models.

15 So I'll start. I'm Paul Casale.
16 I'm a cardiologist. I lead value-based payment
17 and population health for NewYork Presbyterian,
18 Weill Cornell and Columbia University. Next,
19 I'm going to turn to Lauran, and then we'll go
20 around the room for each person to introduce
21 themselves.

22 VICE CHAIR HARDIN: Good morning.
23 I'm Lauran Hardin and Senior Advisor for
24 National Healthcare and Housing Advisors. I've
25 spent the last 20 years leading and designing

1 models, and partner with communities, states,
2 payers, and health systems in standing up
3 models, particularly for underserved and
4 vulnerable populations.

5 DR. KOSINSKI: I'm Larry Kosinski.
6 I'm a gastroenterologist, and have spent the
7 last 10 years of my life, 10 years of my career
8 building value-based programs for a company
9 that I founded and function as chief medical
10 officer, SonarMD. We are specifically
11 currently focused on value-based payments in
12 the gastroenterology space.

13 DR. WILER: Hi, I'm Jennifer
14 Wiler. I'm the Chief Quality Officer of
15 UHealth's Denver Metro Area. I'm a tenured
16 professor of Emergency Medicine at the
17 University of Colorado, and co-founder of
18 UHealth's CARE Innovation Center, where we
19 partner with digital health companies to grow
20 and scale their solutions to improve health
21 outcomes for patients.

22 I've held a number of leadership
23 roles within specialty societies focused at
24 developing payment models for providers, and
25 was a co-developer of an Alternative Payment

1 Model.

2 DR. LIAO: My name is Josh Liao.
3 I'm an internal medicine physician and faculty
4 to the University of Washington in Seattle.
5 There I also serve as the Enterprise Medical
6 Director for Payment Strategies, so support a
7 range of different payment models, including
8 population-based and total cost of care.

9 I also am fortunate to lead a unit
10 called the Value and Systems Science Lab, where
11 we do research and evaluation on these types of
12 models. So I think about methodologies and how
13 do we evaluate if these models have yielded the
14 benefits we want.

15 DR. SINOPOLI: My name is Angelo
16 Sinopoli. I'm a pulmonary critical care
17 physician by training. Presently the Chief
18 Network Officer of UpStream, which is a company
19 that enables primary care physicians to
20 participate in global contracting. Prior to
21 that, I was the chief clinical officer for a
22 large integrated delivery system and there
23 founded and built a large network of about
24 5,000 docs and then also founded a company
25 called the Care Coordination Institute, which

1 was also an enablement company for delivery
2 systems to provide data, analytics, care
3 management, process improvement, et cetera, and
4 I'm happy to be here today.

5 DR. LIN: Good morning. I'm Walter
6 Lin, an internist based in St. Louis. Founder
7 of Generation Clinical Partners. We are a
8 medical practice delivering care to the frail
9 elderly in senior living facilities, and also
10 the seriously ill in their homes.

11 DR. MILLS: Good morning. I'm Lee
12 Mills. I'm a family physician. I'm Senior
13 Vice President and Chief Medical Officer of
14 CommunityCare Managed Health Care Plans of
15 Oklahoma, where we operate a provider health
16 system-owned total capitated plan across
17 multiple lines of business. I came up through
18 medical group management and operated multiple
19 CMMI⁴ models and ACO⁵ models over the years.
20 Thank you.

21 DR. FELDSTEIN: Good morning. My
22 name's Jay Feldstein. I'm an emergency
23 medicine physician by training, and I'm

4 Center for Medicare and Medicaid Innovation

5 Accountable Care Organization

1 currently the president and CEO of Philadelphia
2 College of Osteopathic Medicine. Prior to
3 that, I spent 15 years in the insurance
4 industry and health care both for commercial
5 and government plans, with a fair amount of
6 experience with fully capitated and race-based
7 models. Chinni, I'm going to turn it over to
8 you now for your introduction.

9 DR. PULLURU: Thanks, Jay. Hi, I'm
10 Chinni Pulluru. I am Vice President of
11 Clinical Operations for the Walmart Health and
12 Wellness Business. In this role, I oversee
13 care delivery in our virtual care platform,
14 bricks and mortar clinics, behavioral health,
15 dental, as well as our social determinants
16 platform.

17 Prior to that, I oversaw value-based
18 care and care delivery for a large medical
19 group, DuPage Medical, now Duly Health and
20 Care, where I oversaw implementation of value-
21 based care platforms across the care continuum,
22 growing it tenfold successfully.

23 CHAIR CASALE: Thanks, Chinni.
24 Bruce, if you can introduce yourself.

25 MR. STEINWALD: Yeah. I'm Bruce

1 Steinwald. I'm a mostly retired health
2 economist in Washington, D.C. For the past 50
3 years, I've served in lots of different
4 positions in government and academia and in
5 private sector organizations, doing health
6 economics and health policy in a variety of
7 different settings.

8 * **Presentation: An Overview of**
9 **Proposals Submitted to PTAC with**
10 **Components Related to PB-TCOC Models**
11 **(Part 2) and Other Background**
12 **Information**

13 CHAIR CASALE: Thank you. So now
14 let's move to our first presentation. Five
15 PTAC members served on the Preliminary Comments
16 Development Team, or PCDT, that has worked
17 closely with staff to prepare for this meeting.
18 I'm grateful for their time and effort in
19 organizing today's agenda. At this time, the
20 PCDT will present some of the findings from
21 their background materials available on the
22 ASPE PTAC website.

23 PTAC members will have an
24 opportunity to ask the PCDT any follow-up
25 questions afterwards. So now I'm going to turn

1 it over to PCDT lead Chinni and the rest of the
2 team, Walter, Larry, Laurant, and Lee. So
3 Chinni, I'm going to turn it over to you.

4 DR. PULLURU: Right. Thank you,
5 Paul, and thank you to the team that served on
6 this, as well as the entire ASPE team that
7 helped. So in this presentation, we'll work to
8 discuss best practices, as well as trade-off
9 and barriers of delivery and adoption of total
10 cost of care models. Next slide. I'm not
11 seeing the slides. (Pause.)

12 [FEMALE PARTICIPANT]: One second,
13 Chinni, we're going to try to get them up.

14 DR. PULLURU: Right, thank you.
15 Given the --

16 (Off mic comments.)

17 DR. PULLURU: Thank you. Given the
18 increased emphasis on developing Alternative
19 Payment Models that encourage accountable care
20 relationships, PTAC is examining key issues
21 related to development and implementation of
22 population-based total cost of care models.
23 The Committee's March public meeting began by
24 focusing on key definitions, issues, and
25 opportunities.

1 Today's meeting focuses on assessing
2 best practices in care delivery for population-
3 based total cost of care models. Within this
4 context, PTAC is particularly interested in
5 exploring options for integrating episode-based
6 or condition-specific models within broader
7 population-based accountable care models.

8 From 2016 to 2020, PTAC received 35
9 stakeholder-submitted proposed physician-
10 focused payment models that have been
11 deliberated on the extent to which 28 of these
12 proposed models meet the Secretary's 10
13 regulatory criteria, including Criterion 2,
14 which is Quality and Cost.

15 Many of the PFPM⁶ proposals that have
16 been submitted to PTAC include innovative care
17 delivery approaches that could potentially be
18 relevant for population-based total cost of
19 care models.

20 This presentation provides useful
21 background information to provide context for
22 the rest of today's discussion and tomorrow's
23 discussion.

6 Physician-focused payment models

1 Next slide. PTAC has been using the
2 following working definition of population-
3 based total cost of care models as a guide for
4 focusing discussions during this series of
5 theme-based discussions. A population-based
6 total cost of care model refers to a
7 population-based advanced payment methodology
8 in which participating entities assume
9 accountability for quality and total cost of
10 care, and receive payments for all covered
11 health care costs for a broadly defined
12 population, with varying health care needs
13 during the course of the year or 365 days.

14 This definition will likely
15 continually evolve, as the Committee collects
16 additional information from our stakeholders.

17 Next slide. The Center for Medicare
18 and Medicaid Innovation, CMMI, has set the goal
19 of having every Medicare fee-for-service
20 beneficiary for Parts A and B in a care
21 relationship with accountability for quality
22 and total cost of care by 2030. PTAC is using
23 the following working definition of an
24 accountable care relationship.

25 An accountable care relationship is

1 a relationship with the health care provider
2 that focuses on accountability for quality of
3 care and cost of care for an individual patient
4 or a group of patients for a defined period of
5 time. Within this context, an accountable care
6 relationship would typically include
7 accountability for quality and cost for all of
8 a patient's covered health care services.

9 However, in some cases, a provider
10 could potentially be accountable for the
11 quality and cost of a subset of a patient's
12 health care services for an episode of care,
13 which could be procedure-specific, condition-
14 specific, disease-specific, or related to a
15 particular medical event.

16 Next slide. As we move from fee-
17 for-service to a full capitated, integrated
18 delivery model, there are potential
19 implications to care delivery, and we have to
20 take those into consideration, as they impact
21 the design of the models. First, as an
22 organization takes on more risk, there needs to
23 be significant improvement in care
24 coordination, integration, as well as
25 accountability clinically.

1 This will require increased
2 infrastructure outside of the provider-patient-
3 facing episode. Next, as this need grows,
4 there's also flexibility to innovate in care
5 delivery, including finding new ways to
6 integrate virtual and digital care, whether
7 synchronous or asynchronous. This flexibility
8 shifts the ability to innovate closer to the
9 provider and patient-facing component part of
10 care.

11 One potential consequence that is
12 necessary and can be viewed as limiting is the
13 potential limitation of beneficiary choice.
14 However, this isn't a negative effect as it
15 often can lead to higher-quality, better
16 outcomes and accountability of the care
17 delivery provider.

18 Next slide. As we move from fee-
19 for-service methodology to a full capitated
20 model along the risk continuum, the obvious is
21 that there's increased financial risk for the
22 accountable entity. This risk leads to
23 increased accountability to improve value.
24 This increased value is embedded in every model
25 deliberated by the Committee.

1 The other payment factor trade-off
2 is a reduction in beneficiary cost-sharing.
3 This acts as incentive for the beneficiary
4 member to choose plans that hold the provider
5 organization at increased accountability for
6 both financial risk and value offered.

7 As organizations take on more risk,
8 there is a shift in health plan or purchaser
9 administrative burden for payment determination
10 to the accountable entity. One important
11 factor in payment factor trade-offs is that it
12 can reduce CMS administration and will be
13 distributed to the accountable entity.

14 As we consider models in total cost
15 of care, simplicity to administer the model and
16 financial reconciliation, as well as timing, is
17 an important consideration. We will be hearing
18 this from our Committee as we move into future
19 meetings.

20 Next slide. There are some general
21 consensus about accountable care that we have
22 already recognized. For example, importance in
23 maintaining a patient-centered approach,
24 embedding and improving health equity across
25 the continuum, increasing coordination between

1 providers that are broadly responsible for
2 accountable care relationship with patients, as
3 well as in integrating specialty providers.

4 So all of the participating
5 providers have access to tools to deliver high-
6 quality, coordinated, team-based care. The
7 importance of addressing and realizing health-
8 related social needs and social determinants of
9 care, the emphasis on outcome metrics and
10 adoption of improved care delivery processes,
11 focus on evidence-based high-value care, as
12 well as a focus on reduction of waste and gains
13 in efficiency, as well as maintaining budget
14 neutrality, and seeking to reduce unnecessary
15 complexity.

16 Next slide. There are some areas
17 where additional discussion is also needed.
18 Whether value-based care delivery innovations
19 should focus on high-cost patients with
20 multiple chronic conditions and related
21 episodes of care, or a more broadly defined
22 population. How best do we support providers
23 that are in accountable care relationships,
24 particularly in cases where attribution occurs
25 retroactively?

1 What is a relative amount of
2 accountability for individual providers versus
3 a higher-level accountable entity? Whether
4 accountability can be shared among more than
5 one provider, and if so, how does this work to
6 distribute financial accountability? How do we
7 integrate screening and referrals for HRSNs⁷ and
8 social determinants of health in the context of
9 value-based care relationships, and what types
10 of providers and organizations can serve as
11 accountable entities? How do we expand that
12 potential scope?

13 How best to disseminate information
14 about best practices and innovations to
15 providers and organizations within these
16 accountable relationships, and how much
17 flexibility should accountable entities have in
18 determining how to manage care for the services
19 they're responsible for?

20 Next slide. To picturize and
21 discuss the elements of patient-centered
22 delivery and integration, as well as
23 accountability for diversity of patient

7 Health-related social needs

1 architecture, these particular elements are in
2 no hierarchical order, but rather evenly
3 important if they're divided into four
4 different sectors.

5 First, in considering different
6 patient needs, we must consider that while most
7 patients get their care with primary care
8 physicians being the quarterback of their care,
9 there are subsets of patients who often see
10 their specialists in much higher frequency, and
11 therefore often see this physician as their
12 primary care physician, for example, a
13 cardiologist for a patient with heart failure,
14 or a nephrologist in end-stage renal failure.
15 Models developed need to acknowledge these
16 relationships and develop accountability for
17 care.

18 Second, in considering different
19 needs, encouraging provider alignment and
20 coordination is another element encompassed in
21 total cost of care models. We need to look at
22 attribution methodology to further incent this
23 with primary care, even with plurality, even as
24 with plurality with a specialist. We must
25 develop alignment across different touch points

1 that the patient interacts with the health care
2 system, including social service encompassing
3 social determinants of health and long-term
4 care.

5 For example, a patient statistically
6 potentially sees a pharmacist 11 times more
7 than a physician. This is an important element
8 to coordination of care and access to care.
9 Leveraging all the ways a patient interacts
10 with the health care system to affect
11 coordination can't be underestimated in our
12 total cost of care models.

13 One of the most important elements
14 of care alignment must take into account
15 behavioral health of a patient, and consider
16 how to best provide health access to care,
17 including funding that incentives for providers
18 to develop channels of delivery.

19 There are -- in delivering future
20 models, we must consider innovation that
21 matches the world we deliver care in: Systems
22 such as advanced primary care, innovating the
23 workforce platform to the top of licensure in
24 team-based care, innovating and encouraging
25 clinical pathways that encompass virtual care,

1 as well as digital care, that are both
2 synchronous, as well as asynchronous, encourage
3 a patient to engage in their care more
4 effectively.

5 Allowing for provider systems to
6 innovate these pathways. Team-based care
7 includes integration with community services
8 that address social determinants of health.

9 The fourth element is the
10 foundational element that encompasses all the
11 other three elements, and that is tools,
12 infrastructure, analytics, implementation, and
13 best practices.

14 We must support more ready access to
15 data real time, to enable providers to
16 effectualize appropriate care patterns,
17 increasing and facilitating sharing between
18 organizations and risk-bearing entities to
19 encourage best practices.

20 Some other elements that are in
21 total cost of care models are financial
22 planning implementation resources, to enable
23 smaller, more independent, particularly rural
24 and underserved areas to embrace all the
25 elements that are needed to take on financial

1 risk.

2 Next slide. Considerations for
3 integrating specialty care. It may be more
4 effective to encourage patients to receive care
5 from an accountable provider or from providers
6 whose care is being coordinated to a specific
7 accountable entity. However, this can limit
8 patient choice.

9 Some providers are not comfortable
10 assuming overall accountability for patient-
11 centered value-based care if they only provide
12 a portion of this patient's overall care, and
13 some do not have the analytical tools or
14 prerogative necessary to affect coordination of
15 care with other providers.

16 Integrating specialty and
17 population-based total cost of care models will
18 require addressing any unintended conflicting
19 incentives built into benchmarks, and total
20 cost of care calculations for shared savings
21 and losses that can also affect care delivery.
22 These incentives may conflict across models,
23 including episode-based models that are
24 currently being implemented and tested
25 separately and siloed.

1 For example, the definition of which
2 services are included in total cost of care can
3 potentially incentivize cost-shifting.
4 Consistency in the technical implementation of
5 incentives may help encourage participation and
6 advanced payment mechanisms.

7 Next slide. Some actions for
8 integrating specialty care, including nested
9 models, hierarchical models within the ACO
10 global budgets that operate as an umbrella for
11 accountability. But this requires that the
12 rules and technical implementation of key
13 elements such as benchmarking and saving
14 calculations be designed so they are -- they
15 complement those relevant to the umbrella
16 model.

17 Next, carve-out models, models that
18 separate accountability for certain services
19 outside of an ACO global budget. Other
20 considerations such as mandating provider
21 participation, including specialty
22 participation in population-based total cost of
23 care models. Population-based total cost of
24 care models may not be able to create
25 sufficient incentives to engage specialists in

1 some cases, due to a limited supply of
2 specialty care in some markets, particularly
3 underserved and rural markets.

4 Voluntary participation may result
5 in less accountability, integration, and
6 coordination than would be desirable and
7 necessary for ensuring quality and reducing
8 total cost of care. Structuring technical
9 elements of episode-based models so they are
10 better positioned for integration into
11 population-based total cost of care.

12 Potential structural modifications
13 include extending the duration of episodes into
14 care bundles, making it easier to incorporate
15 long-term quality of care measures into
16 provider incentives, as well as addressing
17 perverse incentives by encouraging
18 participation and coordination between episode-
19 based models, as well as larger total cost of
20 care.

21 One of the most important elements
22 is encouraging coordination across accountable
23 entities and population-based models to improve
24 care for patients who do see providers in
25 multiple models. If successfully done, this

1 would incentivize coordination between
2 accountable entities that may be taking on more
3 or less risk.

4 For example, between ACOs, between
5 advanced primary care models and an ACO, or
6 between multiple episode-based models, as well
7 as an ACO.

8 Next slide. One of the most
9 important elements of success in a total cost
10 of care model includes timely data-sharing to
11 maximize success. Many commercial population-
12 based models include the ability for providers
13 to monitor real-time data on utilization, cost,
14 and other performance metrics.

15 Some of the challenges to effective
16 and timely data-sharing in the current
17 construct include a lack of interoperability,
18 reliance on propriety systems, lack of
19 consistent funding for data collection and
20 sharing, and lack of resources or in-house
21 expertise for smaller practices.

22 A lag of timely data on financial
23 performance in population-based total cost of
24 care models limits participants' ability to
25 accurately forecast or benchmark expenditures

1 and tempers the incentives in shared savings.
2 Many new generation ACOs have stated that
3 delays in shared savings payments make it
4 difficult to use the potential payments to
5 engage providers.

6 Some new generation ACOs left the
7 model altogether because they do not have
8 enough information about their financial
9 performance before the deadline for withdrawing
10 in the next performance year. Some ESCOs⁸ have
11 cited similar challenges.

12 For example, one provider stated,
13 "The hard part is you make decisions now and
14 you do not get a straight answer about what
15 your outcome is if the decisions that you made
16 actually worked. So you are working blind in
17 some situations for years at a time."

18 Next slide. In the next two slides,
19 we'll see some examples of care delivery model
20 innovations. For example, Program for All-
21 Inclusive Care for the Elderly, or PACE,
22 managed care plans, and integrated delivery
23 systems. So integrated delivery systems are

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

1 vertically integrated health service networks
2 that include physicians, hospitals, and post-
3 acute services, advanced primary care models
4 targeting high-risk patients, and complex care
5 management models.

6 Next slide. Some specialty model
7 innovations that are interesting and been tried
8 are CMMI's Comprehensive ESRD⁹ Care model.
9 This model allows nephrologists and dialysis
10 clinics and other providers to form ESRD
11 Seamless Care Organizations, a type of ACO
12 accountable for clinical quality outcomes and
13 spending on dialysis services for Part A and B
14 spending.

15 Other models include diabetes care
16 models. The Maryland Total Cost of Care Model
17 provides diabetes outcomes-based credit and
18 provides recognition to Maryland for investing
19 in initiatives and programs that assist with
20 delaying and preventing diabetes over a course
21 of time. Other models that illustrate this are
22 serious illness models.

9 End-stage renal disease

1 Innovative approaches in PTAC models
2 include -- several previous PTAC models
3 included innovative care delivery approaches
4 with the potential to improve quality and
5 reduce total cost of care, such as primary care
6 medical homes, specialty-based medical homes,
7 remote specialty care support of staff and
8 skilled nursing facilities, as well as nursing
9 facilities.

10 Next slide. Unaddressed issues in
11 performance measurement are significant.
12 Sorry, measurement and evaluation are a
13 significant part of developing total cost of
14 care models, identifying appropriate time
15 periods. Cost and utilization measures may
16 reflect long-term patient -- may not reflect
17 long-term patient care goals or patient-
18 centered care.

19 Addressing disparities. As we've
20 seen with COVID-19, addressing disparities is
21 such an important part of care delivery.
22 Performance-based payments may actually
23 exacerbate disparities if measures do not
24 sufficiently account for variation in patient
25 populations that the providers are different

1 archetypes in different regions of the country.

2 Data issues. Standardization of
3 data elements. Standardization of data
4 elements, as well as variation in coding uptake
5 and practice, can affect performance measure
6 viability. Selection. Issues related to
7 selection and adverse selection may affect the
8 ability to generalize the results of advanced
9 payments methodologies more broadly.

10 Refinement of restratification and
11 severity adjustment. Doing and realizing
12 return on investment for many organizations.
13 Return on investment may be difficult to
14 capture if the scope of the advanced payment
15 methodology is broad. Associated cost and
16 savings can't readily be captured or ROI¹⁰ is
17 experienced over a longer time period, making
18 it difficult for organizations to put in the
19 front-end investment.

20 Smaller sample sizes. Issues with
21 comparison and measurement for a smaller number
22 of episodes pose a substantial barrier to
23 performance-based payment tied to these

10 Return on investment

1 performance measures, particularly in rural and
2 underserved areas where these are much needed.
3 APMs must also need to adapt and include new
4 measures, as we see emerging health issues
5 occur.

6 Next slide. So questions for PTAC
7 to explore. How do we encourage integration
8 and coordination between primary care and
9 specialty providers? Which care delivery
10 innovations are most important for increasing
11 provider accountability and quality with
12 reduction in total cost of care, with broad
13 populations, as well as patients with multiple
14 chronic conditions?

15 How to best integrate episode-based
16 or condition-specific models within population-
17 based accountability care models? How do we
18 integrate referrals for health-related social
19 needs and embed health equity by addressing
20 social determinants of health within all
21 models? How do we balance trade-offs involved
22 in designing population-based total cost of
23 care models that provide best value to
24 patients? And finally, how to encourage and
25 meaningfully support more providers in

1 participating in value-based care and
2 transitioning to population-based total cost of
3 care models?

4 Next slide. Thank you, Paul. I
5 will go ahead and hand it over to you.

6 CHAIR CASALE: Thank you, Chinni.
7 So before I open it up to the full Committee,
8 I'm just going to first ask the other members
9 of the PCDT, Walter, Larry, Laurant, and Lee, if
10 you have anything to add to Chinni's excellent
11 presentation. So please turn your -- flip your
12 name placard on its end just so I know that you
13 would like to make a comment. Any comments?
14 Larry, start with you.

15 DR. KOSINSKI: I'll start, break the
16 ice and make the comment. The complexity of
17 transferring risk from an organization down to
18 individual providers appears to be one of our
19 major challenges, and we can find entities to
20 accept that global risk, but how do you -- the
21 only way you can really integrate care between
22 primary care and specialty care providers is if
23 they're also sharing in the risk. Current
24 models today are heavily skewed towards primary
25 care having capitation, and specialists still

1 being paid discounted fee-for-service.

2 The other major challenges here in
3 design are that not enough of a percentage of
4 the total revenue of specialists is coming out
5 of value-based care arrangements. We have to
6 reach that critical threshold in revenue to
7 specialists, so that they become part of the
8 solution in the care. So these are all
9 significant challenges. I don't have answers to
10 that, but hopefully our expert speakers later
11 on today will give us some light.

12 CHAIR CASALE: Thanks, Larry. Any
13 other comments before I open it up? Okay,
14 Lauran.

15 VICE CHAIR HARDIN: So I'll just
16 briefly add one of the really interesting
17 things as we look at total cost of care equity
18 is in social determinants of health, is where
19 does the payment belong as we move out across
20 the community and partnership with multiple
21 providers that we haven't thought of as part of
22 our integrated system?

23 So some of our speakers today will
24 be addressing that, and it's a very important
25 component as we look at really embedding equity

1 in all of our models.

2 CHAIR CASALE: Thanks, Lauran. I'm
3 going to open it up now to all members. So
4 Angelo?

5 DR. SINOPOLI: Yeah. I would just
6 add to some of the comments, that it's not only
7 figuring out how to include the specialists,
8 but the specialists that are still attached to
9 the hospitals. How do we include the hospital
10 in that risk too, because they typically
11 control the resources, the money, the budgets,
12 et cetera? So --

13 CHAIR CASALE: Agree. By the way,
14 Bruce and Chinni, if you have comments, just
15 raise your hand and let us know that you have
16 one. Other comments from Committee members?
17 I'd say one of the things, there's a lot of
18 great information that was presented, and but
19 along the lines of how to cascade that
20 accountability, and into what -- how do you --
21 and at what level, you know, you can have an
22 accountable entity, but then at the sort of the
23 rubber hits the road as we like to, at the
24 provider level.

25 How are they going to feel

1 accountable, and how do you do that within a
2 total cost of care model? Again, I'm not sure
3 the best way to do it, but I know that, you
4 know, it often starts with attribution, which
5 we talked about a lot. So that the provider
6 actually understands who they're accountable
7 for.

8 I think also mentioned by Chinni in
9 the presentation is around adequate risk
10 adjustment, because we know in the past, in the
11 days of HMO¹¹, there was sort of shifting of
12 high-risk patients as a way to manage a
13 population which, you know, only made
14 disparities worse rather than trying to
15 address them.

16 So you know two, in my view,
17 important issues that sort of underpin a lot of
18 this. So hopefully we'll hear more from, you
19 know, during the day around lots of areas, but
20 particularly I'm always thinking about the
21 provider at the provider level. For them to
22 participate, they have to understand, you know,
23 who their patients are, adequate risk

11 Health maintenance organization

1 adjustment, and then how do they understand
2 their accountability within the system.

3 DR. LIAO: Great presentation,
4 excuse me, and I had a question really maybe
5 for the whole Committee, but maybe starting
6 with the PCDT. I like that schematic that was
7 shown about the care delivery trade-off.
8 There's always put and takes there and, you
9 know, a few slides later when we talked about
10 picturizing kind of what that would look like.
11 There were a few boxes about care pathways and
12 different delivery models.

13 So I'm wondering in the work to put
14 this report together, was there anything about,
15 as we think about those arrows, showing, you
16 know, flexibility in the care delivery model
17 design, but potential limitation in beneficiary
18 choice? Was there also anything we heard
19 related to changes in how clinicians practice,
20 you know?

21 There may be flexibility in the
22 delivery model design, but there may be a
23 desire to reduce unwarranted variation. So
24 what would that look like as clinicians
25 practice, as we move to the right of that

1 schematic, particularly as we can braid that
2 together with this idea of cascading
3 accountability? So, curious, are there any
4 thoughts or comments that came up there?

5 DR. PULLURU: Yeah, I'll take the
6 first pass at that. So one of the things I
7 think that was articulated in there was
8 innovation and care delivery, but also looking
9 at how do we embed things like telehealth and
10 digital care, both synchronous and
11 asynchronously, and when combined with a care
12 team that would actually leverage all of, you
13 know, the example with the pharmacist, that
14 would leverage all of the touch points that a
15 patient has.

16 But not just their physician or
17 provider, but with the entire health care
18 system in order to effectualize that care. I
19 think that was sort of the innovation that was
20 discussed, you know, when we were kind of
21 deliberating.

22 CHAIR CASALE: Lauran.

23 VICE CHAIR HARDIN: Josh, I'd just
24 add that across the country, in addition to our
25 research and what I'm seeing in practice. So

1 it's definitely weaving systems together, so
2 it's no longer a problem to have a behavioral
3 health visit occur in the primary care office
4 and weave those together in the same day, and
5 the same in the community.

6 So right now, homeless services, for
7 example, are separate from health care
8 services. When you weave them together into an
9 integrated system, you stabilize the population
10 much quicker. People get the care in the site
11 where they want to receive it and where they
12 spend the majority of their time, and there's
13 efficiency then amongst providers, and then you
14 get the results.

15 DR. LIAO: And I think that speaks
16 to, I think, that schematic right below that
17 about the payment trade-offs, thinking about
18 how do we then extend within the first slide,
19 about covered services, and how does that come
20 together and --

21 VICE CHAIR HARDIN: Yes.

22 DR. LIAO: --Chinni's point about
23 telemedicine, you know. Is there a shift in
24 how we think about paying for things in the fee
25 schedule and elsewhere? I think that was

1 something that came out, and the schematic
2 helped me kind of see that, so I appreciate
3 that.

4 DR. LIN: Yeah. Just to follow up
5 on what's been said, one of the things I've
6 heard and I think we all know from our
7 practical experience is in the U.S., care
8 follows finance, and as a result, incentivizing
9 the frontline providers in the appropriate way
10 in both quality and cost performance is super-
11 important.

12 That's why we're really excited to
13 hear from our subject matter experts today, who
14 have really innovative care models, but also
15 payment models to support those care model
16 innovations. I think often what we see are care
17 models that are very successful from a quality
18 and patient care perspective, but if not linked
19 with the appropriate payment model, they fail
20 to survive.

21 CHAIR CASALE: Yeah, I would agree
22 with that. I'm thinking of many of the primary
23 care providers in my organization are still in

1 a very fee-for-service RVU¹²-based system, and
2 you know, as busy as their each encounter is
3 and all of the things they need to do, it's
4 virtually impossible for them to be thinking
5 more broadly.

6 So how does, you know, how to switch
7 that payment model so that they can actually,
8 you know, think around the population that
9 they're accountable for? So we're looking
10 forward to hearing from our speakers today
11 about all of that. Other questions or comments?
12 If not, I want to certainly thank Chinni,
13 Walter, Larry, Laurant, and Lee.

14 Extremely helpful background to set
15 the table for our discussion today. So at this
16 time, we're going to take a break until 10:30
17 Eastern Standard Time. Please join us then.
18 We have a terrific lineup of guests for our
19 first listening session of the day.

20 (Whereupon at 10:16 a.m., the above-
21 entitled matter went off the record and resumed
22 at 10:31 a.m.)

23

12 Relative Value Unit

1 * **Listening Session on Assessing Best**
2 **Practices in Care Delivery for PB-**
3 **TCOC Models (Part 1)**

4 CHAIR CASALE: Welcome back. I'm
5 excited to begin our first listening session.
6 Chinni and the PCDT helped us level set with
7 helpful, extremely helpful background
8 information. Now we've invited four outside
9 experts to give short presentations on best
10 practices for total cost of care models based
11 on their experience.

12 You can find their full biographies
13 on the ASPE PTAC website. Their slides will be
14 posted after the public meeting as well on the
15 website. After all four have presented, our
16 Committee members will have plenty of time to
17 ask questions. Presenting first we have Dr.
18 Debbie Zimmerman, who is the corporate chief
19 medical officer from Lumeris. Please begin
20 Debbie and welcome.

21 DR. ZIMMERMAN: Thank you. So first
22 slide please. I'm going to talk today about a
23 total cost of care model in a Medicare
24 Advantage population. I don't see my slides.
25 Am I, maybe I'm --

1 CHAIR CASALE: I think they're
2 putting them up. They're just --

3 DR. ZIMMERMAN: Okay. I'll do the
4 introduction and that will be good.

5 CHAIR CASALE: Okay, thanks.

6 DR. ZIMMERMAN: So we're talking
7 about a Medicare Advantage population. One of
8 my roles is as chief medical officer of Essence
9 Healthcare, which is a Medicare Advantage
10 health plan in Missouri and Illinois. It was
11 started by physicians, so first slide would be
12 great. It was started by physicians with the
13 idea that physicians and health plans working
14 together can really provide better care to
15 Medicare beneficiaries, and I think we've been
16 able to prove that over time.

17 So I'm going to talk a little bit
18 about that model, and it is really based on
19 partnering with physicians around managing
20 total cost of care, of course balanced with
21 quality and access. So this first slide is
22 like -- this is the take-home message, right?
23 These are the learnings.

24 On the right-hand side are our
25 outcomes. So just to say okay, have we been

1 able to achieve the results that we're looking
2 for, and we think of it in terms of the Triple
3 Aim Plus One, right? So we do see per capita
4 costs in our population when we compare to
5 traditional Medicare. Risk-adjusted, adjusted
6 for age, gender, you know, geography, risk,
7 chronic conditions, et cetera, we were able to
8 lower costs by 26 percent. I'm going to talk a
9 little bit about how that happened.

10 Quality. Well, we've been four and
11 a half stars now, those of you that know star
12 ratings, an imperfect measure of quality, but
13 it's a reasonable one. Measures quality of
14 care and quality of service, which is the way
15 we think about it, right? We're actually a
16 five-star plan this year, so very excited about
17 that.

18 We've got the consumer experience,
19 five-star, and PTAC survey and a member
20 satisfaction survey, very low disenrollment.
21 So evidence of a great consumer experience and
22 our providers are very much aligned with us.
23 So given those outcomes, what is it that drives
24 those outcomes, and I know we're focusing on
25 that first one around total cost of care.

1 So what did we think drove those
2 results? So we did a study. The way our plan
3 works is every physician is in a medical group,
4 because in order to have total cost of care
5 incentives, you really need an actuarially
6 credible population, so you have to aggregate
7 lives. In addition, one of our drivers we'll
8 talk about is that you sort of need that
9 learning environment and mentoring environment.
10 You need that in order to perform work, right?

11 So we looked at each of these
12 groups, and we said what were the drivers of
13 performance, and we used total cost of care as
14 the outcome, and these were the six drivers,
15 and these six drivers actually predicted 90
16 percent of performance, because there's large
17 variation between the groups we looked at.

18 I'm going to go through each of
19 these. That's really what I'm going to talk
20 about today. So not surprising first to aligned
21 incentives. The first one is that contract
22 between the payer and the provider
23 organization. Second is, how does it trickle
24 down to the individual physician? How am I
25 incentivized?

1 The third one, which is the biggest
2 lift, is actually changing the way care is
3 delivered, and we spent a lot of our time
4 thinking about that, and that is the heaviest
5 lift. We think core to that is the delivery of
6 accountable primary care. We think that the
7 biggest lift is changing the way primary care
8 is provided, but the rest of the delivery
9 system needs to change as well.

10 Enterprise engagement means there
11 needs to be some commitment, right? If I only
12 have a couple of my patients that are in a
13 value-based care, a total cost of care
14 contract, and the rest are in fee-for-service,
15 I'm not going to make the changes I need to
16 make in my practice. As a health system, I'm
17 not going to make the changes, the investments
18 that need to happen if I don't have that
19 commitment.

20 Leadership in government, really,
21 really key for all the physicians in the group,
22 right? Getting people to change behavior is
23 very hard. Getting physicians to change
24 behavior, potentially harder. You really need
25 great leadership, and then lastly the right

1 information. So I'm really going to talk about
2 these things. These are what I think is core
3 to total cost of care management.

4 So the next slide. I already
5 described on the left-hand side our model. Our
6 model is every patient has accountable primary
7 care, but accountable primary care is in the
8 group, and every group is in a value-based
9 contract. All of them, 100 percent have total
10 cost of care incentives balanced with quality
11 and access.

12 Complete, complete transparency.
13 The payer and the physician groups are totally
14 aligned. Everything is included in that
15 contract, and they understand exactly how it
16 works. And we invest. We're going to talk a
17 little bit more about that, so next slide.

18 A great example of what does it mean
19 to manage total cost of care? We spent a lot
20 of time saying what's the difference between an
21 unmanaged population and a managed population,
22 because the more we know about that, the more
23 we know what programs to develop, the more we
24 know where to focus.

25 This basically says risk score on

1 the X axis, cost on the Y axis, compared to
2 traditional Medicare. Lower costs for high-
3 risk patients. We all know that. Spend a lot
4 of time, complex case management, end of life,
5 reducing readmissions. We know that. The
6 thing that warms my heart that really speaks to
7 population health is you have to invest in the
8 low-risk patients, significant increase in
9 investment and services in those lower-risk
10 patients. That's population health, right?
11 Everybody.

12 We've never seen a medical group be
13 successful in total cost of care in Medicare,
14 if they don't see at least 95 percent of their
15 patients once a year. It just doesn't work.

16 The next slide talks again about how
17 this 26 percent reduction occurs, but it's not
18 an overall equitable reduction. Decreased
19 inpatient, increase outpatient, decreased
20 specialty, increased primary care. It really
21 does change the distribution of costs.

22 Next slide, please. Talk really
23 quickly. You'll be able to get a chance to
24 read these slides, and you can certainly ask
25 questions. But I'm going to talk quickly now a

1 little bit about each of these different
2 drivers. On the left-hand side, the aligned
3 incentives between payers and physicians.

4 We've talked about it, total cost of
5 care, complete transparency, making sure that
6 the level of risk meets the providers where
7 they are, putting a provider group at full risk
8 and having them pay the payer back just is not
9 a sustainable model, and then really investing
10 and helping them perform is really key.

11 Again, balancing those total cost of
12 care incentives with quality and access is also
13 really, really important. And then on the
14 right side how it trickles down. We spend a
15 lot of our time working with physician groups.
16 It's out of our control how they pay their
17 docs. But we spend a lot of time working with
18 them on how to put in place a really fair and
19 equitable compensation model that incentivizes,
20 you know, shared learning, shared
21 accountability, improvement of everybody,
22 right?

23 You don't just want to reward those
24 that are high-performing. You want to figure
25 out how to take, we like to call them high-

1 volume, high-opportunity providers, those --
2 and how to mentor them and improve their
3 performance.

4 So a mix of, we're a group, we're
5 sharing together in how we perform. That makes
6 us accountable to each other, but also I've got
7 to have some skin in the game as an individual
8 physician, right? So we spent a lot of time
9 talking about that with our groups.

10 Next slide. This one could be a
11 whole hour, and 10 minutes is tough to fit it
12 in. This is really how do we change the
13 delivery of primary care, and how do you change
14 the way care is delivered? We spent a lot of
15 time. Yes, care management programs, those
16 described on the right are really important.
17 In my experience, if you don't change the way
18 care is provided, these care management
19 programs will not get you to that 26 percent
20 reduction in overall costs.

21 That physician and that patient,
22 that APP¹³ and that patient, that team and that
23 patient, you have to change the way that care

13 Advanced practice provider

1 is delivered, and you have to change the way
2 obviously that patient also is caring for
3 themselves. So really, really important.

4 We've spent a lot of time and
5 defined what we think the hundreds and hundreds
6 and hundreds of activities are that are
7 necessary to deliver accountable primary care,
8 what the attributes are to deliver accountable
9 primary care, and we work very hard with groups
10 to make this change.

11 Next slide. This is really just a
12 description of some of the investments we make.
13 We put feet on the street. We put people in
14 the offices with one purpose and one purpose
15 only, and that's to help them change their
16 practice to produce those outcomes that we
17 talked about earlier. That's everything from
18 the way they schedule to, you know, pre-visit
19 planning, daily huddles, you know, how to
20 actually work with your team.

21 So everybody practices at the top of
22 their license. How to work with APPs and make
23 sure that your, you know, your patients are
24 getting the best care possible. We have
25 something called rapid practice transformation

1 where we work with offices to help change the
2 way they practice, and we even have a boot camp
3 for providers.

4 Welp, that's my time. Next slide.
5 I have my, I had my timer on. So okay. I
6 cannot emphasize leadership and organization.
7 Really key, I already said. Key, we invest in
8 these. You need mentors.

9 Next slide. This might be last one.
10 Oh, you can skip this one. But it's really
11 important that you have the right structure and
12 that data does trickle down, and the last one
13 is having the right information. I need to
14 know how I'm performing at the population
15 level, because if you ask me, I think I'm doing
16 great. I need to see where my opportunities
17 are as a system and as an individual physician,
18 and then when I have that patient or individual
19 in front of me, I need to know about that
20 individual.

21 What are their gaps in care? What
22 is their care across the continuum? Have they
23 been taking their medications? Have they been
24 in the emergency room? What specialists have
25 they seen, and we believe need to have insight

1 into the cost of care? How can we hold
2 physicians, providers accountable for the cost
3 of care if they don't have insight into the
4 cost of care?

5 So in our model, they have that
6 ability to drill down to the claim level to see
7 the cost of care. I think that's my last
8 slide.

9 CHAIR CASALE: Thank you, Dr.
10 Zimmerman. Great presentation. We're saving
11 all questions from the Committee until the end
12 of all presentations, so we'll hold our
13 questions for now. So next we have Dr. David
14 Kendrick, who is a principal investigator and
15 CEO of MyHealth Access Network. Dr. Kendrick,
16 please begin.

17 DR. KENDRICK: Thank you for
18 inviting me to give this presentation today.
19 I'm the CEO of MyHealth Access Network and the
20 Health Information Exchange for Oklahoma. I
21 also chair the Department of Medical Infomatics
22 and just awaiting my slides here. Other
23 disclosures. Immediate past chair of the board

1 of directors for NCQA¹⁴ and also -- next slide,
2 and also on the board of something called the
3 Patient-Centered Data Home.

4 Next slide, please. Next slide. So
5 our experience with the models from CMMI is
6 pretty extensive. We were originally in CPC¹⁵
7 Classic, CPC+, AHC¹⁶ as well and now entering
8 into Primary Care First, and so these are
9 hopefully practical lessons learned from on the
10 ground work supporting, really picking up where
11 Dr. Zimmerman's last slide ended, which is with
12 information technology infrastructure.

13 Next slide, please. So there are
14 five categories of lessons learned I want to
15 convey to you today with some sub-bullets, and
16 I'll try to get through them all.

17 Next slide. So the first was multi-
18 payer models. We've really enjoyed those and
19 CPC Classic -- I'm not sure. Where am I? All
20 right. So in -- back one, please. Thank you.
21 So in the CPC Classic, of course we had
22 multiple payers, and one of Dr. Zimmerman's

14 National Committee for Quality Assurance

15 Comprehensive Primary Care

16 Accountable Health Communities

1 principles, most of the patients and every
2 participating practice were in the model, and
3 that also brought lots of infrastructure to
4 bear.

5 However, it also created a burden
6 for community convening and governance, to help
7 those private commercial payers work together
8 with a large, one of the largest federal
9 government agencies to do this work.

10 Next slide. And the -- on the model
11 execution side, so now we're into the weeds of
12 what technical changes we were able to make,
13 first, the scope of data available to providers
14 is critical.

15 Next slide. And we always thought
16 about claims data being a mile wide but only an
17 inch deep, and the data in each clinic being a
18 mile deep but only an inch wide. So real
19 patient data looks like this, and this is the
20 role of our organization, is serving as a help
21 data utility, to make sure that the full
22 picture of each patient's care is available,
23 and of course the more -- the sicker the
24 patient, the more fragmented their data, and
25 that's really the theme of our work.

1 Next slide. Then of course 20
2 percent of commercialized changed payers every
3 year, which essentially is a death and birth
4 event from the perspective of that payer with
5 data.

6 Next slide, please. We quantify
7 that data rigorously in -- that fragmentation
8 rigorously in Oklahoma. We show about 70
9 percent of every patient encounter, I mean 70
10 percent of every patient seen, has data in more
11 than one clinical location. That's actually
12 over 90 percent now, we've updated it.

13 This corroborates, is corroborated
14 by data from MyHealth that show that the
15 average PCP¹⁷ has to coordinate care with 225
16 other providers in 117 other organizations,
17 which makes this infrastructure critical.

18 Next slide. And you have one
19 chronic disease, that numbers goes up. Two
20 chronic diseases is virtually 100 percent
21 fragmentation.

22 Next slide, please. Even when we
23 take large EHR¹⁸ vendors, including Epic and

17 Primary care provider

18 Electronic health record

1 Cerner, that fragmentation is about the same,
2 about the same 70-30 split, and it only grows.
3 That fragmentation only grows.

4 Next slide. This is our network in
5 Oklahoma. We have more than 1,400 locations
6 connected with live flowing clinical data, as
7 well as claims and other types of social needs
8 data. More than 110,000 clinical encounters a
9 day statewide, and as you can see, if you read
10 the bottom, it's more than just hospitals and
11 clinics.

12 We're talking about mental health
13 facilities, pharmacies, long-term care, urgent
14 care and even social service agencies, and this
15 is critical because just looking at EHR data
16 doesn't get this job done.

17 Next slide, please. However, the
18 data in MyHealth looks like this. These are
19 patients who received care in Oklahoma at some
20 point in the last two or three years, which
21 means these patients are moving around, and we
22 have to have a national look at this data in
23 order to provide comprehensive care.

24 Next slide, please. We provide
25 patients and our providers with a common look

1 at a patient chart. It's a summarized version.
2 It's cleaned up and organized across all of
3 those sources of data, clinical data.

4 Next slide, please. The next
5 concept aside from data is that patient
6 attribution is a difficult concept for
7 providers, and it's not accounted for usually
8 in the internal analytics of the EHR.

9 Next slide, please. So what happens
10 here is MyEHR tells me about patients I've seen
11 in the last 12 months, but Blue Cross thinks my
12 patients are attributed via a different set of
13 logic, and Medicare models each have their own
14 models and Medicaid, and each commercial payer
15 assigns patients to me differently.

16 So you can see that quick, very
17 quickly providers have a majority potentially
18 of the patients they're obligated or
19 accountable for outside of their line of sight.
20 By "line of sight," I mean they're not seeing
21 them automatically in their quality measures,
22 and they're not seeing them in their
23 denominators.

24 Next slide, please. Alerting in
25 sentinel events, of sentinel events is

1 critical.

2 Next slide, please. So this is care
3 fragmentation alerting, somewhat like ADT¹⁹, an
4 advanced version of ADT alerting. Tells me of
5 all my patients seen or touched in the last 24
6 hours and what activity that was, no matter
7 where it was.

8 Next slide. Next click please. 30
9 days readmission monitoring. Tells me
10 immediately when my patient registers for care
11 somewhere or an impending 30-day readmission,
12 whether it's in ER²⁰, urgent care, et cetera.

13 Next slide, please. Performance
14 measurement and reporting. Our lesson learned
15 here is that community-wide quality measurement
16 is required to assess true performance results.

17 Next slide. So MyHealth serves as a
18 health information exchange, and health payer
19 utility is a trust third party for measurement.
20 We sit in between the payer and the provider,
21 and indeed among in between the social service
22 agencies as well, and then in that capacity
23 serve as both the health information exchange

19 Admission, discharge, and transfer

20 Emergency room

1 in an all-payer claims database. We're able to
2 take the most relevant and recent data from
3 multiple sources to calculate the quality
4 measure, and here's why that's important.

5 Next slide, please. So recall this
6 diagram. These same patients, if they're all
7 diabetes, have diabetes, they're going to have
8 multiple hemoglobin A1cs taken over the course
9 of the years in all the different clinics where
10 they work, where they are seen.

11 Next click, please. And as you can
12 see, each of those EHRs are going to report a
13 completely different set of quality results,
14 based on the hemoglobin A1c that they can see.
15 It's the classic blind man and the camel
16 problem, and they're each going to describe
17 different components of the animal.

18 And so that -- what the problem is
19 here I've got four patients. I've got 11
20 different measures of performance. Which one
21 is true? Well, the fact is none of them are
22 true.

23 Next click, please. However, that's
24 the state of the art today. So if you take
25 that table, turn it on and decide that's the

1 upper left chart, you can't add that up to a
2 population number. You can't tell me at the
3 belly button level what performance is for this
4 population, whereas in a Health Information
5 Exchange, the health data utility, we take the
6 most recent result for each patient and
7 uniquely calculate that patient's status.

8 Next click. And so in Oklahoma, we
9 know everybody who's in control, out of
10 control, or excluded from a measure, and then
11 we can use our attribution logic or the
12 attribution logic provided by each of these
13 stakeholders to determine what the performance
14 is, and you can see each of those calculations
15 of performance on the right. They're very easy
16 to make, once you apply the attribution logic.

17 This is the way we handle quality
18 measures. You can see there are also
19 geographic regions there. That's public health
20 basically, and even employers engage.

21 Next click. Other things about
22 performance measurement. One of the real
23 downsides to total cost of care models is this
24 incentive it creates to fire the sickest
25 patients and avoid having sick patients on your

1 panel.

2 So I think there's an opportunity
3 here to incent providers to take on the sickest
4 patients, if you start to measure and reward
5 deltas in performance. Counts of patients that
6 improve versus counts of patients who did not
7 improve, and start to apply that approach to
8 measurement at least for a component of the
9 model.

10 You should use common metrics across
11 all models, and that goes without saying, and
12 more rapid and interim final results so that we
13 don't have to end the model, lose all the
14 infrastructure, and then scramble to rebuild
15 it. We really need more real-time quality
16 measurement and so on, and that's possible with
17 this infrastructure.

18 So next click. Some specific model
19 feedback. Of course, we have the cost models
20 that we can report on by service line, and this
21 is across all payers. That's critical for
22 practices to understand and for them to study
23 each payer's proprietary reports.

24 Next click. So the next click, next
25 set of items are about model-specific results.

1 So CPC and CPC+, we found - next click -
2 effective care coordination requires health
3 information exchange, and we also submit
4 electronic referrals.

5 We studied this extensively starting
6 in 2007, and this was really the process of
7 making referrals of patients across a
8 community, especially where patient referrals
9 are happening outside of an organization.

10 We found thousands of referrals that
11 were simply dropped, and everybody's aware that
12 at the end of the year, staff are on the phones
13 calling clinics, trying to close loops on
14 referrals simply to meet that metric. That's
15 artificial in our opinion.

16 Next click. So we studied and found
17 that there are about 25 unique states a
18 referral could be in, and if you have an
19 electronic hub in the middle that could monitor
20 these states, next click, you could have a
21 workflow like this wherein the sending and
22 receiving provider, whether they're a PCP or a
23 specialist, doesn't matter.

24 But sending and receiving can
25 coordinate all the steps of that referral, and

1 even feed that back into the electronic health
2 records system.

3 Next click. Then we were able to
4 demonstrate significantly improved rates of
5 loop closure happening behind the scenes with
6 the machines handling tracking of the results
7 of that, rather than labor-intensive phone
8 calls.

9 Next click. The next item here was
10 to leverage that infrastructure to do
11 electronic consultations, to enable specialists
12 as consultants to triage the cases, to make
13 sure they needed to see them before they saw
14 them. This has become critically important to
15 practices when they take on risk, and what we
16 were able to demonstrate using this workflow -

17 Next click, was a significantly, a
18 significant cost reduction within each patient
19 from before to after their consultation, as
20 well as across all populations, those who
21 received the electronic consult versus those
22 that did not for \$130 PMPM²¹ cost savings,
23 comparing those two populations.

21 Per member per month

1 Next click. We also were a part of
2 the AHC model. Next click. We actually were
3 able to put in place a model that could reduce
4 provider burden for screening social
5 determinants of health.

6 So this shows that just like
7 clinical data is highly fragmented, so too is
8 social services, social determinants data, and
9 you can see these - if a patient needs a food
10 pantry, they are very likely to need housing or
11 transportation or other social services. So we
12 set about trying to defragment this data as
13 well.

14 Next click. We put in place a
15 mobile screening system triggered by what we
16 uniquely knew as a health information exchange,
17 that is, the patient registration for care,
18 delivered a screening to the patient's phone
19 they complete while in the waiting room in
20 under three to four minutes. They complete
21 that screening. We score it immediately.

22 Next click. Next click please.
23 Then if they're positive for a social need, we
24 have a database of almost 5,000 community
25 services across the state of Oklahoma tailored,

1 and we're able to deliver back - next click -
2 to the patient's phone a tailored referral to
3 meet their needs as closest to them or nearest
4 where they're sitting physically at that time,
5 and they can simply click a link and be talking
6 to the food pantry or the housing service while
7 they're still waiting to be seen in the
8 emergency room or the clinic.

9 We also feed this data back into the
10 practices so they're aware of this information.
11 Next click. So we've now offered more than 2.8
12 million actually offers for social needs
13 screening. We've had over a half a million
14 responses, and we've dealt with 100,000 social
15 needs at this point and referred them for
16 services.

17 This scaled very well and turned out
18 to be a COVID-proof process, as people had
19 their phones even during telemedicine.

20 Next click. And so we can tell by -
21 very granularly where social needs are by sites
22 of care. Next click. By payer type as well,
23 and we show of course even commercially insured
24 patients have a 17 percent rate of social needs
25 in our community, and this is of great interest

1 to those populations.

2 Next click. So we've demonstrated
3 we can work with clinical data, claims data,
4 and now social determinants of health data. We
5 put the three together into this site, the
6 virtual cycle of improvement.

7 Our biggest challenge now is that
8 these models are ending, and so our social
9 needs screening program has nowhere to go.
10 It's ending.. We're working on sustainability,
11 but all the indicators are that it's going to
12 be a positive result for the model, but at this
13 time, there is no follow-on model to extend it.

14 The same thing with CPC+. Data
15 aggregation ended for us in 2021, so we've
16 given up the ability to work with that claims
17 data unfortunately. However, when we put the
18 three together, we've been able to demonstrate
19 -- next click please -- maximal impacts.

20 So for example, when we compared
21 practices in CPC+ who also participated in AHC
22 and did the social determinants of health
23 screening, you can see the blue line there.
24 Significantly different cost trend for those
25 practices.

1 Next click. And utilization of
2 emergency rooms among the practices who
3 participated in the social determinants of
4 health screening, as well as CPC+.

5 Next click. So the sweet spot is
6 putting all of these together, and next click.
7 You can see the three on the left. The daily
8 visits of my patients on the upper right, the
9 total cost of care in the middle on the right
10 is the trend of cost spend, and the lower right
11 is the trend of this patient's social
12 determinants of health needs, social needs, and
13 then I'll start to wrap it up.

14 Next click. Same patient --
15 different patient, different cost trend,
16 different emphasis. Next click. And so -- next
17 click. What we were able to show was that
18 dwell time was one of the most important things
19 as we move from CPC Classic to CPC+. Those
20 practices in red moved through CPC Classic into
21 CPC+ and had a different start time.

22 So I became convinced that the dwell
23 time in these models was one of the most
24 important interventions, and over time,
25 everyone could achieve these results if they

1 just had enough exposure to it.

2 Next click. This was the same
3 information but for cost trend. Next click,
4 and then I'll close.

5 So next click. So one of the things
6 that I, we've observed in our community is we
7 spent 10 years building this infrastructure
8 hand-in-hand with these CMMI models, using them
9 as the direction to build this infrastructure,
10 and really believe that this serves as a great
11 laboratory for rapid start-up of these models,
12 quick evaluation, and the ability to iterate
13 quickly on those results, and then finally a
14 channel through which to deploy those results.

15 Thank you, guys, for your time, and
16 I'll be ready for any questions that may come
17 along.

18 CHAIR CASALE: Thank you Dr.
19 Kendrick. So now we have Ms. Yi-Ling Lin, a
20 health care actuary and financial strategist,
21 who joins us from the Terry Group. Please go
22 ahead.

23 MS. LIN: Hi, good morning, good
24 morning. Thank you for having me today. My
25 presentation is going to be a little bit

1 different. It's going to be pretty high-level.
2 I know numbers sometimes scare people, but I'm
3 going to try to boil it down to a couple of
4 different sort of fundamental principles that
5 we've learned as we've worked with our clients.

6 I am a consulting actuary, and our
7 clients tend to be hospital systems, physician
8 groups, also payers and employer groups. So
9 we've seen this sort of thing from a variety of
10 different perspectives within the industry.

11 So next slide, please. So what I'd
12 like to concentrate on today are three
13 fundamental principles that we've noted, that
14 we think that will really move the needle if
15 people sort of pay attention to it. You know,
16 what we don't want to do is be moving our
17 chairs on the deck of the Titanic, right? We
18 really want to be steering the ship to try to
19 avoid that iceberg.

20 And so a lot of things we feel like
21 right now are geared towards trying to just do
22 short-term benefits and really lose kind of the
23 long-term focus of trying to improve the health
24 of the entire country and our populations, and
25 bend that cost curve for the long term.

1 So the first thing I'm going to talk
2 about is the use of historical data, and what I
3 feel is an over-reliance on it. Data is really
4 important, don't get me wrong, but there is
5 just this crutch that we're using that really
6 says that we are trying to look in the past and
7 expect that the past is going to be totally
8 indicative of the future, and I don't think
9 that's actually true.

10 The second thing I'm going to talk
11 about is this one-year time horizon. So
12 everything in the industry right now, the way
13 that people get paid, all the quality measures,
14 everything is on a one-year time horizon, but
15 we all know that health care is not a one-year
16 time horizon. So there's this mismatch that's
17 going on there.

18 And then the third thing I'm going
19 to talk about is the use of risk scoring. So
20 risk scoring or risk adjustment is that
21 mechanism where we try to assign a value to
22 somebody's health status, and then we actually
23 use that for a variety of purposes within the
24 industry. So these are again only three
25 fundamental principles. There's obviously a

1 lot of other things that are very important,
2 but we're going to concentrate on these three
3 today from an actuarial perspective.

4 So next slide, please. So using
5 historical data, as I said what I believe is
6 that there is an over-reliance on historical
7 data. So my experience with working with our
8 payer clients and our provider clients is that
9 they ingest all this data, which is very
10 valuable, but then they set measures for next
11 year based on those historical measures, and
12 they might say something like well we -- and
13 I'm going to use some really round, non-
14 realistic numbers but just easy to follow.

15 So my cost per patient per month is
16 \$100 from last year from my data, and let's try
17 to hold the trend so that next year the cost is
18 no more than \$105 per month per patient. And
19 so that ends up getting into contracts, value-
20 based contracts where that measure, that 105 is
21 the target.

22 Well, that's an anchor to the past.
23 That's not really a direction for the future.
24 Is \$105 really the right amount, or is the
25 right amount really \$85? Or should it be \$125

1 if we increase a bunch of preventative services
2 and things that are not being used
3 appropriately?

4 So that trend number anchoring on
5 historical data I think is misleading in the
6 sense that we really need to find something in
7 the future that says what we really believe
8 that utilization of the health care services
9 and costs in the future should be some dollar
10 amount, and then putting a plan together to get
11 some Point A where we are now, to where we
12 think we should be in the future, not always
13 anchoring to where we are or where we have
14 been.

15 The second thing that I've noticed
16 that happens is that that \$105 target amount
17 that's for next year really penalizes
18 organizations that do really well in total cost
19 of care arrangements. So what happens is, you
20 know, everybody starts, and let's say we're
21 going to start everybody at that \$100
22 historical data, and next year we're going to
23 have you target 105, okay.

24 So Provider System A meets that 105.
25 Well, great. The mechanism for all these

1 contracts is that well, now your experience
2 under our plan is \$105. So next year we're
3 going to increase that another five percent.
4 So your base is now \$105, but Provider System B
5 does better. They beat it, and they come in at
6 \$102. Well, the way the mechanism works is now
7 Provider System B is held to the \$102 plus five
8 percent.

9 And so what's happening is that
10 Provider System B is performing better, and yet
11 they're being penalized by being paid less in
12 the future, because we continue to anchor on
13 that historical mark. And so what this
14 encourages is that the systems will say oh, I
15 see the \$105 mark. I'm going to barely beat it.
16 So I make a little money on this arrangement so
17 I look like I'm doing well, but I'm really not
18 shooting myself in the foot for Year 2, Year 3,
19 Year 4.

20 And so I think we really need to
21 evaluate contracts and mechanisms for payment
22 that are based solely on trends. We really
23 need to be looking at benchmarks and where we
24 want to be in the future, and then get that
25 from Plan A to Plan B, so in a spectrum.

1 The next slide, please. I may be
2 having a lag in my Internet. Are you guys
3 seeing the next slide, that one-year time
4 horizon?

5 CHAIR CASALE: Yes, we're seeing
6 that.

7 MS. LIN: Okay, great. So the next
8 thing I want to talk about is that one-year
9 time horizon. So a lot of these contracts and
10 arrangements are based on these one-year
11 measures, as I said.

12 This is payment, this is quality
13 measures, all sorts of things. And so what
14 happens is that provider systems are constantly
15 asking, well, what's my ROI? Why should I
16 invest in XYZ care management program? Why
17 should I invest in community outreach? Why
18 should I invest in XYZ initiative?

19 And those questions, while they may
20 be very altruistic and within the mission of
21 those organizations, unfortunately, they do
22 have to answer to the financials. They need to
23 stay afloat, right? They need to stay open for
24 those populations, and so the constant question
25 of what is my ROI measured on a one-year time

1 horizon continues to come up and continues to
2 impede long-term progress towards serving the
3 population and improving care for everybody.

4 I think this one-year timeline also
5 encourages a lack of planning for years that
6 are unpredictable, right? So I'm -- because
7 it's a one-year time horizon, I'm always going
8 to assume that next year is going to be a
9 normal year. And so for insurance companies,
10 they don't tend to behave this way, and
11 insurance companies have been around 100 years,
12 some of them.

13 And so they manage things like
14 reserves, reserves meaning I have a bunch of
15 money set aside for bad years, and if I happen
16 to have a good year, I might be able to release
17 those reserves, meaning I can take that money
18 that I set aside and say, oh, I've had a great
19 year. I don't need to keep this much, right,
20 because I've had a great year. I'm going to
21 let some of that go and let that premium cost
22 go down for next year.

23 If I have a poor year, then I have
24 this pile of money on the side that can help
25 mitigate some of those high costs. So that's

1 how insurance companies manage their finances.
2 I don't see the same thing for provider
3 organizations right now. I don't think that
4 that sophistication of financial management has
5 kind of worked its way into that part of the
6 system, and so I think we need to be
7 encouraging that sort of thing.

8 The other things on the slides that
9 I've just pointed out are things that we all
10 know just from the last couple of years, the
11 crazy things that are happening, right? We
12 have supply chain issues, people having trouble
13 getting the things that they need. We have a
14 situation now where medical inflation is
15 actually above normal CPI²² which is -- or under
16 normal CPI, which is completely abnormal,
17 right?

18 Normally CPI, as we've experienced
19 in decades, is very low, and then the inflation
20 is higher. We've actually flipped right now,
21 which is very strange. And then of course, the
22 pandemic and the mental trauma and everything
23 that's going on, and we don't know the long-

22 Consumer Price Index

1 term impacts of all of that on folks, and we
2 won't know, I think, for a very long time.
3 People turning away care that they should be,
4 because they're afraid of catching COVID and
5 all these other things.

6 So next slide, please. I think this
7 is actually the last slide, so hopefully I was
8 brief enough. So the use of risk scoring. So
9 risk scoring or risk adjustment is this
10 mechanism that was invented to try to tag a
11 value on every individual that says how much
12 will this person cost either this year or next
13 year. There's two different kinds of risk
14 scoring.

15 But risk scores were developed
16 algorithmically, mathematically as a predictor
17 of cost. They don't actually reflect
18 somebody's need. So for example, a risk score
19 for some -- for a woman who is currently
20 pregnant is actually pretty high for the
21 current year because we know she's going to
22 have a baby this year, right?

23 But next year, that risk score
24 should come down, and that's the way a risk
25 score works. It is based on cost. But it's not

1 actually based on that person's health need.
2 So what happens though is that people are using
3 this scoring mechanism sort of against its
4 intentional purposes. So the intentional
5 purpose was to predict cost, and people are
6 using risk scores to allocate resources towards
7 care management or pinpoint folks that need
8 more, more outreach or things like that.

9 It is also being used for payment
10 purposes, and so as a provider system, if
11 you've taken on risk for a population, and that
12 risk score for the people you've gotten is
13 artificially low, because those people have not
14 been going to the doctor because they've not
15 been getting their preventative services. That
16 risk score is going to be low because their
17 history says that they don't use services.

18 But the reality is that person,
19 those people's health needs are actually high,
20 because they have not been using their
21 preventative care and taking care of themselves
22 for their chronic conditions, et cetera. And
23 so there's this mismatch here of predicting
24 cost and what people's actual health needs are.

25 Now I believe that a lot of risk

1 scoring mechanisms, and there's a variety of
2 them out there, are starting to incorporate
3 SDOH²³. But I caution that SDOH measures often
4 in these risk scoring mechanisms right now are
5 based on proxies, proxies such as zip code,
6 proxies based on race, proxies based on income
7 level.

8 These again are proxies, right? So
9 they don't actually say need. We're just
10 trying to guess as an overall, you know, what's
11 the need of this zip code? But that doesn't
12 actually get down to the individual level where
13 if you're using this risk score to deploy some
14 care management tools or aim interventions at
15 specific people, it's not going to get there,
16 right, because then I'd be aiming at an entire
17 zip code, not a specific person where we know
18 something is truly needed for that person.

19 So I think investments in the system
20 using risk scoring should be deployed
21 everywhere, and not just to people who are
22 covered under these Alternative Payment Models.

23 Social determinants of health

1 So often, these risk scores are only
2 used for a specific contract or a specific, you
3 know, value-based system, but what happens at a
4 provider level is you don't actually treat
5 somebody when they come in the door and say,
6 oh, you're part of this contract. I'm going to
7 do this differently, and you're part of this
8 contract, I'm going to do this other thing.
9 That doesn't quite happen.

10 And so we need to encourage adoption
11 of all these things across the entire
12 population, not tied to just specifically that
13 contract that you're in. So I think my time is
14 up, so I will hand it back over. Thank you so
15 much for having me.

16 CHAIR CASALE: Thank you. So our
17 last listening session presenter is Ms. Shari
18 Erickson, who is the Chief Advocacy Officer and
19 Senior Vice President of Government Affairs and
20 Public Policy at the American College of
21 Physicians. Her organization submitted a
22 proposal to PTAC jointly with the National
23 Committee for Quality Assurance. Shari, please
24 go ahead.

25 MS. ERICKSON: Thank you so much for

1 having me, and I appreciate the opportunity to
2 speak to the group. As was indicated, ACP²⁴
3 submitted this model, submitted a model to the
4 PTAC previously, and along with NCQA. Just as
5 a little bit of background for those that
6 aren't aware, American College of Physicians
7 represents 161,000 internal medicine physicians
8 across the country and internationally. We
9 have members that are -- they're general
10 internal medicine physicians, as well as those
11 that are subspecialists in internal medicine as
12 well.

13 So that's why we were really
14 interested in looking at models that could
15 really incorporate, involve both primary care,
16 as well as subspecialists in ways that hadn't
17 really been introduced before. Our model
18 ultimately -- go to the next slide please --
19 our model ultimately was recommended by the
20 PTAC to HHS for a five-year pilot to address
21 and refine some of the issues that were raised
22 from the review process.

23 It was identified as meeting all the

24 American College of Physicians

1 criterion that are specified by the Secretary
2 for these models, and so we're hopeful that we
3 can continue these discussions with CMMI and
4 others that may try to move some of these
5 aspects forward.

6 This is a reminder for those that
7 may not be as familiar with the model. It
8 includes sort of a process that first engages
9 the patient with their physician in a
10 collaborative manner to agree that a specialty
11 referral is appropriate, that referral occurs
12 to a specialty practice.

13 In this process, the specialty
14 practice prescreens this referral and
15 accompanying documentation to ensure that it is
16 truly appropriate, so that we eliminate any
17 potential additional challenges with regard to
18 administrative burden, et cetera, for
19 inappropriate referrals that may occur.

20 The visit then with that specialty
21 practice triggers an active phase of
22 attribution for this model, and the specialty
23 practice role may vary. They could be involved
24 in co-managing the patient's treatment, they
25 could be the primary manager or somewhere in

1 between, to ensure the most appropriate care
2 for the patient.

3 Next slide, please. So in the
4 process of developing this model and then also
5 in terms of the overall input that ACP provides
6 to CMS and other payers, et cetera, on value-
7 based and total cost of care models, we really
8 identified a number of best practices from our
9 perspective to truly help clinicians engage in
10 these types of accountable care arrangements.

11 A big one, and this is -- I think
12 many of the things I will say now are
13 reflective of things that you've already heard
14 from the other presenters. The measures really
15 need to be focused on a more limited set that
16 are truly patient-centered, actionable,
17 appropriately attributed, and evidence-based
18 for these public reporting and payment
19 purposes.

20 We also need to find mechanisms to
21 support the use of clinically meaningful
22 measures for internal quality improvement.
23 Incentivizing the use of QI²⁵ measures really

25 Quality improvement

1 will allow for greater innovation opportunities
2 and engender trust, which I know came up
3 earlier as well. There needs to be some safe
4 harbor opportunities for practices to engage in
5 innovative types of approaches here.

6 We do need to move, you know, and
7 that will take some time to evolve us to that
8 place. In the meantime though, we could try to
9 move towards measurement more at a practice
10 level than at the individual clinician level.
11 We at ACP have actually reviewed a number of
12 internal medicine-relevant measures for
13 validity, and we recommend prioritizing the use
14 of those, and also prioritizing the use of
15 measures focused on prevention, things like
16 cancer screening, tobacco, alcohol, and drug
17 use screening, et cetera.

18 The other thing that we've
19 recommended strongly is that performance
20 targets need to be provided to clinicians and
21 clinical care teams in a prospective and
22 transparent manner, and that this feedback be
23 accurate, actionable, and timely and
24 appropriate, and attribution and benchmarking
25 are critical. This came up earlier in the

1 conversation.

2 Voluntary patient attribution is
3 really a gold standard, but patient
4 relationship codes are one promising form of
5 attribution. But absent these, we need robust
6 case minimums that should be used. Usually,
7 benchmarks need to be fixed across all
8 participants. Relative benchmarks, as we've
9 seen, create really arbitrary winners and
10 losers, and we need to use the most current
11 data available, perhaps via shorter performance
12 periods, to try to move this forward.

13 Next slide, please. Other best
14 practices that we've identified and that are
15 really incorporated into our model are that the
16 primary care and specialty care practices need
17 to be able to work collaboratively to establish
18 a patient care plan. It needs to be customized
19 to account for individual patient and family
20 circumstances and preferences.

21 This leads to a more, yeah, a
22 mechanism to really truly have patients engaged
23 in their care and be able to, for lack of a
24 better word, say being more, sorry. I'm having
25 some background noise. Being more able to

1 engage in their care in a way that it actually
2 helps move forward higher quality outcomes.

3 Also tied initially, an additional
4 piece of this are care coordination agreements
5 between primary care and specialty practices.
6 It needs to be clear that all involved in the
7 patient's care understand their role and
8 expectations.

9 Actually, we just recently put out
10 just last month an updated policy around this
11 that gets into some detail as to how this can
12 occur, that some of the best practices can be
13 around this, clarifying when the specialty
14 clinician is acting as that patient's primary
15 clinician, or if they agree to co-manage a
16 patient's care.

17 There are a number of different
18 critical elements and helpful elements, et
19 cetera, that should be engaged in trying to do
20 this. Communication of data-sharing protocols
21 needs to be clearly established within these
22 agreements. These are including mechanisms
23 that ensure notifications are prioritized based
24 on urgency.

25 These are all things that can and

1 should be established up front, in order to
2 ensure that these models are successful. We
3 need clarity when the handoff needs to occur
4 back to primary care. There are templates that
5 can be put in place for these types of
6 transitions of care that do account for patient
7 preferences, and each practice should establish
8 an internal plan within that practice that
9 establishes and defines team members for each
10 of the clinical and care coordination tasks.

11 Next slide, please. So how do we
12 encourage specialty engagement? There are a
13 number of models that were spoken about
14 earlier, where we've had primary care
15 clinicians involved in them, that are a little
16 bit more challenging, I think, to engage
17 specialty care clinicians in a number of
18 models.

19 One of the issues is that these
20 models really haven't been scalable to
21 different types of specialties, and that's
22 something that, you know, we propose through
23 our medical neighborhood model, is something
24 that could occur, you know, something that
25 could be scalable but also built on a

1 fundamentally similar framework. This allows
2 it to be understandable, predictable, et
3 cetera, to the primary care and specialty
4 practices.

5 Communication and information-
6 sharing is critical. Specialty clinician
7 practice should be involved in pre-screening. I
8 mentioned this earlier, all referrals and the
9 accompanying documentation, and I discussed
10 earlier the care coordination agreements.
11 Reimbursement structure needs to be able to
12 support specialty care engagement, and there
13 also needs to -- we also need to ensure that
14 we're reducing unnecessary and duplicative work
15 and administrative burden.

16 This is why triaging those referrals
17 and having that pre-screening is critically
18 important. Total cost of care models need to
19 incorporate incentives for patients to engage
20 with those that are participating, things like
21 transportation, copay waivers, et cetera, just
22 innovative ideas that we can consider layering
23 into these models. And total cost of care can
24 be reviewed and aggregated in each practice, as
25 well as across both primary care and specialty

1 care practices.

2 Next slide, please. How do we
3 operationalize this, and this is something
4 that's laid out in that paper that I just
5 mentioned that we released just about a month
6 ago. It includes critical elements of the
7 referral that need to be included. We need a
8 prepared patient, that's again working together
9 with the patient up front to ensure that they
10 know what's happening and why.

11 We need to have patient demographics
12 and scheduling information. All kinds of
13 special considerations for that patient should
14 be and can be considered up front, including
15 their language needs, any other cognitive needs
16 that they may need to be addressed, caregiver
17 assistance, et cetera.

18 The referral information needs to
19 clearly identify what the clinical question is.
20 Why is this referral happening and have the
21 data associated with it. And we outline some
22 core data that should be incorporated in these
23 referrals. And then our referral request needs
24 to have referral tracking associated with it,
25 both in primary care and the specialty care

1 practices, again through care coordination
2 agreements, to lay out how this occurs and
3 ensure that the turnaround and the closing the
4 loop happens.

5 Next slide. And a response. So
6 moving beyond the referral itself, and that's
7 really what we delve into in our newer paper,
8 is, you know, there needs to be a clear answer
9 to the clinical question or, you know,
10 addressing the reason for the referral, and
11 there needs to be agreement this is the type of
12 thing that can be laid out through the care
13 coordination agreements.

14 What is the role of specialty care
15 both now and over a longer term for this
16 patient? And we need to confirm new and
17 existing or changed diagnoses that occur during
18 the specialty practice visit, medical and
19 equipment changes. Also any testing that's
20 occurred or additional procedures, and it needs
21 to be clear what education was provided to the
22 patient and what still is recommended moving
23 forward.

24 Are there any secondary referrals
25 that occurred, and then can any recommended

1 services or actions be done by the primary care
2 or the patients that are medical home that
3 needs to occur following the specialty practice
4 visit?

5 Can we get next slide? The other
6 thing is there needs to be a clear indication
7 of what the specialty care practice is going to
8 do. What has the patient been instructed to
9 do, and what is the referring -- what the
10 referring physician needs to do and when. This
11 is critical to successful care coordination
12 beyond the referral, and we need to find, you
13 know, easy to find and refer in the response
14 note all of these elements.

15 Next slide. Moving on beyond this
16 and really something that could be layered into
17 this type of a model is integration of
18 behavioral health, with primary care, as well
19 as with specialty care, if you think about it
20 in the context of a model such as this. The
21 collaborative care model is one model that
22 allows patients to be seen by primary care and
23 evaluated for behavioral health issues, in
24 consultation with psychiatry and then be
25 referred as needed.

1 And that's a good start, but I'll
2 say the challenge with this is that the
3 implementation of a model like this in primary
4 care is not really supported today. The up-
5 front cost to build the infrastructure to do
6 this successfully is just simply not covered
7 through the existing codes and payment
8 mechanisms that are out there right now.

9 So how can we consider integrating a
10 model such as this with the medical
11 neighborhood model, allowing even the specialty
12 care practices to engage more fully in the care
13 of patients and those with complex needs?

14 Next slide, please. The other
15 aspect I want to hit on which came up earlier
16 too in a couple of the presentations is the
17 need to address health equity and social
18 drivers of health. One of the things that ACPs
19 are calling for now and moving forward in
20 particular is payers need to prioritize
21 inclusion of underserved patient populations in
22 these models. We need to do this with every
23 single model.

24 It's just no way we can figure out
25 how to do it if we don't do it now. We have to

1 create validated ways to measure the cost of
2 caring for these patients, and I believe this
3 was spoken about earlier as well. Those that
4 are experiencing health care disparities and
5 equities based on personal characteristics, you
6 know.

7 Those who are disproportionately
8 impacted by social drivers of health. How can
9 we start to figure that out if we don't
10 incorporate them into the models moving
11 forward? And patients and practices and
12 clinicians need to be incentivized to engage in
13 innovative approaches to do this, you know.
14 There need to be safe harbors set aside perhaps
15 for those practices that really are interested
16 in taking on some innovative ways to help do
17 this within their practice.

18 And actually I'll mention that ACP
19 has more policy on this coming soon actually.
20 We have a paper being released in the next few
21 weeks that will detail some additional ideas
22 around this issue. But it's critically
23 important that it be layered in moving forward
24 to all models.

25 Next slide. I think that's it. I'm

1 finished. So I just saw my note to wrap up as
2 well, so perfect timing.

3 CHAIR CASALE: Great, thank you. So
4 thank you all so much for sharing your
5 experiences with us today. You've certainly
6 helped us cover a lot of ground during this
7 session.

8 So now I'd like to open up the
9 discussion to our Committee members for
10 questions, and just a reminder to turn your
11 tent cards up when you have comments and
12 questions. Lee.

13 DR. MILLS: Sure. Thanks so much
14 for those great presentations. I'm interested,
15 Dr. Kendrick and Dr. Zimmerman, if you all can
16 comment on both the complexity of the metric
17 universal process and the critical nature of
18 the timeliness of data, reporting, and
19 financial accountability in a total cost of
20 care environment?

21 DR. ZIMMERMAN: Sure. You want me
22 to start?

23 DR. KENDRICK: Absolutely.

24 DR. ZIMMERMAN: I'll start with my
25 menu you had on payment. So in Medicare

1 Advantage, you know CMS has done us a favor.
2 They've actually pre-defined a set of quality
3 measures that we're all working on.
4 Interestingly, there's 40-plus measures that go
5 into star ratings. We actually put about 10 to
6 15 in the physician contracts, because those
7 are the ones that we believe they can influence
8 the most.

9 Some of them are actually not star
10 measures; some of them are proxy measures like
11 the access to care measure I mentioned, because
12 we know -- for instance, readmission rate is
13 not credible even at a medical group level
14 likely, depending on how many lives they have,
15 and certainly not an individual physician
16 level. But we know that if you follow up
17 within seven days, you will reduce readmissions
18 by, you know, 63 percent in our study.

19 So what do we incentivize physicians
20 on? That follow-up. So we have those defined
21 measures, wonderful. They're, you know, many
22 of them are, you know, NCQA and we are very
23 clear on the two standard measures wherever
24 possible, proxies when we need to. But to your
25 point about the timeliness, I can't influence a

1 follow-up if I wait for a claim for
2 readmission. I can only do that if I know
3 someone was discharged from the hospital.

4 So the ADT feeds in and partnering
5 with HIEs²⁶ is really critical so that we know,
6 and we have a lot of health systems who say
7 well, we know all about our discharges. Well,
8 yeah. You know if they're within your health
9 system. Fifty percent of your care for your
10 attributed population we know occurs outside
11 your health care, your system. So we need
12 that, and I love the concept of a national HIE,
13 because patients travel, right, and so I love
14 that idea.

15 And then lastly, I'll talk about
16 timeliness for cost of care. Using claims
17 payment for cost of care, it is retrospective.
18 It is delayed. I have lots of conversations
19 with physicians to say I understand, you know,
20 it's already happened. But let's look at what
21 that trend tells us, and let's identify
22 opportunities. Let's -- it is very, very
23 valuable.

26 Health information exchanges

1 Now not to the risk adjustment
2 issue, which I loved, you know, about future
3 care. But at least we can look at trends. Do
4 we have an opportunity in inpatient and
5 outpatient? Do we have an opportunity to care
6 for heart failure patients better? Do we have
7 a Hispanic population that has a higher cost of
8 care, a higher ED²⁷ visit rate? Let's look at
9 our opportunities.

10 So that retrospective perspective, I
11 think, is okay, you know. We have a two-month
12 delay, a pretty short delay. That's actually
13 okay for that, but I need timely information to
14 be able to act on it, that discharge, that ED
15 visit. So I don't know if that answered your
16 questions but --

17 DR. KENDRICK: So okay great.
18 Thanks. So I would make three quick points as
19 well. The first one is in the current
20 measurement approach and the data availability
21 scenario, I think you've heard from all of the
22 presenters about the workarounds that have to
23 be put into place, you know, the proxies in

27 Emergency department

1 essence for social determinants and other
2 things that most get stuck with.

3 So I'm in the business of making
4 that data available in real time, and then
5 exercising, acting on that data, because of
6 course the work we're doing is not some blob of
7 1,000 patients. It's literally a million
8 decisions on a thousand patients that happen
9 every day, that we're trying to influence the
10 most complex system you can imagine.

11 So having the low-level patient data
12 on each of these domains of information is
13 critical. It's just unfortunate that our
14 current measurement approach doesn't get it
15 done, and we need to be, I think, measuring
16 patient-centric at the community-wide level
17 across all sources, and in that vein then, one
18 of the things we did was on the charter board
19 at NCQA was to focus on shifting the concept
20 from certifying and validating the measures
21 themselves, to certifying and validating the
22 data set being used to do the measurement.

1 Because the data set can be
2 certified to be complete with all sources of
3 data on the patient's record, and accurate code
4 normalization. Identity resolution can be
5 good. Then we can involve our measurement
6 approach to measure the right things, because
7 as Dr. Zimmerman was indicating, we only have
8 to find a proxy for 30-day readmission, some
9 proxy activity someone can do because there's
10 no way to accurately measure it without the
11 full community data.

12 The last thing I would mention is
13 the real-time or the more rapid availability of
14 cost of care. I was a medical director at
15 Archimedes, which is a California start-up,
16 where we did full-scale simulations of human
17 physiology and anatomy and predictions of
18 things, and one of the things I worked on
19 there, we actually got a patient done, was
20 using clinical data outputs to drive predictive
21 cost.

22 And so I really think that with the
23 live clinical data, we could arrive at some
24 conclusions and approaches that would allow us
25 to see what the cost is probably going to be

1 six months from now when we get the fully
2 adjudicated claims coming back from different
3 organizations, and that that would be a really
4 good directional indicator to provide very
5 early on in the process for providers.

6 CHAIR CASALE: Great, thank you. I
7 think Jen, you're next?

8 DR. WILER: I too want to thank
9 all of our presenters for excellent
10 presentations, and just so much valuable
11 information. My question is for you, Dr.
12 Kendrick. It is so impressive what you've been
13 able to put into place, and I think there's a
14 couple of things that we can learn from your
15 experience that I'd like to ask about.

16 You mentioned that in order to
17 create this impressive system around data
18 analytics that serves up real-time data at the
19 point of care, to help influence decisions and
20 ultimately patient outcomes, requires 10 years
21 of build and infrastructure. And I like the
22 word that you used around "dwell time", and
23 that not only creating the infrastructure is
24 important, but then letting the process work to
25 actually actualize the outcomes.

1 So this Committee talks about that a
2 lot around a couple of items, and I'd like you
3 to comment on them. The first is around
4 capital to build this infrastructure. It takes
5 -- there is risk in building the infrastructure
6 with delayed opportunity to evaluate its
7 performance. So my first question is or
8 request is to hear a little bit more about
9 capital investments.

10 And then you mentioned sadly it
11 sounds like the current payment model or
12 infrastructure will be retiring with grants,
13 and that could you -- we also talk often about
14 care model redesign, payment incentives, and
15 then obviously the last factor is
16 sustainability, where we do see high-quality
17 outcomes.

18 So my other questions or what I'd
19 like to hear more about is what's your
20 sustainability plan?

21 DR. KENDRICK: Great questions. So
22 let's see. So the last two slides that I did
23 not get to, unfortunately I took too long,
24 indicated, would have shown you that there are
25 75 other organizations like MyHealth across the

1 country that are already in existence. They're
2 not all at the same level of sophistication,
3 some more, some less.

4 But suffice to say that the work at
5 the community level within these states and
6 regions has been done to build these
7 governances. It covers about 290 to 310
8 million lives in this country already. So
9 there's a substantial infrastructure there, and
10 the good news is it's infrastructure. So it
11 wasn't built specifically to be a research lab
12 for CMMI; it was built because of the
13 interoperability pressures that ONC²⁸ faces and
14 that the providers all face to meet meaningful
15 use, and they are not just to check boxes in
16 federal government programs.

17 But we know to avoid making
18 mistakes, to avoid prescribing things patients
19 are allergic to and, you know, doing the wrong
20 procedure on the patient and so on. And so
21 that infrastructure has had a pretty steady --
22 had steady investment starting in 2009 with the
23 American Recovery Act and the beginning of

28 Office of the National Coordinator for Health Information
Technology

1 meaningful use, and even before that, as much
2 as a decade or two before that, several
3 communities around the country began building
4 an infrastructure.

5 So I emphasize that this is like an
6 interstate highway system, right? But we use
7 the term now -- we're trying to get away from
8 the term "health information exchange," because
9 it makes it feel like a health care program.
10 We're starting to use the term "health data
11 utility," to indicate that look, this is like
12 clean water or electricity. It's an essential
13 component of every community.

14 It just so happens that the work of
15 CMMI could build on top of this, could really
16 leverage these things, and that these are not
17 unicorns. They exist in many places, and again
18 I will emphasize it's that base of governance
19 and trust that has to exist in order to build
20 the technology on top. Technology is the easy
21 part generally, and we've been blessed with
22 great governance and collaboration across --
23 even when we had a state government that wasn't
24 really engaged in making this happen, the
25 community was able to pull it together.

1 So that's the answer I think
2 hopefully to your first question. I'm happy to
3 take a follow-up on it, and the second question
4 was about, can you remind me, sorry?

5 DR. WILER: Comments about
6 sustainability.

7 DR. KENDRICK: Oh yeah, yeah. So we
8 always build, you know, these organizations are
9 generally nonprofits for a reason, right? It's
10 tough to ask everybody, especially say tribal
11 health systems for their data with a profit
12 motive on the back end. So we build these as
13 nonprofit organizations, and unfortunately the
14 major funding for meaningful use to sustain
15 them and continue to grow them ended last
16 October a year ago.

17 So they're on their own now and into
18 sustainability mode. MyHealth didn't really
19 have access to those funds, but we were able to
20 bootstrap and build thanks to CMMI models, and
21 so as you can see we sort of used -- we think
22 of CMMI models as the stepping stones we've
23 used to expand our functionality, which is why
24 it's even more acutely felt when we have to
25 pull back on capabilities because the end of a

1 model has arrived.

2 There was an audible scream across
3 Oklahoma when we had to delete all of the
4 Medicare data from the CPC+ and CPC programs,
5 because we can -- what I showed you, that we're
6 great directional indicators of impact. We'll
7 never be able to finish that research because
8 we had to delete the data behind it.

9 And really the health data
10 utilities, the only place you're going to
11 enroll the commercial claims and the Medicare
12 claims together in one place to be able to
13 analyze them. So in terms of sustainability in
14 what we've done is say look, we now have a
15 shrink-wrapped product for social determinants
16 of health screening, and we sign up -- in terms
17 of lives, we think we can deliver that service
18 to everybody in Oklahoma.

19 We've already announced we want to
20 be the first state to have border-to-border
21 universal social determinants of health
22 screening and intervention. We think we can
23 deliver it for 25 cents a screening, which is
24 remarkable when you think about the labor cost
25 it would take just to do those individual

1 screenings with a human.

2 So we've put it on the marketplace
3 in Oklahoma, and we're hoping that payers and
4 health plans and programs sign up to take
5 advantage of these services.

6 CHAIR CASALE: Great, thanks so
7 much. Jay.

8 DR. FELDSTEIN: Thank you, and again
9 great presentations by all our presenters. I
10 have two questions for Dr. Zimmerman. My first
11 one is I appreciate the cost savings from a
12 fee-for-service comparison, but I'm curious.
13 Have you been able to sustain your trends year
14 over year within your plan, either cost savings
15 or reduced medical trends?

16 And my second one is what's your
17 approach to your pharmaceutical cost
18 management?

19 DR. ZIMMERMAN: Okay. So we look at
20 it -- we look at medical costs in multiple
21 ways, and that was just one that was sort of an
22 easy benchmark. But yes, we look at trend.
23 Now, you know, I hope you'll allow me to
24 exclude 2020-2021, because as I say to my CEO,
25 you know, a pandemic is not really good for

1 medical costs, right?

2 Either we're underspending because
3 people aren't getting the care they need, or
4 we're overspending because, you know, people
5 are sick. So 2020-2021, excluding those, we do
6 look at our trend year over year, and we have
7 had a significantly lower trend than the
8 industry. So if the industry was at four or
9 five percent, we were -- we were having a much
10 lower trend sometime in the one or two percent.

11 Now again, did not hold through
12 2021, so we're fingers crossed for 2022. So we
13 do look at -- we do look at other, other data.
14 The other thing that we've seen, and I'm going
15 to get your name wrong, but Yi-Ling, you can
16 speak to this too, right? We've seen different
17 areas pop up in medical cost. Like I'm old,
18 Medicare beneficiary age, so you know, I
19 remember when inpatient was the majority of the
20 spending.

21 Well, that's not the case anymore.
22 It's significant, but that's not the case
23 anymore, and we've seen pharmaceutical costs,
24 which is why you're asking I'm sure, increasing
25 both in the medical spend, specialty spend, and

1 in ambulatory pharmacy. So we do see different
2 things, you know, increasing over time, so we
3 do look at all the trend. It isn't as simple
4 as the overall trend.

5 And then your question on
6 pharmaceutical cost is I will say
7 interestingly, we have a plan in California and
8 California physicians historically have not
9 taken cost, total cost of care. You know, we
10 think they're very, very advanced, but they
11 take medical cost, but they don't take total
12 cost of care to include pharmacy. We think
13 it's really important to do both, because of
14 course it's important that people adhere to
15 their pharmaceutical regimen in order to manage
16 medical cost.

17 So we do cover things clearly as a
18 payer. We have our partner, our PBM²⁹, so we
19 can work with them on preferred networks, on
20 you know, all sorts of things there. But we
21 also work very hard to balance the pharmacy and
22 the medical costs.

23 So for instance, a few years ago we

29 Pharmacy benefit manager

1 came out with a zero copay insulin benefit.
2 Why? Because what our physicians told us was
3 insulin was putting their beneficiaries into
4 the coverage gap, and they weren't able to
5 afford it. It was really impacting their
6 overall, their health and the real cost of
7 care. So we invested and said we need to take
8 away that barrier. So we do think holistically
9 about pharmacy costs. We do traditional prior
10 auth and those sorts of things.

11 But we also spend a lot of time on
12 both technology and programs to increase med
13 adherence and then on the medical side we work
14 in areas, for instance, oncology or
15 rheumatology. We work with the specialists and
16 programs to improve the effectiveness of the
17 care that we're providing there. Did that
18 answer your questions?

19 DR. FELDSTEIN: Yes, thank you.

20 CHAIR CASALE: That's great, thanks.
21 Josh.

22 DR. LIAO: Great. Just one more
23 echo for all the great presentations that will
24 be heard. I actually have two questions for Dr.
25 Zimmerman as well, and maybe I can separate

1 them because the first one is a little bit, a
2 little bit long. But you showed some very
3 impressive results in Slide 2 and 5, and then I
4 was struck by a word after that that showed up
5 in Slides 6 and 8 around maturity.

6 This idea that, you know, right out
7 of the gate giving full risk and then paying
8 back to the payers not what we want. And I
9 think in principle that's true, and I'm
10 wondering if you can kind of give us more
11 detail around how you thought about maturity
12 with respect to incentives for early behaviors
13 for managing populations? Contrast that with
14 more mature or later incentives, or the sizes
15 of those? What were those behaviors?

16 And then kind of related to that, I
17 think you mentioned on Slide 8 that the care
18 management programs were structured in a way
19 based on maturity. So again, how did you
20 assess that, maturity in the context of care
21 management, and how do those supports change
22 over time, kind of early versus late? We'd
23 love the detail on that.

24 DR. ZIMMERMAN: This has been a huge
25 learning, right? So early on in the plan, our

1 plan was started by a group of physicians who
2 already were really good at managing total cost
3 of care. They had the infrastructure, they had
4 the data and analytics, they had the case
5 management programs, and they were really good
6 at it.

7 And it's like great, we'll just
8 provide all the right data, all the right
9 contracts, all the right, you know, and we're
10 good to go. Well, that has not been our
11 experience, and so we have learned the hard way
12 that it is not just -- of the six drivers, it
13 isn't just putting that in place, right? You
14 actually have to understand what it is, what
15 does it mean to deliver accountable care?

16 So here's what we do early on, and
17 it is a work in progress. I am not telling you
18 we have it 100 percent right yet, because we
19 just don't, and so we're all learning, and I
20 love this hearing from each other, and my
21 mind's sort of going a mile a minute.

22 But so here's what we do around
23 contracting. To put a group -- so a couple of
24 things. One is you get an actuarially credible
25 population. So if you're starting out in a new

1 market, and we're opening a new plan, and a
2 medical group only has 300 patients. It is --
3 it's not fair to put them in total cost of
4 care. Elaine, I'm assuming you'd agree with
5 me.

6 I don't know what that number is.
7 Our actuaries tell me it's about 1,500 to
8 2,000. I don't know if you'd agree with that,
9 but something like it. You need it. So first
10 of all, you have to be careful about the number
11 of lives. Even if you have the number of lives
12 to put a group at total cost of care, downside
13 risk I think is not responsible initially.

14 What we do is we thought long and
15 hard about most behaviors. Now we're using
16 Medicare Advantage as an example here, so I'll
17 use those drivers. What do you need to do in
18 Year 1? Here's what you need to do. You only
19 need to do a few things. You need to number
20 one make sure that you document the chronic
21 conditions, right? You need to document the
22 chronic conditions so that you get an accurate
23 premium the next year, but you also need to
24 know. We need to know who your diabetics are.
25 We need to know who the diabetics are that have

1 complications, and we can't manage the
2 population without that, so we need to know
3 that.

4 Second is we've got certain quality
5 metrics that the star rating Year 1 is that
6 performance period. We've got to start working
7 on those. We've got to put in place that
8 collaboration, that leadership, that shared
9 performance, that accountability, those
10 incentives, all of that in place. We've got to
11 put that in place.

12 And then it is about two things:
13 access to primary care. You've got to see all
14 your patients, and you've got to see sicker
15 patients more, and in our model we like our
16 primary care physicians to see their patients
17 at least as often as they see a specialist. It
18 isn't that they don't need to see five
19 specialists; if they need to see five
20 specialists, they need to see you just as much.
21 So we do a PCP to specialist ratio, and we look
22 at -- we look, try to get that to about one.

23 Follow-up after discharge and the
24 access to care. Call me first. Educating the
25 consumer. Making sure that they understand

1 your world, as their primary care may be
2 different than it was last year. Let's talk
3 about what I'm going to do for you and what
4 you're going to do as well. You have some
5 accountability in this too, right?

6 And then the fifth one from Year 1
7 is around managing those highest-risk patients.
8 Like let's start with those, right? Let's know
9 who they are, not necessarily just using a risk
10 score. I agree with Yi-Ling. We have, we have
11 a methodology that looks -- because there's a
12 lot of people with very high-risk scores that
13 we can't do anything about, right?

14 If you have a transplant, you know,
15 we could maximize our reinsurance and our
16 contract. We probably can't change the
17 trajectory of your disease. Who is impactable?
18 Who do we find that's impactable? Let's
19 identify those people. Let's manage those.
20 Let's put in place complex case management,
21 end-of-life programs, transitions of care
22 programs, those sorts of things.

23 But that's it. Let's work on those
24 things. Let's put those things in your
25 contract, right? And then over time evolve,

1 and that's come from a lot of learnings. So
2 maybe I answered both your questions.

3 DR. LIAO: Thanks, that's very
4 helpful. My second is I think hopefully quick.
5 I've raised this issue of kind of how alignment
6 occurs down to the level of clinicians or
7 clinical groups, and in one of your slides, you
8 mentioned that the goal for physician
9 compensation is 30 to 50 percent under value,
10 under value-based compensation.

11 I'm wondering if you can comment on
12 maybe two pieces of that. One, those results
13 that you showed, the impressive results, was
14 that at that goal? Were you able to achieve
15 those even short of it? And two, have you
16 found that, you know, the results track with
17 the level of compensation, or is there a
18 threshold that you're seeing that we would need
19 to get to to see those results?

20 DR. ZIMMERMAN: Yeah, yeah, yeah.
21 Now you're asking questions about human
22 behavior, right, and what incentivizes human
23 behavior. I think that we did see that those
24 groups that had the 30 to 50 percent
25 compensation performed better. But it was --

1 is it because that's how I'm paid? Sure. It's
2 also -- think about it, and we've heard this
3 from many presenters. It's also where
4 resources are devoted. It's also where
5 information is shared, right?

6 We're all working towards those.
7 It's a priority for me, but it also is a
8 priority for my organization. And so we're all
9 working in the same, in the same way. I do
10 like to say though that people and physicians,
11 physicians are people, are incentivized by a
12 lot of things, and let's remember that.

13 And you know, you'd like to be
14 recognized for your good performance. Here's a
15 really, really quick story. I've given awards
16 among our 12 physician groups for the highest
17 performance on clinical metrics. One year I
18 gave, and that was the year of the winter
19 Olympics. I gave medals: gold, silver, bronze.
20 I brought a little step stool in. The gold
21 team, you know, the gold physician medical
22 director stood up a little higher than the
23 other two. It cost \$35. That silver team said
24 we're going to get you next year, and they were
25 number one the next year. And we're like go

1 ahead and compete. .So don't forget that there
2 are other things. We want to do a good job.
3 Physicians, for instance, that work for a
4 health system may think very differently about
5 their goals in life than an independent
6 physician group. So we want to model that
7 compensation so it meets individual goals.

8 DR. LIAO: Thank you. As a human, a
9 physician, and a behavioral scientist, I
10 appreciate that.

11 CHAIR CASALE: Thank you. Walter.

12 DR. LIN: I also wanted to just
13 extend my gratitude to all the presenters. All
14 very informative, it was really good. My
15 question is also for Dr. Zimmerman. It strikes
16 me that one of the important tools, Essence and
17 indeed all Medicare Advantage plans have at
18 their disposal to achieve their results is that
19 of a narrow provider network, one consisting of
20 higher-quality, lower-cost providers achieved
21 through contracting and credentialing. This is
22 a tool that has historically been missing in
23 CMMI, value-based demonstration projects, as
24 one of the key tenets of CMS has always been
25 the preservation of provider choice for

1 Medicare beneficiaries.

2 My question is how essential is a
3 narrow network of providers to the success of
4 the impressive outcomes from Essence and
5 Lumeris you shared with us, and do you think it
6 is possible for CMS to move to a world of
7 value-based care without somehow limiting
8 provider choice?

9 DR. ZIMMERMAN: Yeah. Hi, Dr. Lin.
10 It's a great question and one that I think we
11 are going to be able to answer, because we are
12 going into other markets with different
13 products that will have larger networks. So
14 ask me in a year or two, and I'll have a real
15 answer for you. Now it's a hypothetical.

16 So I think than narrow, it's a
17 definition of engaged. I think you can have a
18 broad network if the physician organizations
19 are actually engaged and committed to managing
20 the population, and I will say in St. Louis you
21 know this very well. We actually have almost
22 every health system in our network, and that's
23 from a primary care perspective. And then from
24 a specialty perspective, I think the same thing
25 goes. If we have an engaged primary care, what

1 we have found is we can have a very large
2 network of specialists. We can even pay them a
3 premium, higher than market, because they're
4 going to see the more complex patients..
5 They're not going to see the, you know, the
6 sort of less complex patients so they may see
7 fewer patients.

8 But those that they see will be more
9 appropriate, and we'll make sure to give them a
10 premium for caring for those patients and
11 coordinating care with primary care. So I do
12 think we can get there without it. I think
13 those other levers are ones that we really need
14 to think about. Whether it be referrals,
15 utilization management, ability to pay
16 differently.

17 Yes, I think without some of those
18 levers, I think it will be difficult to achieve
19 those savings, and then lastly, I'll say maybe
20 we don't need to get 26 percent savings either.
21 I think we'd all like to mitigate our trend and
22 see some, we'd love to see some downward. But
23 we can all do this together and really help
24 solve this problem for our country.

25 CHAIR CASALE: Great, thanks.

1 Larry.

2 DR. KOSINSKI: Well, I'm going to
3 split the questions around a little bit and not
4 pick on Dr. Zimmerman anymore. I would like to
5 ask Shari a question, and I have to preface
6 this by saying I was one of the subject matter
7 experts on the ACP document that you
8 referenced, most of which you talked about was
9 structural.

10 But have you done much work on the
11 payment model associated with your
12 recommendations?

13 MS. ERICKSON: Sure, yeah. So, we
14 really haven't had an opportunity to do so
15 because there hasn't been an opportunity to
16 implement it within the Innovation Center or
17 with others at this point. So we'd be very
18 interested in doing more along those lines and
19 we -- and so, you know, I think that that's
20 something that it looks maybe we can have
21 somebody else who could comment on this as
22 well.

23 But we have not had an opportunity
24 to do a lot more testing of it, other than
25 what's laid out in the detailed proposal.

1 CHAIR CASALE: Dr. Kendrick, did you
2 have your hand up?

3 DR. KENDRICK: Yeah. I was just
4 going to comment. I also participated early on
5 in the development of this ACP model, and our
6 experience on the ground was that what you're
7 asking providers to do, especially in this
8 triage event that the specialist might engage
9 in, is really kind of a fee-for-service
10 activity to get their attention to it.

11 And we found that something on, you
12 know, Level 2 kind of Level 3 payment would get
13 the right level of attention to these
14 consultations to get them dealt with, so that
15 we could have a guaranteed dermatologist
16 opinion within 48 hours, for example, and we
17 did that across thousands of referrals. So
18 just to give you some, some ballpark.

19 MS. ERICKSON: And to add onto that,
20 I would say we have continued discussions among
21 our subspecialty societies to engage interest
22 in doing some testing of the model. So there
23 is interest out there along these lines should
24 we be able to move it forward.

25 DR. KOSINSKI: Thank you.

1 CHAIR CASALE: Angelo.

2 DR. SINOPOLI: Yeah. My question is
3 again for Debbie, and so thinking back to your
4 comments about the specialty care, particularly
5 in more tertiary systems for the specialty care
6 patients. So it's low percentages of those are
7 actually at-risk patients. What are you doing
8 or what have you seen in terms of being able to
9 engage those specialists to really participate
10 with a primary care doctor around driving
11 value?

12 DR. ZIMMERMAN: Yeah, it's a great
13 question. So as always, and I think you heard
14 this from all the presenters today, we're
15 trying hard to use our data to direct us as to
16 where the opportunities are. And so for
17 instance we find our -- Dr. Fusco is our
18 medical director for Utilization Management.
19 Let's just it's the three O's and the C's.
20 It's cardiology, ophthalmology, oncology, and
21 orthopedic surgery, and then we see a lot of
22 dermatology.

23 So we try to focus on where the
24 opportunity is, where is really the opportunity
25 to educate and train. It varies, but the

1 majority of time we find that specialists are
2 our best advocates here, who will meet with
3 primary care physicians and say look, you know.

4 When you're presented with this
5 problem here, let's develop, you know. We can
6 develop some clinical governance or, you know,
7 here's how you care for this patient. Here's,
8 you know, try this first. Use conservative
9 therapy first. I don't really want to see them
10 until you've done XYZ and educate them, and
11 then -- and that conversation can happen.

12 I do find a lot of -- we also, we've
13 also been using data, episode grouper data and
14 then some other data around unnecessary care to
15 identify opportunities with specialists, and to
16 me that data goes first to the specialists. It
17 does not go to the primary care to try to
18 change referral panels.

19 This goes to the specialist first,
20 number one to ensure that the data's credible,
21 number two, we need everybody to get better.
22 We will not solve this problem by saying oh,
23 we've got, you know, 30 percent high-
24 performing, you know, cardiologists. We're
25 going to send everybody there. That's not

1 going to -- that's not going to help. We have
2 to get everybody to improve. So to me, that
3 data goes to the specialists. The specialists
4 vet it, the specialists identify opportunities.
5 They work together to improve the care both
6 within their subspecialty, as well as the way
7 they interact with primary care.

8 CHAIR CASALE: Great. We have about
9 two minutes left. I have one question for Yi-
10 Ling around benchmarking. I thought you had a
11 lot of interesting comments related to the
12 challenges of using historical benchmarks. I'm
13 just curious your thoughts of alternative ways
14 of calculating benchmarks, and how do you take
15 into account improvement over time that's
16 likely to occur for those who are in a value-
17 based arrangement?

18 MS. LIN: Yeah. I think, don't get
19 me wrong, but historical data is very important
20 for getting a frame of reference, but I think
21 there's an over-reliance on it was my point.
22 And so for benchmarking purposes, we want to
23 look at where you're at, and we want to look at
24 where we think you can be. Maybe the best-
25 performing provider systems in the country,

1 looking at specific measures to say what are
2 the desirable readmission rates, what are the
3 desirable, things like that, and then -- and
4 build a path between the two. So, I don't
5 think that always anchoring to the past or to
6 your immediate results, or the results of your
7 neighbors is always the best. Let's try to
8 find what the ideal state is, where we are
9 currently at and build that bridge between.

10 CHAIR CASALE: Great, thank you. So
11 at this time, I want to thank again our panel
12 and all of our speakers. Just terrific
13 presentations. I think we could keep this
14 discussion going much longer. But we need to
15 take a break, which we are taking now until
16 1:00 p.m. Eastern Time. So please join us
17 then.

18 We have a great lineup of guests for
19 our second listening session on assessing best
20 practices in care delivery for population-based
21 total cost of care models. Thank you.

22 (Whereupon at 12:00 p.m., the above-
23 entitled matter went off the record and
24 restarted at 1:01 p.m.)

1 * **Listening Session on Assessing Best**
2 **Practices in Care Delivery for PB-**
3 **TCOC Models (Part 2)**

4 VICE CHAIR HARDIN: Good afternoon
5 and welcome back. I'm Lauran Hardin, Vice
6 Chair of PTAC. I'm pleased to welcome our
7 second listening session on assessing best
8 practices in care delivery for population-based
9 total cost of care models. We've invited four
10 outside experts to give short presentations on
11 their vision for population-based total cost of
12 care models, based on their experience.

13 You can find their full biographies
14 on the ASPE PTAC website. Their slides will be
15 posted there as well. After all four
16 presentations, our Committee members will have
17 plenty of time to ask questions. Presenting
18 first, we're honored to have Dr. David
19 Grossman, who is the interim Senior Vice
20 President of Social and Community Health at
21 Kaiser Permanente. Please begin, David.

22 DR. GROSSMAN: Great. Thanks so
23 much, and thank you for this opportunity to
24 present Kaiser Permanente's total cost of care
25 model today. I'm a pediatrician, and I lead

1 Social and Community Health, where our team
2 oversees integration of social health
3 assessment and interventions, so that we can
4 provide socially informed care to our members,
5 and this is of course done to KP's work on
6 health equity.

7 Next slide, please. For those that
8 you are -- that are not familiar with Kaiser
9 Permanente, really a quick primer. We are the
10 largest private nonprofit integrated health
11 system in the United States with over 12-1/2
12 million members, about 23,000 employed
13 physicians, and over 200,000 employees in
14 addition.

15 Our care span includes the full
16 continuum. It also includes a set of eight
17 non-proprietary health services research
18 centers. Our plan, and as I'll describe, you
19 know, in the following slides, our health plan
20 and our care delivery are deeply integrated and
21 intertwined, and sometimes are difficult to,
22 you know, dissect separately.

23 Next slide, please. So this, this
24 map. Next slide, thanks. This map shows the
25 distribution of our member population in the

1 U.S., and as you can see the significant
2 majority of our members reside in California.
3 In many of them, we are largely concentrated in
4 metropolitan areas or large population centers,
5 and our penetration generally runs in any
6 community from about 20 to 40 percent of the
7 insured population.

8 Next slide. So although Kaiser
9 Permanente is actually a brand name, I think
10 for the purposes of the discussion it's
11 important to tease out what actually is Kaiser
12 Permanente. It's actually a set of discretely
13 separate chartered, mostly nonprofit
14 organizations that are all focused on serving
15 our enrolled members.

16 The Kaiser Foundation Health Plan at
17 the top there provides the main function to the
18 health plan, and then serves as the
19 distribution source for global payments to the
20 other organizations in the group. The Health
21 Plan manages its hospitals through a separate
22 nonprofit called Kaiser Foundation Hospitals,
23 through a series of hospital service
24 agreements, and those services are provided
25 either in Kaiser Permanente facilities or as

1 needed in contracted facilities.

2 In California, it's mostly owned.
3 Outside California, it can be either owned or
4 contracted. Some regions like Washington,
5 Washington state, and Georgia, for example, do
6 not have Kaiser Foundation Hospital-owned
7 hospitals. Care is provided in contracted
8 facilities, Kaiser Permanente, but the care is
9 actually provided by the KP providers.

10 So then the Health Plan also has
11 medical service agreements with eight separate
12 Permanente medical groups, all self-governed
13 and one for each region. California has two
14 regions.

15 The medical groups are mostly
16 shareholder-owned, but some are now moving
17 towards a public benefit model where, as some
18 of you are aware of, a certification called a B
19 Corp organization that serves community
20 interests. Each Permanente medical group has a
21 medical services agreement with its regional
22 health plan subsidiary that provides mutual
23 exclusivity, and gives the medical group
24 control over things like clinical guidelines,
25 policies, network composition, and also appeals

1 process.

2 So next slide. Thanks. So Kaiser
3 Permanente is distinguished not only by its
4 integration of care, finance, and delivery, but
5 also the integration of the components of care
6 delivery. So we provide the full constellation
7 of care in most regions. The model is also,
8 importantly, is primary care-centered, and the
9 entire system is linked through an electronic
10 record, which allows providers, regardless of
11 where you're at in this wheel, you can see all
12 aspects of care delivery, including all aspects
13 of care coordination and case management.

14 And both mental health and social
15 health are fully integrated into that wheel and
16 into the system.

17 Next slide. So the, KP's global
18 budgeting process allows a lot of flexibility
19 in how care is delivered. The constraints of
20 what we perceive an arcane fee-for-service
21 don't - do not generally exist. So specialty
22 care can often be delivered through
23 teleconsults to primary care without any kind
24 of billing process or a need for worry about
25 having to see the patient in person in order to

1 satisfy billing requirements.

2 In our system state, you know,
3 throughout our system, and I've practiced most
4 of my career here in Washington state, we've
5 been, for example, you're really able to adapt
6 to COVID. So our telehealth encounters
7 rocketed to about 75 percent with virtual
8 encounters, without any concerns about revenue
9 loss from the conversion, and it allowed us to
10 be much more flexible, I think, than many of
11 our competitors.

12 Kaiser Permanente was one of the
13 earliest adopters of the electronic health
14 record and that investment was absolutely
15 critical to our success in becoming tightly
16 integrated and also enabled much more patient
17 engagement and becoming patient-centered, with
18 the earliest versions of the patient portals
19 that were offered by Epic.

20 The Care Everywhere Program, which
21 we use, also an Epic product, has been also
22 critical to our ability to offer seamless care
23 across state lines, regardless of whether our
24 members move temporarily or permanently. So
25 this has obviously an impact in reducing

1 redundant care or redoing previously done
2 services because all those past services are
3 easily visible.

4 I think finally another major
5 difference in the experience of our medical
6 groups is that they spend far less time having
7 to adapt practices for different payers. So
8 the coverage policies at Kaiser Permanente
9 align fully with medical group practice
10 guidelines, they're developed by the medical
11 groups, and that many of these referrals for
12 services are auto-approved based on the
13 Permanente affiliation, in essence gold
14 carding.

15 And for patients, I think it's a
16 really distinctly different experience as
17 they're not caught in the middle between
18 providers and plans, you know, fighting over
19 coverage and payment.

20 Next slide, please. So the medical
21 groups are actually paid a global fee that's
22 based on a capitation formula, and then -- and
23 they in turn pay their physicians and other
24 providers on a salary basis. There's a
25 negligible fee-for-service billing inside our

1 system. We have to do it generally more for
2 external requirements, and as I'll talk about
3 in a second, for some other special purchasers.

4 But the medical groups can earn
5 extra incentives both as a group, but also
6 reward individuals based on quality and
7 experience, performance targets that are set
8 through a process between the Health Plan and
9 the medical groups called Memorandum of
10 Understanding. So those members may or may not
11 pay an incentive, depending on performance.
12 It's generally driven entirely on strategic
13 initiatives and quality.

14 The source of the revenue to drive
15 our system is obviously largely premium
16 payments from purchasers, but also includes
17 substantial patient cost share revenues.
18 There's very little fee-for-service in our
19 system, but for those employers that are self-
20 funded or risk-based, the model is driven by
21 fee-for-service payment plus a global
22 capitation fee that covers much of the non-
23 billable integrated services like case
24 management and care coordination that are vital
25 to the success of our model.

1 Next slide, please. So our latest
2 integration experiences with bringing social
3 health into the mainstream of medical care, and
4 as a nonprofit, we do have a long legacy of
5 serving not only our members, but also invested
6 in the health of the communities in which our
7 members reside, recognize the importance of
8 public health and the environment, and the
9 social environment.

10 So KP provides about \$3.6 billion in
11 community benefit that are a combination of
12 charity care, but also an extensive grant and
13 community investment portfolio. The focus is
14 on a set of key areas that are mostly commonly
15 uncovered through our community health needs
16 assessment process, which we do across the
17 country.

18 We also recognize the importance of
19 doing social health needs assessments at the
20 member level, and we're now making that visible
21 at the point of care and in the electronic
22 record for purposes of care coordination and
23 care planning, as well as socially-informed
24 care.

25 Next slide, please. So this next

1 box represents sort of the model that we are
2 using in social health. We are still in the
3 process, and this is still -- we're still, I
4 would say, in the relatively earlier phases of
5 this journey, where we are set up to identify
6 the social health needs of our members by using
7 standard tools, and then through that process
8 connecting our members to resources in the
9 community, and those can be through a variety
10 of pathways which I'll describe in a second.

11 And then enabling and supporting a
12 follow-up with those members, particularly
13 those that have complex social needs or a mix
14 of complex social and clinical needs, and
15 ensuring that they get the appropriate follow-
16 up as part of their overall care planning.

17 This in turn allows us to monitor
18 the use of these community-based services and
19 amass data and understand the performance of
20 our community partners, and their ability to
21 help, and it informs our local investments in
22 those community-based organizations, much in
23 the way we would be supporting a provider
24 network.

25 So next slide, please. This is my

1 final slide, and in this as you can see here,
2 what we're doing is the screening process is
3 through a variety of pathways, which include
4 episodic care using standard screening, which
5 could be done either through the provider, or
6 say, medical assistant, or through digital
7 self-service tools, or through actually even
8 outreach to a call center that we staff for
9 purposes for people who desire to actually go
10 direct through that medium.

11 We've also listed in our web an
12 ability for a social services locator platforms
13 that's available to the public, so that they
14 can see what kind of resources are available in
15 their zip code. We have set up what we call a
16 Thrive Local platform that is powered by Unite
17 Us, that provides electronic communications and
18 connections with community-based organizations
19 in our communities. We have over 5,000
20 community-based organizations that are
21 connected to the network, and when a provider
22 sends a resource referral, it's delivered
23 electronically just as it would be in our
24 system to a specialist.

25 And then we can monitor to make sure

1 it was accepted, that the service was received,
2 and then the feedback is actually received back
3 into the electronic health record. The areas
4 that we're focused on in these areas, we're
5 putting an emphasis early on food resources, on
6 housing resources, social isolation, and
7 financial resources.

8 We also are using our ability to use
9 artificial intelligence, as well as, you know,
10 algorithmic logic to identify members that are
11 likely in need of services, even without
12 screening them, and reaching out to them and
13 offering them services like food assistance.
14 Recently, we reached out to about 4.2 million
15 of our members to enroll them in SNAP³⁰, and we
16 were successfully able to enroll probably
17 about, of those, about 80,000 took advantage of
18 that opportunity and successfully completed an
19 enrollment application into SNAP through that
20 outreach.

21 So those are some examples of how
22 this works, and of course, this is all needs to
23 be integrated, very closely integrated into our

30 Supplemental Nutrition Assistance Program

1 care delivery system and to our health plan,
2 and as we're finding more and more purchasers
3 are interested in understanding how they can
4 play a role on this effort as well. So with
5 that, I'll conclude and turn it over back to
6 the moderator. Thank you.

7 VICE CHAIR HARDIN: Thank you so
8 much, Dr. Grossman. That was very interesting.
9 I'm sure Committee members will have many
10 questions for you. They're holding those until
11 after all four presenters have completed. Next
12 we have Dr. Ali Khan, who is chief medical
13 officer at Oak Street Health. Please go ahead.

14 DR. KHAN: Thank you so much for
15 having us, and thank you to the Committee for
16 this opportunity, specifically to Dr. Chinni
17 Pulluru for making this possible. We're
18 thrilled to be here today, to really dig into,
19 you know, our findings from the wild, right?
20 What's making this work for us, both from a
21 value-based care perspective and a health
22 equity perspective in the real world, and
23 exactly what we're doing.

24 So we'll try to dig into a little
25 bit of context, but really focus very similarly

1 to where Dr. Grossman was, around how that
2 integration of information and where, you know,
3 details and follow-through really matter.

4 So next slide, please. So you know,
5 from a context setting perspective, none of
6 this is obviously surprising to this Committee,
7 but important to recognize. We know the
8 challenges before us in American health care.

9 We are expensive, we don't
10 necessarily get the value or the output that we
11 hope for from a quality perspective in terms of
12 what we spend, and all too often, particularly
13 for seniors and older adults, negative
14 experiences, chronic disease burden, and cost
15 concentration are all forcing those seniors to
16 make choices every day, as my patients do on
17 the west side of Chicago, between whether to
18 pay for a medication or whether to pay for an
19 electric bill, and how, you know, that impacts
20 their overall quality of life and their
21 activation as a whole, right?

22 Ninety-six percent of Medicare spend
23 obviously relates to chronic disease, and we
24 see this all the time in the hospitals where I
25 work and in the primary care setting, where

1 myself and many of my colleagues at Oak Street
2 work, and thinking about how we address this in
3 a multi-faceted model is really the core focus
4 for us.

5 Next slide, please. Of course, we
6 also know that for many communities, these
7 problems are even more concentrated. I happen
8 to work in this map of Chicago in the darkest,
9 the darkest quadrant on the west side through
10 to the left of your screen, in a community
11 called East Garfield Park, which is only
12 separated from downtown in the Loop, that white
13 center in the middle of the map, by three miles
14 and about six train stops.

15 We have about 18 years in terms of
16 life expectancy, which is not surprising when
17 we see the overlap between social
18 vulnerability, as measured by the CDC³¹, health
19 risk factors, and race, and what that does in
20 terms of how social risk factors drive
21 considerably worse outcomes, as underscored
22 during the COVID-19 pandemic.

23 Next slide, please. We see those

31 Centers for Disease Control and Prevention

1 same challenges through good data from RAND and
2 CMS when we look at some of the process
3 measures that many of us know and love. So
4 when we look at racial and ethnic disparities,
5 consistently whether -- from in either gender,
6 we see notable discrepancies in screening, in
7 treatment, and in prevention across racial and
8 ethnic categories.

9 The challenge of the work ahead of
10 us becomes quite considerable when we think not
11 only about raising the bar in terms of
12 elevating the quality and the consistency of
13 care delivered for this segment of the
14 population, but also how we reduce inequity
15 within that work at a very, you know,
16 thoughtful and intentional level.

17 Next slide, please. That really is
18 the basis for us at Oak Street Health. We are
19 a national network of primary care centers for
20 Medicare-eligible patients. We operate 100,
21 actually 140-plus centers over 20 states, soon
22 to be 21, as we head to Colorado in a few
23 weeks, taking care today of about 115,000
24 members at full risk with us, either Medicare
25 Advantage, Medicare/Medicaid dual eligible

1 programs, or direct contracting today. There
2 are 150,000 members overall, including
3 traditional Medicare fee-for-service
4 beneficiaries.

5 Next slide, please. Which as you
6 can see spans much of urban and working class
7 communities, suburban and immigrant communities
8 across 20 states, including much of the Rust
9 Belt, the Southeast, the Southwest and
10 increasingly into, you know, more atypical
11 urban settings. We are not in Southern
12 California, we are not in South Florida. We
13 have attempted to make this work in communities
14 like Chicago; Philadelphia; Cleveland; Memphis;
15 Jackson, Mississippi; Dallas-Fort Worth; and
16 Albuquerque, New Mexico.

17 Next slide, please. The reason for
18 this kind of motive in the 10 years since we
19 were founded is really because of the people
20 that we serve, 42 percent of whom are dual-
21 eligible for Medicare and Medicaid, 86 percent
22 have at least one chronic condition. Seven,
23 most of whom come to us on their first visit
24 with seven or more medications.

25 I can tell you, you know, as someone

1 who every week, including tomorrow, starts
2 every visit with pill counts and bottle checks,
3 that far too often our patients are coming to
4 us on seven, eight, nine, 10, 11 medications,
5 but they're wondering why they're passing out
6 every three days.

7 What they don't see is that they've
8 got three prescriptions written by three
9 different people, all for the same anti-
10 hypertensive or Lisinopril at the same dosing,
11 and that they're dutifully taking each one.

12 And so -- and yet their blood
13 pressure is in the systolics of, you know, the
14 90's which is quite low, and they're wondering
15 why this is happening to them. Or they ask,
16 you know, I've been getting my medication
17 online - from a mail order pharmacy, and I've
18 got it all with me.

19 And they bring enormous bottles
20 dating back three years or more of the same
21 Metformin that they continue to receive every
22 three months, thus, you know, checking the mark
23 on whether their prescription drug was filled
24 from a Medicare quality perspective, but
25 without the actual last-mile focus on whether

1 they're actually taking those medications.

2 So we spend a lot of time with each
3 of our patients, particularly many of whom are
4 obviously Black, Latinx, or indigenous, and 50
5 percent of whom, and we know this because we
6 screen 100 percent of them, have at least one
7 social risk factor if not more than one. So
8 this is, you know, this is not cherry-picking.
9 This is really dealing with the bulk of the
10 challenge in American medicine for the
11 populations who need it most.

12 Next slide. We see this, you know,
13 across the way. It's not solely an Oak Street
14 problem. Good data from Humana earlier this
15 year shows that the majority of Medicare
16 beneficiaries enrolled in Medicare Advantage
17 are carrying two or more social risk factors,
18 right, and that oftentimes it is not
19 loneliness, and it is not housing security,
20 although those are certainly quite large
21 problems, but financial strain, right, and the
22 simple work of ensuring that is everybody
23 accessing the financial supplements that
24 they're eligible for, and that they're
25 screened, and they're actually getting those

1 resources, is one of the biggest challenges
2 which is, you know, something that we focus on.

3 Next slide. So we promised to focus
4 on the details, and so I want to be candid in
5 terms of how we do this, both at Oak Street and
6 across the way. The first piece here more than
7 anything else becomes really focusing on our
8 differentiation moving from reactive to
9 proactive primary care, whether it's us,
10 Aledade, Cityblock, the Chens, so on and so
11 forth.

12 We can take capitation in this
13 setting, being at full risk, and it enables us
14 to invest in three things relative to typical
15 primary care: time, resources, and follow-
16 through. Time, as you can see in the setting
17 of distinct differences in how many patients
18 that we are taking care of from a panel
19 perspective, that enables more focus and builds
20 -- using the ability to leverage large
21 multidisciplinary teams, to really dig in on
22 the challenges, both social and medical, for
23 those patients.

24 Visit length, where for us the
25 average visit length is 40 or 60 minutes; the

1 most common length is 40 to 60 minutes with
2 each of our patients, and we're seeing them on
3 average nine times a year as opposed to, you
4 know, from a Medicare standard perspective of
5 1.4 to three times a year, and then that shift
6 to proactivity, right, where we are constantly
7 looking to make sure people don't fall through
8 the cracks, and our operating models are geared
9 towards regular, frequent touch points, and so
10 in a high-intensity model to ensure that people
11 do not fall through the cracks and that our
12 focus on crossing the T's and dotting the I's
13 remains in place.

14 Second is resources. Those big
15 teams are teams of physicians and nurse
16 practitioners and physician assistants, yes.
17 But they're also nurses, rural community health
18 workers, podiatrists, pharmacists, you know,
19 social workers, behavioralists, chaplains.
20 We've come together with each of us working at
21 the top and the bottom of our licenses, to
22 ensure that we can actually fill in the
23 details.

24 We don't wonder whether our patients
25 have gotten a test followed up. We actually

1 find out to ensure that piece of follow-
2 through, right? Instead of wondering about med
3 affordability, we can connect somebody in real
4 time now going to a pharmacist to help identify
5 what makes sense from a formulary perspective,
6 but also to understand which pharmacies are
7 available that will deliver in a home setting
8 in a way that's convenient, and connect them to
9 our social workers and patient relation
10 managers to ensure they've got the income
11 supplements that they -- that they're entitled
12 to to reduce that cost of care.

13 Instead of hoping that our patient
14 with severe mental illness is going to see the
15 state's BH³² clinic, we have behavioral health
16 embedded in health. So I can do a warm handoff
17 and deal with everything from SUD³³ and SMI³⁴, to
18 garden variety depression and anxiety, to make
19 sure that we're handling things in real time
20 and doing so together.

21 It's so easy as a practicing primary
22 care physician to get caught up in the day-to-

32 Behavioral health

33 Substance use disorder

34 Serious mental illness

1 day of somebody who's presenting to me with an
2 urgent issue or who needs a form signed or who
3 needs something in that moment. So that
4 without the intentionality, the shift to
5 proactivity or the team structure to get it
6 there, we wouldn't get the results that we
7 deliver, because we catch people when they
8 stumble. We try to help them when they're
9 worried.

10 Next slide, please. Of course, data
11 and you know, population health rigor obviously
12 helps influence this approach. A lot of the
13 work that we do is supported by first and
14 foremost integrating a number of different data
15 sources publicly available and proprietary, to
16 get a whole holistic picture on our patients.

17 We leverage that in terms of helping
18 us to understand what the dosage of primary
19 care is in terms of the frequency and intensity
20 that -- at how we want to engage in
21 longitudinal primary care, to help us put that
22 picture together and determine a level of worry
23 that we have for our patient.

24 Population health management becomes
25 the second piece, right, where we have a number

1 of different tools that are expanding every
2 day, by which we can generate consistency, to
3 engender the proactive thinking at regular
4 intervals and pull in the kind of democratizing
5 tools like integrated specialty care through
6 electronic consultations, home-based primary
7 care, medication management, and others, to
8 really ensure we're dealing across or working
9 across the whole ecosystem.

10 And third, really, is that care
11 navigation support, right, so that making sure
12 that we're holding the hands of our patients to
13 -- we have the time to do the right thing, to
14 do all the steps required. And it's that kind
15 of work, whether it's happening by me or it's
16 happening by a primary authority, somebody else
17 entirely, that's the hard deeply meaningful
18 work that we do every day in our sector,
19 particularly at Oak Street, right.

20 We enable the time, resources, and
21 follow-through through a model that's optimized
22 for this population, data-driven, and
23 intentionally holistic, to build trust.

24 Next slide. We see that trust play out in the
25 kind of work that we can do, even with the

1 segment of the population that is obviously
2 heavily underserved through traditional
3 measures. We see major, you know, sort of
4 national standards from diabetic control,
5 breast cancer screen, colorectal cancer
6 screening, and as our peers do in the value-
7 based care space, that we can consistently take
8 a population that is at higher risk and has
9 more structural barriers to achieving five-star
10 performance, and bring them to that level over
11 and over again, state after state over the past
12 10 years that we've shown.

13 Next slide, please. We see this
14 particularly in our -- in the integrated
15 behavioral health, where we know that by
16 rigorous screening, consistent warm handoffs,
17 and integration with behavioral health team and
18 care plan into the primary care setting, we see
19 substantial reductions in depressive symptom
20 management from within Oak Street, than from
21 general population trends, be it even in the
22 best places, like New York City Health and
23 Hospitals, have really championed both this
24 measure and really focusing on patient
25 reporting outcome measures.

1 Next slide, please. This is -- we
2 see this, these results outside of Oak Street
3 as well. This is excellent data from Aledade
4 showing their trends from the utilization
5 perspective, as they have driven a number of
6 independent practices into, you know, more
7 substantial, more engaged primary care
8 relationships, what that effect has on both ER
9 utilization and patient utilization and total
10 cost of care.

11 Next slide, please. I think the
12 challenge for us is like how do we move past
13 these utilization measures, right, that we all
14 quote against a data set that some would argue
15 may not even be comparable from a traditional
16 Medicare into really demonstrating true impact
17 on the patient and true impact on what their
18 journey is and how we've actually bent that
19 cost curve, that utilization curve.

20 For us, from what we have, we can
21 see, over and over again, moving away from
22 investing three cents on the dollar in American
23 primary care, from a health care dollar, into
24 flipping that paradigm on its head, as we've
25 been able to do in the value-based care

1 experience, yields, consistently, this kind of
2 impact in terms of, you know, more than halving
3 a possible admissions and ER visits relative to
4 Medicare benchmarks, dramatic reductions in 30-
5 day readmission rates, even when we include
6 observation stays in that space, and higher
7 patient, you know, outcomes and satisfaction.

8 Next slide, please. For us at Oak
9 Street, we've seen this. We won't go here
10 because we're running out of time.

11 Next slide, please. One more,
12 sorry. There we go. For us in Oak Street, as a
13 MSSP-ACO³⁵ for five years, we saw with deploying
14 the same model without the benefit of risk
15 adjustment, without the benefit of a lot of
16 things often MA³⁶ is labeled for, we achieved the
17 intensity of the care model with the fourth
18 highest savings rate of all 513 ACOs in the
19 cohort, with a significant, you know, taxpayer
20 savings to patient versus the CMS target,
21 showing that the value-based care model can
22 produce these consistent results over and over
23 again.

35 Medicare Shared Savings Program ACO

36 Medicare Advantage

1 Next slide, please. One more
2 please, just in the interest of time. So
3 despite progress in quality and equity, we are,
4 we try to be very honest that we think that the
5 value journey has moved from toddler stage into
6 gangly pre-adolescence and adolescence at this
7 point. We're excited about this conversation
8 today around, you know, thinking about what
9 does incentive design look like in terms of
10 expansion of Medicare payment models and more
11 deeply link equity and quality, equity and
12 payment reform in equal measure, as what we are
13 debating today with Medicare stars and what we
14 are seeing with the -- in the first signals of
15 ACO REACH³⁷.

16 How do we think about this from a
17 scalability perspective when we think about the
18 entire segment that still serves sub- 10
19 percent of Medicare beneficiaries? How do we
20 apply those lessons of scale to Medicaid and to
21 high-risk commercial segments? And then
22 thirdly, I think, is really, what really
23 resonates is, the pursuit of clinical

37 Realizing Equity, Access, and Community Health

1 excellence, right?

2 I know a number of colleagues, they
3 will be digging in on this. What are the right
4 measures? How are we evaluating clinical
5 outcomes and equity in equal measure? How are
6 we integrating those with patient report
7 outcome measures, and what benchmarks are we
8 driving towards? Can we do that collectively,
9 or should those be proprietary?

10 We at Oak Street say no. We're
11 going to drive towards the future that we know
12 we need to have. Thank you for your time
13 today. I'm looking forward to the questions.

14 VICE CHAIR HARDIN: Thank you so
15 much, Dr. Khan, for that very interesting
16 presentation, and perfect transition to our
17 next speaker, Dr. Dana Safran, who is president
18 and chief executive officer at the National
19 Quality Forum. Please begin.

20 DR. SAFRAN: Good afternoon. Thanks
21 very much for the introduction. I'm really
22 pleased to have the opportunity to be part of
23 this panel today, and much of the information
24 that I'm going to share with you really dates
25 from before I was in my current role as

1 president and CEO of NQF, and back from a time
2 when I was on the executive team at Blue
3 Cross/Blue Shield of Massachusetts.

4 I'll be talking about some of the
5 particular methods that we used in our global
6 budget contract called the Alternative Quality
7 Contract, or AQC, that I think really
8 differentiated that model's ability to achieve
9 the twin goals that we had of improving cost --
10 improving quality and outcomes while reducing
11 cost and cost growth.

12 So that will be the first segment.
13 Second, I'll talk a little bit from the
14 perspective of what are the highest-priority
15 gaps that I think need to be filled for value-
16 based payment models to be successful, and then
17 finally I'll talk a little bit about the issues
18 around health equity and adjustment for social
19 risk.

20 So if we go to the next slide,
21 please. I'm going to assume given your
22 background that most of you are quite familiar
23 with the Alternative Quality Contract, so I
24 won't walk through that model. But for any of
25 you who are familiar with it, this is a model

1 developed in 2007, launched in 2009, so well
2 before the ACO movement was underway, and in
3 fact a catalyst for that movement because of
4 some of the results that I'll share with you
5 that emerged from this work.

6 The things that differentiated the
7 model from, at the time, what were the
8 traditional fee-for-service payment models,
9 were a provider systems being paid on a global
10 population-based budget, having symmetrical
11 two-sided risk on that budget, having a
12 significant opportunity for upside earnings
13 based on quality performance on a very broad
14 set of quality and outcome measures, and having
15 long contracts, five-year period contracts with
16 a fixed cadence of inflation pre-defined before
17 the contract started so that providers
18 understood what growth would look like over
19 each of the five years and decide to come down
20 over time, so that by the end of the period,
21 growth looked like general inflation and not
22 the two, three times inflation rates that we
23 had in 2007 when we began.

24 So next slide, shows you just a
25 snapshot of the -- next slide, please. Thank

1 you. Shows you a snapshot of the quality
2 measures that I developed in 2007, and that was
3 really a part of this payment model, the
4 opportunity for quality to be the important
5 backstop against any impulse to stint that
6 might occur from a global budget set of
7 incentives with two-sided risk.

8 What you see is that there were two
9 settings, ambulatory and hospital, and for each
10 setting we had a range of process, outcome, and
11 patient experience measures. Today's measure
12 sets, I would argue, look very similar to this
13 measure set developed in 2007, and that's what
14 I'll be speaking about in the second segment of
15 this set of remarks.

16 But if we go to the next slide, one
17 of the things that I really wanted to emphasize
18 for this audience is that there were some
19 particular methodological innovations that we
20 used in our incentive model that I think really
21 contributed very importantly to the success
22 that the AQC had in driving improved quality
23 and outcomes. Two that I would highlight are
24 besides having the broad quality measure set
25 that you saw on the previous slide, for each

1 measure we had a range of performance targets,
2 not a single number. That was novel at the
3 time.

4 At the time, performance-based
5 payment really typically had one performance
6 target, and a provider either made that and got
7 rewarded or missed it even by hundredths of a
8 point and got nothing, which was very
9 demotivating. So having a range of targets was
10 very important.

11 The other thing that was important
12 that we did was we based those targets on
13 absolute performance, not relative performance.
14 In the Q and A, we can talk a bit about how we
15 did that if you'd like. But the net effect of
16 that was that it was not a tournament among
17 providers in the model. So as a result, our
18 providers in our network statewide were very
19 willing to collaborate and share best
20 practices, because one organization's success
21 at gaining ground in the quality measure set
22 did not come at the expense of another
23 provider.

24 And what you can see is that across
25 the range of performance targets from what we

1 called Gate 1 to Gate 5 on the X axis,
2 providers had the opportunity to earn up to an
3 additional 10 percent on that global budget,
4 which was tens of millions of dollars in most
5 cases.

6 Next slide. I won't spend a lot of
7 time here, but one of the reasons that the AQC
8 model was as influential as it was, nationally
9 and even internationally, was that we had the
10 great, good fortune to have a team from Harvard
11 Medical School studying the results of what we
12 were doing while we were doing it, publishing
13 year by year by year, and showing in fact that
14 this model was improving quality and health
15 outcomes.

16 You see that panel, roughly in
17 middle of the screen, with the blue line
18 signifying improved outcomes in our cohort, the
19 orange line signifying outcomes in a national
20 set of benchmarks. And what you'll notice is a
21 very, very steep increase in the performance on
22 outcome measures from the third data point,
23 which is the year that the contract launched,
24 all the way through the follow-up period.

25 And this improvement in outcomes

1 really required novel care models, very much
2 like what Drs. Grossman and Khan have
3 described, where we think outside the literal
4 and figurative box of the clinical setting to
5 where patients live and work, in order to
6 address the unique individual barriers for each
7 human being, of what will stand between them
8 and good outcomes.

9 That's very different from the care
10 models that we get as we know under fee-for-
11 service. We also saw significant cost savings,
12 and those are captured in a series of *New*
13 *England Journal* and *Health Affairs* articles,
14 the latest of which was an eight-year
15 retrospective that showed 12 percent cost
16 savings over, over traditional fee-for-service
17 contract models.

18 Next slide, please. Actually, I
19 think in the interest of time, I'll skip this
20 slide. I can come back to it later. This is
21 about how we shifted the incentives after
22 several years, but we can still link the shared
23 savings to quality performance. We can talk
24 about that if that's of interest.

25 This slide I'll just speak briefly,

1 because I think Drs. Grossman and Khan have
2 really articulated the kinds of care delivery
3 innovations that lead to the -- that are really
4 significant improvements in quality outcomes
5 and costs that we are talking about. But these
6 are the four broad areas that summarize the
7 kind of interventions that we saw our network
8 making from the very first year and all the way
9 through.

10 Next slide. So one of the really
11 critical, this is the second part of my
12 remarks, gaps that we have is, as I pointed
13 out, measure sets today look very much like the
14 one that I developed in 2007, and yet for over
15 a decade, we've been saying we need to move to
16 more outcomes-oriented measure sets.

17 When I was contributing to the work
18 of the LAN³⁸, we called these "big dot
19 measures," and the value of moving to big dot
20 measures for value-based payment is really
21 many-fold. But one of the points of value is
22 the measures in measure sets today and in the
23 one I developed for the AQC really are the

38 (Health Care Payment) Learning and Action Network

1 product of a fee-for-service mind set, very
2 much process-oriented. You do a thing, you get
3 paid for the thing, you measure the thing.

4 Whereas, really what we're trying to
5 get to in value-based payment are the outcomes,
6 and fortunately those allow for a much more
7 parsimonious measure set because, you know,
8 global budget contract, if you're measuring on
9 process it's going to have to measure an awful
10 lot of things, whereas if we move to big dot
11 outcome-oriented measures, we can be much more
12 parsimonious and much more consistent with the
13 real intention and purpose of value-based
14 payment.

15 But despite nearly a decade of
16 consensus that that's where we need to go, we
17 haven't gotten very far.

18 Next slide shows that there are five
19 -- next slide, please. Shows that there are
20 five broad clinical areas that represent more
21 than 50 percent of medical spend for both
22 commercial and public sector payers, and yet
23 very few, if any, outcome measures exist in
24 NQF's endorsed portfolio of measures.

25 So this is one of the priority areas

1 for me as the CEO of NQF, hoping to make
2 progress on this in the years ahead. I know
3 we're at the end of my time, so I'll just say a
4 few words about health equity if I could.

5 Let's jump ahead two slides, please.
6 This is a set of results that were published in
7 *Health Affairs* from the AQC, and what I want to
8 draw your attention to here is the yellow and
9 the green line at the top, and what that was
10 showing was that the AQC was succeeding in
11 narrowing long-standing disparities in health
12 care quality among our lowest, our most
13 vulnerable, patient populations relative to the
14 most advantaged patient populations.

15 You can see from the blue and the
16 orange line just below that, no such closing of
17 the gaps was occurring outside of the AQC. And
18 it helped to shape my own perspective about how
19 we address social risk in payment models. What
20 I share right now is my own perspective.

21 If you could jump ahead two slides,
22 please. My own perspective and not that of
23 NQF, which is why I don't have NQF's logo on
24 this final slide, but my perspective is this,
25 that at this time where we are all prioritizing

1 improvement in health equity, we can invest in
2 health equity by adjusting payment, not
3 adjusting measure scores for social risk.

4 We can adjust payment in other of
5 two ways or both, by having providers with
6 higher social risk receive preferred base
7 payment rates or a lower benchmark, as is done
8 in the ACO REACH program. We could also create
9 a multiplier so that for a given level of
10 performance, those with a higher social risk
11 are earning more for the same level of
12 performance.

13 In this way, I would say we have our
14 cake and eat it too on the concerns expressed
15 by both sides of the argument, those saying,
16 you know, we need to adjust for social risk,
17 those saying we can't adjust for social risk
18 because we -- if we do so on the measure side,
19 that we mask and conceal the important
20 differences that can be there.

21 We can have our cake and eat it too
22 by adjusting, but on the financial side, and in
23 so doing, invest in health equity as opposed to
24 obscuring the disparities. So thanks for your
25 attention. I look forward to our discussion.

1 VICE CHAIR HARDIN: Thank you so
2 much, Dr. Safran. That was very interesting.
3 Our last listening session presenter is Dr.
4 Adam Weinstein, who is chief medical
5 information officer for DaVita, Incorporated,
6 and an advisor for the Renal Physicians
7 Association. Please go ahead.

8 DR. WEINSTEIN: Thank you and thank
9 you for inviting me to this conversation. You
10 know, today I'm wearing my Renal Physicians
11 Association hat. We are an advocacy
12 organization representing nephrologists
13 throughout the United States, and I think in
14 contrast to my colleagues here, I bring sort of
15 the tactical frontline physician representation
16 of what these models can mean for doctors and
17 patients.

18 I want to take a few minutes to
19 start with, and if you could move to the next
20 slide, please. The definitions. So the world
21 of nephrology is an acronym-laden world filled
22 with lots of very specific definitions, and I'm
23 not going to go through all of these, but I
24 wanted to include this in the slide deck for
25 future reference.

1 The two you're going to hear me talk
2 the most about is CKD, which is chronic kidney
3 disease. I think many of us are familiar with
4 that term, but ESKD³⁹ and ESRD are used
5 interchangeably, and it is the state in which a
6 patient no longer has enough kidney function to
7 sustain them without dialysis or a transplant.
8 The rest of the vocabulary there is there for
9 your review if you need it throughout the rest
10 of the presentation.

11 Next slide, please. So I want to
12 start by talking about the physiology and the
13 logistics of kidney care delivery. In contrast
14 to I think many of my colleagues here, you
15 know, we represent a large group of
16 nephrologists that are in a variety of practice
17 conditions. Some are part of large health
18 systems. Many are independent practices that
19 work in communities throughout the United
20 States.

21 Some practices are as large as 30 to
22 70 if not more nephrologists. Most practices
23 are between four and seven nephrologists

39 End-stage kidney disease

1 delivering care in a variety of settings from
2 rural to urban. The problem with kidney
3 disease is that it is a continuum of care that
4 requires ongoing monitoring. We have really
5 good ways to keep track of people's kidney
6 function using creatinine clearance or the
7 estimated glomerular filtration rate, which
8 then breaks out into stages of chronic kidney
9 disease.

10 When someone has somewhere early
11 Stage 3 to mid-Stage 4 kidney disease, they are
12 in a window where we can do the most to
13 mitigate risk and avoid potential expensive
14 costs. As people's kidney function begins to
15 fail further, and they enter late stage 4 or
16 Stage 5 and as they enter end-stage kidney
17 disease, we know this to be the period in which
18 their medical complexity is high, and the costs
19 associated with the care can be very high if
20 upstream work, that is work in that period of
21 greatest potential for risk mitigation, is not
22 taken.

23 There's a series of jobs to be done.
24 Things that nephrologists as the quarterback of
25 care, especially for Stage 3 and beyond

1 patients, can be doing to either slow
2 progression and/or prepare patients
3 appropriately for what's called an "optimal
4 start," which is a period where they can start
5 dialysis or get a transplant with the least
6 amount of cost and the most amount of medical
7 support.

8 The biggest problem we have in the
9 world of nephrology is that it takes a lot of
10 colleagues in other domains to care for these
11 patients. So irrespective of how good a
12 nephrologist is, you're only as good as the
13 community of providers that are working with
14 you. Nevertheless, the nephrologist is in fact
15 the best quarterback for managing this
16 particular disease state, since it's what we
17 do. It's our bread and butter.

18 And so no matter what payment model
19 that we are participating in, and in the
20 appendix to this deck, I've included what is 17
21 years of numerous payment models that
22 nephrology has been participating in in one
23 form or another, the nephrologist has to be at
24 the center of it to make it work.

25 Next slide, please. So I think it's

1 important to talk about why kidney disease as a
2 disease state rather than a population works
3 well as a total cost of care model. There's a
4 number of features about nephrology care and
5 really kidney disease patients that lend
6 themselves well to this kind of payment scheme.

7 Number one, there's obvious
8 significant financial incentive or savings to
9 be had when care is delivered appropriately and
10 optimally for our patients. Dialysis, as you
11 know, is very expensive, and transplants are
12 less expensive, especially if done
13 preemptively. Moreover, when patients have to
14 start dialysis, if done in a way that is
15 planned and thoughtfully executed, there's
16 significant cost savings to be had, as well as
17 quality of life for the patients.

18 Numerous, tens of millions of
19 patients have some degree of chronic kidney
20 disease, and these patients are typically
21 diagnosed years before they enter that window
22 of highest cost and highest complexity. Our
23 patients are easily defined by lab data, and
24 there's administrative data to keep track of
25 their progress, both in the form of claims, as

1 well as CPT⁴⁰ and ICD⁴¹-10 codes.

2 There are measurable and cost-
3 effective solutions that can slow the
4 progression of kidney disease, and of course we
5 understand at least some set of best practices
6 that keep patients healthy on dialysis and
7 getting transplanted. And lastly, attribution
8 is relatively simple, though not perfect. But
9 we have a numerous tock marks on the timeline
10 that I displayed on the previous slide that
11 allows us to link patients to physicians and
12 other care providers in the communities in
13 which they live.

14 Next slide, please. So I probably
15 should have termed this slide "the actors,"
16 rather than the ideal components. But I think
17 it's important to see the list of people and
18 stakeholders that go into caring for kidney
19 disease patients. Obviously CMS and payers
20 have a strong interest in ensuring patients get
21 high-quality, optimally priced care. But
22 patients and the caregivers, I think, are
23 critical components of this.

40 Current Procedural Terminology

41 International Classification of Disease

1 Much of what we do in nephrology
2 involves engaging patients in behaving
3 different, taking medicines, a lot of the
4 things my colleagues have discussed, but
5 perhaps more so given the complexity of their
6 renal disease. Nephrologists and providers,
7 and more importantly their nephrology
8 practices, are business entities.

9 These entities are built around fee-
10 for-service medicine by and large, and most of
11 the payment systems that have been put into
12 place over the last 17 years carve out a small
13 percentage of the practice, which I'll talk a
14 little bit more in the next slide.

15 But really I think it represents the
16 fact that when you're a nephrologist or
17 nephrology practice participating in one of
18 these programs, that you're being asked to take
19 a subset of your patients, think and work
20 differently about that subset while you're
21 still caring for the rest of your practice in
22 the more traditional fee-for-service model.

23 There's a new entrant in the kidney
24 care space, which are kidney care companies.
25 Some of these are dialysis organizations like

1 the one I work for, DaVita. Some are
2 independent organizations that are helping
3 nephrologists and nephrology practices take on
4 the logistics of managing patients and
5 population health, as well as bearing some of
6 the financial risk in the newer models that
7 have come out.

8 And lastly, we interact heavily with
9 other specialties and health systems. Within
10 the kidney care payment systems, these folks
11 have often been neglected, really. They are
12 marginally incentivized, and while they're
13 critically important, our patients are
14 hospitalized quite frequently, they're often
15 not as involved in the processes that need to
16 be put in place to be to reach maximum success.

17 And if you could go to the next
18 slide and my last slide, please. I want to
19 close by talking about where the features that
20 have been most successful have come from over
21 the last 17 years. I think you're going to
22 hear a lot of the same themes that my
23 colleagues talked about, and I'll start with
24 the nephrologist and the nephrology practices.

25 For independent nephrology practices

1 really, you know, these are the folks that want
2 to be the quarterbacks and provide the most
3 frontline care, and we're asking them to flex,
4 flex into population health activities, flex
5 into delivering care between office
6 appointments. That means they need to have IT
7 that works well and integrates with other
8 community members. It means they need to have
9 the right tools and data available.

10 For them, meaningful rewards
11 financially, as well as quality of care
12 rewards, are important. Most nephrology
13 practices are willing to take moderate risk but
14 are not really capable of putting up investment
15 up front, and are really dependent on
16 simplified reporting and accountability burdens
17 to be successful.

18 The kidney care organizations, that
19 is the newest entrants in this market space,
20 really have started to fill some of the gaps,
21 but are not quite there yet. They are more
22 willing to take on risk and invest up front.
23 They are willing to provide the IT and
24 analytics that most small and moderate-sized
25 practices can't provide, and they really need

1 to take the time to contract with all the other
2 entities in this space.

3 Health systems and payers are still
4 not fully engaged in the nephrology care space
5 for capitated and at-risk payments, but really
6 they are critical for providing data such as
7 ADT notifications and partnership for
8 delivering care through some of the
9 subspecialties that are so critical for our
10 patients.

11 And lastly, I think you've heard
12 numerous comments about what patients and care
13 providers want, and certainly our patients are
14 no different than I think many of the patients
15 represented amongst my colleagues here. We
16 really look to be able to incentivize and work
17 with patients differently within these care
18 models.

19 I'll close by saying that I think
20 the most common word I heard today amongst all
21 of our presentations is time, and I would say
22 that from the perspective of a kidney doctor,
23 all of these things take time to develop. And
24 so no matter what care models are developed,
25 they need to be thought about in five- and 10-

1 year increments, not one- and two-year
2 increments.

3 They need to be thought about as
4 laying out a set of boundaries that are adhered
5 to for a number of years, so that you can build
6 IT systems that cross all of the entities in
7 these communities, as well as give time for the
8 practices to adjust their workflow, as well as
9 to engage patients in what is really lifelong
10 behavior changing that's necessary to
11 successfully navigate one of the new payment
12 models that might come down the line.

13 So with that I'll stop. I will
14 refer you to the fact that I have a few slides
15 in my appendix that might add some extra value,
16 and likewise I am happy to take questions as
17 part of the question and answer. Thank you.

18 VICE CHAIR HARDIN: Thank you so
19 much, Dr. Weinstein. It was very interesting.
20 I want to thank all of you for sharing your
21 experiences and your unique knowledge with us
22 today. Now we're going to open it up to
23 Committee members to ask questions. If you'd
24 like to pose a question, please tip your name
25 tag straight up, and I want to open it up to

1 the Committee. Angelo.

2 DR. SINOPOLI: Yeah. My question is
3 for David Grossman. So I heard about the
4 automated mechanisms for sending referrals to
5 the community-based organizations. I was
6 wondering how you partner with them to hold
7 them accountable for actually delivering
8 services and outcomes?

9 DR. GROSSMAN: Yeah, thanks so much
10 for that question. I think that's a, that's a
11 work still in progress for us. Our first order
12 of business is actually to create the incentive
13 and the means by which to get these community-
14 based organizations actually even to be part of
15 the network and involved.

16 I think a secret to success there is
17 to try to work in collaboration with the rest
18 of the community, and not make -- and not have
19 this be seen as necessarily a delivery-specific
20 background, but one in which we can try to
21 recruit other delivery systems and plans to be
22 part of the same network.

23 I think that enhances the ability
24 for us to be able to have that level of
25 accountability and expand the accountability to

1 be not just from a single delivery system or
2 plan, to a broader community level of
3 accountability. As we, as you well know, the
4 issue around those services and how these types
5 of community resources may be converted into
6 coverage benefit, will probably play a role in
7 terms of how the accountability process
8 evolves.

9 But for now it's really, you know, as we unfold
10 this process and engage our partners in the
11 community, I think that the process will
12 involve giving feedback and providing
13 statistics and data at the level of engagement
14 -- referrals have been -- the percentage of the
15 referrals that have been accepted, the
16 percentage of information that comes back into
17 the record, as starters, just in other words,
18 these process outcomes to make sure that in
19 fact these services are actually being
20 delivered. It's going to be a little more
21 difficult challenge to assess quality in terms
22 of those services, and I think that's something
23 that we as a community are going to have to
24 really think hard about. Thank you.

25 VICE CHAIR HARDIN: Thank you so

1 much, Dr. Grossman. Paul.

2 CHAIR CASALE: Yeah, hi. A question
3 for Dr. Khan. Thanks for the great
4 presentation. You know, on your Slide 10 when
5 you talk about the value-based models, under
6 population health interventions, you list
7 integrated specialty care. You know, we talk
8 about under these total cost of care models,
9 amongst the Committee, about how to engage
10 specialists, how to think about how specialists
11 fit into the total cost of care model.

12 And so I'd just be curious to hear
13 more around how, how you engage with the
14 specialists in general and, you know, I know
15 some of this is virtual but then, you know, how
16 much is virtual versus in-person and how you
17 work that into your care delivery model?

18 DR. KHAN: That's a great question.
19 Thank you for it. I've actually probably have
20 a -- well, a bunch of points of resonance about
21 what Dr. Weinstein put out, because from a
22 ground level perspective, a lot of this comes
23 down to, you know, what is the kind of
24 connectivity that we're getting, right, how do
25 we drive towards bidirectional communication,

1 and are the specialists that we're working
2 with, you know, nephrology is a good example,
3 are they like -- are those individual
4 nephrologists, you know, excited about what
5 we're trying to do, aligned from that
6 perspective and eager to dig in, right?

7 Because I think we do see across
8 lots of specialties heterogeneity, in terms of
9 whether some folks are really excited by the
10 idea of robust generalism, and you know,
11 bringing hopefully higher-quality consults,
12 things that are more worked up, things that are
13 more focused, and some are not, right, like in
14 terms of the traditional fee-for-service
15 system.

16 Even when those -- there are those
17 that are, right, traditional methods of
18 communication, traditional methods of
19 information transmission, stuff like that, will
20 often stymie, right? I can spend 15 minutes
21 writing a beautiful consult on a very specific
22 thing that I want, that I need a kidney biopsy
23 for, and if that gets transmitted as CKD-3,
24 everything is lost, right?

25 So on that level, I think we deploy

1 a couple of things. So first, we do leverage
2 electronic consultation in a couple of
3 different ways through the partner organization
4 that we have now acquired, RubiconMD. So
5 asking questions, both highly specific and very
6 general, in order to ensure that our primary
7 care clinicians aren't worrying alone, in terms
8 of just asking the question they want to ask.

9 Whether it's what's the next
10 medication that I should add for this
11 diabetic, to hey, I've got this patient who I
12 think may have lupus nephritis, and I'm curious
13 about whether you would start something versus
14 just, you know, versus wait for biopsy, given
15 sort of the family history and everything else
16 that we're seeing, right?

17 That kind of spectrum in an eConsult
18 platform is something that we're able to get
19 back not in the like 10 or 11 weeks that it can
20 often take for a patient of mine to get prior
21 authorization from a plan, schedule, follow-up,
22 and then, you know, actually see them then with
23 those records back to me, but oftentimes it's
24 four to six hours, right? That starts a
25 conversation.

1 Now when we pair that with the
2 legwork that we do in every city and every
3 community that we enter, of going out, taking
4 publicly available data, taking proprietary
5 algorithms from folks like Care Journey and
6 Garner and others, to try to identify who are,
7 who are specialists that are potentially high-
8 value practitioners, right, as defined by those
9 proprietary agents. How do those -- how do
10 their -- how do those patterns or those
11 findings match up against the clinical
12 experiences of me and my team, my colleagues in
13 terms of who's good to work with?

14 Then we layer on a bunch of work in
15 trying to build relationships with targeted
16 foci, right? So I may go in Maryland to Dr.
17 Weinstein's practice and be like hey, this is
18 who we are. We'd love to work with you. We
19 can do this in a couple of different ways, but
20 again communication, rapid turnaround, and, you
21 know, good engagement on both sides are going
22 to be really crucial, to make sure that we're
23 driving towards exactly that vision of, you
24 know, potentially co-quarterbacking, passing
25 the ball back and forth, so on and so forth.

1 When we do that work, we now are
2 able also to say hey, we can preferentially put
3 you all on this eConsult platform. If you'd
4 like all -- a good segment of our volume can go
5 to you, and so that way we're establishing the
6 bidirectional communication necessary up front
7 to that eConsult platform, where the
8 specialists can then tell us hey, you know,
9 it's time for this person to really go into a
10 procedure, go to biopsy, start -- needs to come
11 in to get listed for transplant, so on and so
12 forth, and we can turn that around quickly.

13 So it is -- it's not one main
14 solution, but it becomes this piece of how are
15 we leveraging, you know, tools that we have
16 today from a digital perspective, to
17 democratize and speed up access to specialty
18 consultation for patients that are often
19 without, and then secondly, how can we use
20 those tools plus good old-fashioned analog
21 interaction and shoe leather to build the
22 relationships necessary in any community health
23 environment to actually get that piece of
24 follow-through.

25 So those two together have been what

1 have been showing most promise for us,
2 particularly as we get to scale in certain
3 places, right, like here in Chicago where we
4 take care of 60,000 lives. That's a much
5 easier conversation to have than when we've
6 opened up, you know, a few weeks ago in
7 Phoenix, and we take care of 300 people. So
8 some of that matures as we go along.

9 VICE CHAIR HARDIN: Josh.

10 DR. LIAO: Great. I want to thank
11 all the speakers for great presentations. My
12 question is also for Dr. Khan. I appreciated
13 you sharing the data from the Acorn Network in
14 the kind of fee-for-service space and comparing
15 that to MA. You know for me personally, I
16 think a lot about the key differences that
17 might prevent someone from using the same thing
18 on both sides.

19 So I'm wondering if you can comment
20 on that slide that Paul referenced, Slide 9,
21 where you're identifying time, specialization,
22 support, technology integration. If you can
23 kind of cover some ground mentally with me and
24 say what are the things that you think you've
25 seen from Oak can be done pretty similarly

1 across MA and fee-for-service, comparably, to
2 see those benefits that you're showing on that
3 slide?

4 What are the things that you've done
5 successfully in both but really need to look
6 different in delivery? And then what are those
7 things that you say look, in an ACO setting,
8 it's very hard for us. We found it's hard to
9 do, and so we don't do those in that setting
10 where maybe we could under MA or other things?
11 So kind of -- if you could bucket it in those
12 three ways, that would be very helpful.

13 DR. KHAN: Yeah, and I'll give the
14 caveat of like easy to do it versus like
15 financially sustainable to do it are two
16 different things, right? I think from the
17 context of the core of what we do, right, in
18 terms of bringing a patient in, risk
19 stratifying them, identifying the amount of
20 primary --

21 Like the right bolus of primary
22 care, building the longitudinal care management
23 plan that integrates with that clinical care
24 plan, right, and then setting the large, the
25 core of the large team, particularly nursing,

1 community health workers, social workers, and
2 the like, in addition to our primary care
3 clinicians against that work, that is --

4 That, you know, it consistently
5 works across both settings, right? We can do
6 that over and over again, and that for us has
7 seen similar results, as demonstrated by our
8 performance in MSSP⁴² around delivering -- like
9 the delivering that consistent experience and
10 that consistent pace of follow-up has worked
11 for us on both sides.

12 I would say where we end up running
13 into challenges is probably in the areas of
14 when we start to layer on additional services,
15 that we just financially can't -- like can't
16 sort of take on further in a non-MA or non-
17 capitated environment, right?

18 So for us, historically that's often
19 been integrated behavioral health, where we
20 are, you know, doing a lot of work to refer
21 people out, but making sure that we can, you
22 know, bring that in, where we are doing a lot
23 of work in training of our own folks using

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1 national, urban and rural ECHO⁴³ programs with
2 UChicago and the University of New Mexico, how
3 to manage and treat SMI and primary care with
4 our own internal consults at least from a
5 curbside standpoint, how we leverage electronic
6 consultation through Rubicon and others.

7 That's one area. Podiatry becomes
8 another area. Some of the ancillary stuff that
9 we do particularly on transportation, right, is
10 often something that we can't gate, open the
11 gate for from a Medicare fee-for-service
12 perspective because the economics grow
13 challenging. So I think it becomes the basic
14 model, right, of like higher touch, higher
15 intensity, proactive primary care using a
16 large, team-based model can deliver a lot of
17 good.

18 I think when we look at some of the
19 aspects that we feel are core differentiators
20 to driving the next level of value and
21 integration, from a patient-centered
22 perspective, particularly when we think about
23 navigating the specialty world or navigating

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1 just last mile challenges when it comes to
2 transportation, medication delivery, financial
3 support, that's a challenge, right?

4 Like for example, when I was in
5 clinic yesterday, I had a new patient with, you
6 know, recent asthma exacerbations, had lost her
7 nebulizer years ago from the health plan that
8 she had gotten it previously. She's on
9 Medicare Advantage with a Blue, and for us
10 since we're at full risk, I just go back, I
11 grab the nebulizer, and I hand it to her,
12 right?

13 Like and you know, we fill the
14 script for the meds in a -- from a medication
15 perspective -- in a pharmacy. She goes out,
16 she's got that set up. I can't do that on
17 Medicare fee-for-service today outside of
18 Alternative Payment Model constructs, and that
19 I think becomes sort of the typification of the
20 challenge.

21 VICE CHAIR HARDIN: Larry.

22 DR. KOSINSKI: Like Josh, I'd like
23 to thank all of you for excellent
24 presentations. Your experience brings
25 information to our Committee that's extremely

1 valuable for us in making our decisions. I
2 have two questions. The first one is for Dr.
3 Grossman, and I'm focusing both of my questions
4 from the view of the specialist.

5 So if I'm a specialist inside
6 Kaiser, and I obviously have an opportunity to
7 work elsewhere other than Kaiser, what are the
8 benefits to me as a specialist in working in
9 this environment? Do I have some freedom from
10 some of the preauthorization problems that
11 exist in the private practice world? Do I
12 realize more incentive payments from value-
13 based care than I would in the private practice
14 space? How do you keep your specialists on
15 board?

16 DR. GROSSMAN: Thanks, Dr. Kosinski.
17 I think that, and that's a -- obviously a
18 really important question, how well does the
19 model work to retaining the workforce and also
20 making sure that it's a satisfactory
21 experience? I think that, of course you know
22 there's been kind of emphasis on primary care,
23 medical home, and the potential rewards
24 associated with an advanced primary care
25 practice, perhaps less emphasis on sort of what

1 is the process for a specialist, and how does
2 that keep them engaged?

3 I think that freeing specialists of
4 the constraints of the fee-for-service is in
5 and of itself rewarding, in part because Kaiser
6 Permanente, the Permanente medical groups, do
7 not impose volume requirements or -- although
8 we do track our overall RVU⁴⁴ and productivity.
9 We generally do not, mostly from the standpoint
10 of setting minimum thresholds, we do not
11 obviously incentivize the increased use of
12 services or -- and do not put part our
13 specialists under a hamster wheel to generate
14 more volume.

15 I think the other issue is in trying
16 to create a unified medical group and multi-
17 specialty group, enhancing the relationship
18 between specialists and primary care, much as
19 Dr. Khan was just describing earlier, is super-
20 important, I think, for our groups' overall
21 levels of satisfaction. And specialists can
22 also play a mentorship role, for example, in
23 the region that I work for, the National

44 Relative Value Unit

1 Program Office of Kaiser Permanente, I recently
2 moved from the Washington Permanente Medical
3 Group over to the health plan side in Oakland,
4 after 30 years' practice here in Seattle, and
5 for example, our diabetic practice is radically
6 different than what you might see in a
7 traditional environment, where the
8 diabetologist actually sees the more severe,
9 complicated cases, and trains and actively
10 supervises a cadre of internists and family
11 physicians who are in a sense deputized to take
12 care of the less, of the more, and including
13 advanced-level practitioners, those that are
14 less severe.

15 And that enables our practitioners
16 and our specialists to practice to the top of
17 their license, and really also enriches the
18 practice mix for primary care physicians at the
19 same time. So you know, the type of model that
20 we use here, I think, is one that definitely
21 does appeal to specialists in general. We have
22 not -- we generally are very competitive in
23 attracting applicants for specialty positions.
24 I hope that's helpful.

25 DR. KOSINSKI: I think it is. I'd

1 like to address a slightly different twist on
2 the question to Dr. Khan. Since you engage
3 your specialists, and it sounds from your
4 presentation like you have a tremendous
5 relationship with select groups of specialists
6 that see the world the same way as Oak does,
7 what percentage of their business typically are
8 they obtaining from Oak?

9 Are your specialist groups almost
10 exclusive to Oak? Are they deriving a very
11 significant percentage of their business from
12 Oak? Please expand on that.

13 DR. KHAN: Yeah. You know, it's
14 actually a good question and as Dr. Grossman
15 was giving his answer, I was smiling to myself
16 only because the idea of having the captive
17 specialist network as he does would be such a
18 gift.

19 You know, before my time at Oak
20 Street, I spent a number of years at CareMore
21 Health in California, a part of Anthem/Blue
22 Cross/Blue Shield. But in a world in which,
23 you know, even as a health plan and a clinical
24 provider, we had the kind of relationships, Dr.
25 Kosinski, that you allude to, where oftentimes

1 the percentage of volume that a certain
2 specialist group might be getting from us at
3 CareMore was running upwards of 45 percent,
4 right, because of the strength of those
5 relationships and the strength of those
6 networks.

7 At Oak Street, I think because we
8 are so geographically dispersed across 20
9 states, but even in our most dense market,
10 right, still only serving 60,000 beneficiaries,
11 there's not a single specialist that we work
12 with today where we are probably -- where we
13 represent anything more than 10 percent of the
14 volume that they have, right?

15 And I think therein lies a very key
16 difference, where 10 years ago it was almost
17 always outlier practices that were willing to
18 engage in this way. Now we are seeing health
19 systems and multi-specialty groups who want to
20 become a little bit more forward-thinking.
21 Like that shift has gone from like one percent
22 now to maybe like 35 percent, or who see like
23 hey, this is a great model for us to test out,
24 to see what we can learn from, and then do we
25 try to leverage something similar within our

1 own groups? Do we leverage across our -- work
2 on MSSP, so on and so forth, right?

3 What they're willing to kind of
4 prototype with us, and we bring sort of a
5 prototype hypothesis over and over again into
6 communities across the country. But where we
7 haven't developed the kind of relationship
8 where it's like, you know, we're the bulk of
9 their business, I do think we are seeing this
10 across the value-based space in certain places.

11 Particularly look at the large MSO⁴⁵
12 aggregators. So Agilon, for example, in Ohio,
13 I was talking to their CEO, CMO the other day.
14 They're able in a market like Akron to, you
15 know, to bring 40 percent of membership in that
16 region to a specialty group and be like hey,
17 work with us because we control a pretty big
18 chunk of change.

19 We're not that lucky, so we have to
20 go a lot more on -- so we're focusing on the
21 details and getting to programmatic excellence,
22 to demonstrate that it's, you know, a good
23 investment to work with us.

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1 DR. KOSINSKI: Thank you.

2 VICE CHAIR HARDIN: And Josh, did
3 you have another question?

4 DR. LIAO: I did.

5 DR. GROSSMAN: I was wondering if I
6 could just add one other comment to Dr.
7 Kosinski's question, if that's okay. I just,
8 two other issues. One is that I think it's
9 important to recognize that because Kaiser
10 Permanente is a nonprofit organization, we are
11 somewhat constrained in terms of what we can do
12 in terms of offering financial incentives, and
13 our salary structure is actually competitive.

14 But clearly physicians that come to
15 work for Kaiser Permanente don't come because
16 it's the best-paying offers in the community.
17 Instead, what they're doing is trading off a
18 practice lifestyle and philosophy of practice,
19 you know, that is rewarding to them but not
20 necessarily the highest-paying offer in the
21 community.

22 The second issue, I think the other
23 big difference that I neglected to mention was
24 the seamlessness with their integration of the
25 health plan and the practice is really

1 important. The lack of needing to fight and
2 appeal and go back and forth and bicker with
3 multiple insurance companies I think no doubt
4 also contributes to the level of satisfaction
5 and is an attractive feature for someone
6 working in the Permanente Medical Group. Thank
7 you.

8 VICE CHAIR HARDIN: Very helpful.
9 Go ahead, Josh.

10 DR. LIAO: My next question actually
11 is for Dr. Safran, and thank you for reviewing
12 kind of your experience with the AQC. I guess
13 my question is, you know, within the context of
14 a global budget and one of the themes I'm
15 taking away from these sessions is that it
16 provides some flexibility financially to do a
17 number of things. I was struck by the fact
18 that there were, as I understand it, additional
19 PMPM quality dollars kind of regardless of what
20 the budget deficit or surplus was.

21 I'm curious if you could just share
22 with us, given that PMPMs are something that
23 we're thinking about in these models, what are
24 certain things that partners are able to do
25 with those PMPM dollars maybe that they

1 wouldn't have been able to do without them? Or
2 you know, based on those learnings, how might
3 we think about PMPMs going forward in these
4 TCOC models?

5 DR. SAFRAN: Yeah, Josh, thanks for
6 that question, and I'll answer it in two ways.
7 First what I'll say is that I think that PMPM
8 dollars provided enormous opportunity to invest
9 in those four different types of interventions
10 that I highlighted in a slide that I only went
11 lightly over. But new kinds of staff, new ways
12 of engaging patients, information technology
13 and data systems, and new ways of relating to
14 others in the network.

15 Probably the least was invested in
16 the latter of those four categories, but you
17 know, new staffing models. I think you've
18 heard quite a bit about that today, bringing
19 behavioral health specialists into primary care
20 settings, bringing pharmacists on staff,
21 bringing social workers and others in sort of
22 allied behavioral health specialties on staff,
23 so staffing.

24 Patient engagement strategies that
25 leverage those new kinds of staff, that

1 involve, for example, direct patient outreach
2 in between visits, after a hospital discharge,
3 really the things that have the care extend
4 outside the clinical setting to provide the
5 kind of support that I referenced, that I think
6 contributed to that improvement in outcomes
7 that we saw.

8 So that's one thing I would say.
9 The other thing I would say is that the
10 constraint of our model was that those dollars,
11 those payments were generally made, you know,
12 in the year following. They were a reward for
13 performance in the last measurement period.
14 And some of, I think, the attraction of models
15 that are not a global budget but rather an
16 actual capitated payment are that they address
17 some of those cash flow issues and perhaps, I
18 think, I don't personally know of any evidence
19 that demonstrates that that does create a
20 front-loading of those investments. But
21 that's, I think, the intent. What we did as a
22 kind of surrogate for that was especially in
23 the early years, we created some infrastructure
24 payments that were grants, if you will, but
25 sums of money to help organizations invest in

1 electronic health records, because remember
2 this was 2007.

3 It was still very early for many
4 organizations to invest in other things that
5 they needed and where we didn't want them to
6 have to wait until a performance-based payment,
7 you know, next year or two years down the road.

8 VICE CHAIR HARDIN: And Paul.

9 DR. KOSINSKI: I have a question for
10 Dana, as well. Dana, it's nice to see you, and
11 thanks for a great presentation. One of the
12 topics we talk about a lot is accountability
13 and level of accountability, you know, whether
14 it's the entity level, and how do you cascade
15 accountability. So when you think about
16 quality measures, and you mentioned the
17 advantages of outcome measures, often -- as I
18 think about it, it's often challenging to think
19 about what is the right level of accountability
20 when it comes to outcome measures, as often
21 it's hard to assign that to a specific
22 provider.

23 And of course, it depends a bit on
24 what the outcome measure is, but I know you've
25 thought about this a lot. I'm just curious

1 about your thoughts in general.

2 DR. SAFRAN: Yeah. Thanks for that
3 question, Paul. So what I'd say is that in the
4 AQC model, the accountability was with the
5 system, and the system, you know as you
6 probably know, could include anything from a
7 large enough primary care practice, meaning had
8 at least 10,000 members, so we could compute
9 actuarially sound budgets, and was willing to
10 accept accountability for total cost of care
11 across the continuum, even though they didn't
12 have, you know, specialists or hospitals in
13 their contract, all the way to, you know, a
14 multidisciplinary practice or a system that had
15 multiple hospitals and everything in between.

16 So accountability at that level for
17 outcomes, and I would say that both with
18 respect to ambulatory outcomes and hospital
19 outcomes, that was kind of appropriate and
20 fair. Where I think your question comes into
21 play is what about for the individual clinician
22 or the individual team who's actually directly
23 involved with a certain episode of care and the
24 outcomes from that?

25 That's where, you know, I would say

1 both the art and science of measurement that
2 I've dedicated my career to, tells us that
3 that's not a good idea. That, you know, the
4 science part is we rarely have adequate sample
5 size, especially for an individual payer.
6 Yeah, an individual payer with an individual
7 clinician or even team, to compute stable,
8 reliable information about performance on a
9 given measure.

10 But also from the perspective of
11 art, it doesn't create the incentives that we
12 really want to be creating now and that value-
13 based payment I think is trying to drive, which
14 is really knitting that fabric that is health
15 care, that no single individual clinician or
16 even any single team can provide. So I think
17 by creating the incentives at the system level,
18 that's appropriate.

19 The challenge, which I know you're
20 aware, well aware of, but that I can't end the
21 response without saying because it would be
22 incomplete, is that how that institution
23 cascades those incentives down to the
24 individual clinicians matters, right? Because
25 when that -- when the payment for the

1 individual clinicians is primarily based on
2 RVUs, for example, you know, we are really
3 living with, you know, a foot in two canoes.

4 It's very different from the sense
5 that phrase is usually used. But you've got
6 individuals incentivized completely differently
7 from how the organizations incentivize, and I
8 think that that gets us stuck and unlikely to
9 see the progress that we want from value-based
10 payment. So I think that it's important for
11 organizations to cascade the right incentives
12 down to the frontlines, but not by, you know,
13 creating accountability for individual measures
14 and the results of those measures. I hope that
15 answers your question.

16 DR. KOSINSKI: Yeah, thank you.

17 VICE CHAIR HARDIN: Walter.

18 DR. LIN: I have a question for Dr.
19 Khan around the flow of funds in the Oak Street
20 model, both to the organization and then, as
21 Dr. Safran was just mentioning, how Oak Street
22 incentivizes the frontline primary care
23 provider. So the first part of my question is
24 just a kind of a real simple structural one.
25 Does Oak Street Health have its own health

1 plan, or does the organization take delegated
2 risk from incumbent Medicare Advantage Plans?

3 DR. KHAN: Great question, Dr. Lin.
4 Always happy to take it from a fellow Yale
5 internal medicine grad. By and large, so we
6 are not a plan, first and foremost. We
7 obviously, for the 120,000 or so members that
8 we are at full risk for, we are in full like
9 percentage of premium arrangements, with a
10 variety of health plans, I think 40-plus around
11 the country, including all six major nationals.

12 For a subset of those plans, we
13 happen to be delegated for a partial set of
14 functions, most often usually in care
15 management utilization management. It is very,
16 very rare that we are taking on network claims,
17 you know, griveances, appeals, those sorts of
18 features. So which, you know, creates a
19 different locus of control and a different
20 areas of focus, than necessarily what I enjoyed
21 coming from the plan perspective at CareMore a
22 few years back.

23 So by and large then, like
24 occasionally there are upfront capitation
25 payments included as part of those percentage

1 of premium arrangements, but that is the main
2 structure, and then there are some plans from
3 which we are in a primary care cap, with a
4 small number of plans kind of across the
5 country, often as a bridge towards driving
6 towards full-risk arrangements for the
7 following year.

8 DR. LIN: Thanks, and then the
9 second part of the question is around how Oak
10 Street incentivizes its primary care focused
11 model to engage the frontline PCP to reduce ER
12 utilization and patient hospitalization, total
13 cost of care. What kinds of -- it doesn't have
14 to be too specific, but in general compensation
15 arrangements do you have, and how have you seen
16 that change primary care provider behavior?

17 DR. KHAN: Great question. So I
18 think similar to the Kaiser model we are -- we
19 feel like we are offering, you know,
20 competitive, above 50 percentile salaries from
21 a primary care perspective across the
22 workforce, which makes a difference.

23 It doesn't close it, but it does
24 make a difference in terms of sort of the
25 shifting of primary care reimbursement, and

1 thankfully, I guess for whatever reason, the
2 Kaisers of the world, the Oak Streets of the
3 world, and the Ioras of the world have induced
4 somewhat of a sea change on the fee-for-service
5 sidetowards better primary care salaries.

6 I say this as a general internist,
7 although most of those prices those, you know,
8 heavily are RVU-rated. For us obviously there
9 is no RVU component. We do maintain a
10 significant portion of total compensation in
11 bonus eligibility, but those bonus measures are
12 driven almost entirely by engagement, quality,
13 and quality measures, right?

14 So how we've done from a panel
15 perspective in terms of, at the individual
16 level and at the center level, of you know,
17 bringing all of our primary care patients back
18 every year before -- either staying on, staying
19 in programs, staying adequately at the annual
20 AWV⁴⁶ and, you know, really having engaged in
21 that way, right?

22 We may look at like -- we may look
23 at performance on stars measures across the

46 Annual wellness visit

1 panel, and how they're driving from that
2 perspective in a risk-adjusted manner, right?

3 It's these kinds of measures, right,
4 that we're really trying to drive towards. We
5 did a couple of quarters last year where we
6 really focused heavily on COVID vaccination or
7 boosters, right?

8 So in terms of what we've seen is
9 that in terms of driving primary care and team
10 behavior, those same bonus measures cascade
11 across the entire team, from our welcome
12 coordinators who are checking in patients to
13 our drivers who are providing transportation to
14 our social workers, so on and so forth.

15 Different weights and measures, but
16 by and large really optimizing on that aspect
17 or patient experience and consistency or
18 follow-through. So with that, we are able to
19 derive a whole team kind of engagement in the
20 pursuit of those measures, which I think
21 unlocks -- we think unlocks a bunch of
22 creativity at its best, right?

23 When a team is like you know what?
24 The whole point of a model like this is to just
25 -- let's just go to their house, and we can

1 block off two hours because that's the right
2 thing to do, because we know like he's having
3 trouble coming in, and we know this patient's
4 hard of hearing, and he's got other challenges,
5 right?

6 Or sometimes it can be what I did a
7 couple of weeks ago, right, which is knock on a
8 bunch of doors in a parking lot in a semi-
9 abandoned mall out in the west side of Chicago,
10 looking for a patient of ours with our social
11 worker, who we knew had a pretty honking
12 diabetic foot infection, but, and was in a gray
13 Celica, that she thinks is a Celica, but she
14 really only knows it's a coupe, right?

15 And so we're literally walking
16 around this entire mall parking lot, trying to
17 -- I try and see who's in every single one of
18 these gray coupes, because that's the right
19 thing to do from an engagement standpoint. So
20 what we found is that that kind of approach can
21 be very useful in starting to do the work of
22 unlocking years of like reactive practice into
23 doing something more, that feels very odd to
24 our PCPs in particular.

25 But that is actually the work, I

1 think that Kaiser has exemplified this so well,
2 of just getting out into the community and
3 meeting people where they are.

4 DR. LIN: Great. Those examples
5 were really vivid and I think well
6 illustrative.

7 VICE CHAIR HARDIN: I think this is
8 a perfect note to close this session. We want
9 to thank you all so much for this excellent
10 discussion. I have a feeling we could continue
11 asking you questions for a good another hour.

12 We want to welcome you to stay on
13 and hear the next presentation or listen to the
14 rest of the meeting as much time as you have
15 available. We'd love to have you on, and we
16 want to sincerely thank you for sharing your
17 time, expertise, and excellent thoughts about
18 total cost of care.

19 * **PTAC Member Listening Session on**
20 **Assessing Best Practices for Care**
21 **Delivery for PB-TCOC Models**

22 Next, I'm honored to move into our
23 PTAC Member Listening Session, and we have one
24 of our very own members presenting based on his
25 experience with many delivery system models.

1 Angelo Sinopoli, Committee members, will be
2 presenting and members, please have your
3 questions ready for Angelo after his
4 presentation. Angelo, please go ahead.

5 DR. SINOPOLI: Thank you, Luran,
6 and I appreciate the opportunity to talk today,
7 and right now I am the chief network officer
8 for UpStream, but I want to emphasize that this
9 presentation is not really about UpStream,
10 although I'll highlight some characteristics of
11 UpStream to fit into the discussion here.

12 What I'm really trying to bring to
13 the table today is kind of a series of
14 experiences working with very large, integrated
15 delivery systems, large networks and companies,
16 consulting with other networks particularly
17 across the Southeast and other areas, and then
18 my more recent experience with UpStream, and
19 kind of identifying -- I think you're going to
20 hear repeated messages from today. I think
21 we're all on the same page in terms of where
22 things go in and what needs to happen.

23 So I'll just walk through this and
24 kind of highlight these things as we go. So if
25 you can go to the next slide. So this is just

1 a pyramid that I always like to look at,
2 because it does represent all of the building
3 blocks that are necessary for a very high-
4 functioning integrated network. And I will
5 tell you that from my experience, with notable
6 exceptions, some of those that just presented
7 today, these don't exist in most clinically
8 integrated networks, okay.

9 But ideally, these are the things
10 you'd want to have active participation in, in
11 every one of these building blocks. If you're
12 missing some of these building blocks, you're
13 not going to be the Kaiser, you're not going to
14 be some of those that we think about day-in,
15 day-out. But it still is useful to look at
16 these building blocks as you're building your
17 pyramid to understand where you need to be.

18 Because I'm going to talk just a
19 couple of minutes about this, and talk about
20 some of the more important pieces, at least
21 from my perspective, and some areas where I
22 think historically we've kind of missed the
23 boat a little bit. And so obviously physician
24 leadership is the single more important
25 building block of this pyramid. You've got to

1 have engaged physicians who understand what
2 needs to happen, and I think there's been a
3 tendency in the past to not appreciate the
4 importance of primary care.

5 I think that is rapidly changing
6 over the last few years, and I think
7 appropriately so. Primary care has been seen
8 mainly as where attribution occurs, and where
9 referrals come from, and a way to grow the
10 network and grow a volume. But it's not been
11 really seen as that's where the patients get
12 managed, and that's where the cost containment
13 and the quality improvements occur. So that,
14 that is changing, and I think we need to
15 emphasize that.

16 The next layer up is after you get
17 that physician engagement, you've got to have
18 appropriate care models that are informed by
19 data and analytics. And again, I've built a
20 large data and analytics company, but I'll tell
21 you again that most places do not have adequate
22 data and analytics, and most entrants into the
23 market trying to get into value-based care
24 typically will rely on their hospital systems
25 for data, and they'll rely on payer reports.

1 Those two things are okay for a
2 beginner set, but they're not good enough to
3 really get you to that next level. The
4 expertise within hospital systems aren't
5 focused on the kind of things we're going to
6 talk about, and their analysts, their data
7 scientists, et cetera, are a different breed
8 than what we need from a value-based component
9 standpoint.

10 And then developing the delivery
11 network. I will mention UpStream here. I
12 think one of the differences in UpStream
13 compared to some of the value-based companies
14 is that we take all comers, okay. Just as
15 compared to trying to aggregate patients into a
16 center, we partner with every primary care
17 patient (sic) that sees Medicare patients, and
18 our goal is to bring all of them up.

19 Some of them have lots of Medicare
20 patients; some of them have only a few. But we
21 partner across the board, and we treat them all
22 the same. We isolate them in terms of their
23 quality and outcomes, and so if you're in a
24 given network, and you have one practice across
25 the street that's doing poorly but the other

1 one across the street is doing great, we
2 incentivize the practice that's doing great,
3 okay.

4 So as practices, and I'll talk about
5 the model in a minute. As practices improve,
6 they see that reward immediately as opposed to
7 18 months down the road. We'll talk about
8 that. I think developing a financially
9 sustainable model, in my personal opinion, I
10 think this is where we've fallen down a lot
11 too, because we are so timid to get into risk
12 arrangements that we fail to recognize that if
13 you don't have enough upside potential, you
14 can't generate enough money to cover the
15 expenses.

16 The secret to success in these
17 models is data and it is expertise. This kind
18 of expertise doesn't come cheaply, and so you
19 can't -- as somebody said to me "If you think
20 expertise is expensive, wait till you hire
21 inexperience." So you've really got to go
22 after those people that know how to do this
23 work and invest a lot of money up front.

24 But I'll show you that there is
25 money out there. I'm not talking about private

1 equity money; I'm talking about money from CMS
2 that can cover these things.

3 So next slide. So this is just a
4 layout. You've all seen this slide, the
5 continuum of care. The only reason I put it up
6 there is to point out a couple of things.
7 Number one is you do have to think about and
8 address the entire continuum of care. You're
9 not going to be successful in Medicare if you
10 don't have a great post-acute program, for
11 example. So you've got to do that.

12 But the other thing that this
13 continuum of care slide represents to me, which
14 it's supposed to represent the continuum, what
15 it also represents to me is the fragmentation.
16 So you can even see from this slide that
17 there's multiple boxes, there's multiple
18 entities within each box. They all have great
19 initiatives going on, but even coming from
20 integrated delivery systems, they're still
21 fragmented.

22 The fabric that we heard about
23 before is the ideal thing that we're all
24 striving for. But it's hard to obtain that
25 fabric seamlessly across every aspect of the

1 organization. The other thing that I would
2 point out is that primary care, in that left
3 lower box, has been again traditionally ignored
4 as a site of where the actual care occurs.

5 And when I say "care," I don't mean
6 the care from the physician, but the team, and
7 we'll talk a little bit more about the team,
8 creating a team focus there in that practice,
9 and creating what we refer to as linear
10 integrity.

11 And so that primary care practice
12 with the right support systems and the right
13 team, can be that mini-care management company,
14 that for its patients is deriving that linear
15 integrity across to the hospital, across to the
16 post-acute systems, across to the community-
17 based organizations and driving very direct
18 care in a relatively low technology standpoint
19 of their risk stratification and data
20 analytics.

21 Next slide. So again, just
22 reemphasizing this is that changing how we
23 think about primary care, it is the first
24 contact that patients have. It's the first
25 opportunity to do risk stratification. It's

1 the first opportunity to intervene. I think
2 primary care has been a missed opportunity in
3 general to intervene, and go to the next slide,
4 and we'll talk a little bit more about that.

5 So transforming primary care to
6 really -- rather than being the old PCMH⁴⁷
7 model, being a true primary care transformation
8 model, okay. And that requires an embedded
9 care team with multiple resources, and
10 interestingly enough, the money is out there
11 today to cover that. Most people don't utilize
12 it. I think when we did our own study, we
13 realized that chronic care management fees were
14 only charged about 14 percent of the time,
15 okay.

16 That's a huge missing opportunity
17 for primary care docs. So if you add up the
18 chronic care management opportunities, the
19 transitional care management opportunities, the
20 remote patient monitoring opportunities, the
21 annual wellness visit opportunities, there's a
22 significant amount of dollars there that can
23 transform a primary care practice into a care

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1 management hub that can identify or risk
2 stratify those patients, manage those patients
3 through the primary care practice, and create
4 great outcomes.

5 Now that team that is supported
6 through those revenue flows needs to be very
7 specific, and so it can't just be that you're
8 hiring anybody, just another nurse to put in
9 the practice. You've got to really think
10 through what you're hiring. Again, that team.
11 So we had a doctor present at the APG⁴⁸ meeting
12 last week in San Diego, and he stood up and
13 said, okay, I'm a primary care doctor, and I
14 just saw a patient who had five chronic medical
15 problems. They're on 12 medications. They had
16 side effects from medications. They had
17 transportation problems. They had social
18 determinant problems.

19 Tell me how I'm supposed to
20 strategically decide which one of those
21 problems to address in a 15-minute visit? The
22 answer was you shouldn't have to, you know,
23 prioritize any of those at all, and if you had

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1 a team around you, number one, that would have
2 not occurred to begin with, because they're
3 cycling in the back addressing those things
4 before you come, before that patient gets in to
5 see you.

6 When you see the patient, you
7 already know what's going on with that patient
8 and what's being done for them. The other
9 thing that team can do is what our team does,
10 is that before those visits, is we have every
11 patient come in and see that care management
12 team, which includes a clinical pharmacist, and
13 they're specifically trained to do certain
14 things.

15 But that team will reach out and get
16 medical records from every specialist that that
17 patient has seen, because although it sounds
18 reasonable that you would expect that those
19 would get sent to you, they don't; that you can
20 retrieve them electronically, you can't. My
21 previous clinically integrated network had 83
22 different electronic medical records, okay, and
23 you never got anything from the
24 ophthalmologist.

25 And so this team serves to aggregate

1 all that data, bring the patient in. They'll
2 spend as much as 90 minutes with a patient,
3 going through all those reports, going through
4 how they're doing, listening, trying to
5 understand what the patient needs are, what
6 their expectations are, and what we've seen is
7 that once those patients come in and see that
8 care management team, that there's almost 100
9 percent retention rate in that model.

10 So they begin to recognize those
11 ancillary support team members as their team
12 members, and they become very attached to
13 those. They're available to them 24-7, and
14 they -- we embed those in every primary care
15 practice, and those patients will call that
16 pharmacist or call that nurse care manager for
17 any kind of problems they have. That takes a
18 lot of workload off the primary care doc.

19 They also handle all of the pre-
20 auths from the pharmacies, from the insurance
21 companies, et cetera, so the primary care
22 doctors love it. And they work to close all
23 the gaps in the practices. They bring those
24 patients in and they look at where those gaps
25 are. They schedule their mammographies, they

1 schedule their colonoscopies, et cetera.

2 Next slide. So it does have to be
3 the right combination though, and they do have
4 to be trained. So you can't just get a
5 pharmacist and stick him in there. So we put
6 our pharmacists through something called
7 UpStream University, and they're actually
8 trained in motivational interviewing. They're
9 trained to listen. They're trained to look for
10 these very specific indicators of health
11 outcomes and to document those and to address
12 those issues, to address those social
13 determinants.

14 These embedded teams, although we
15 say embedded, we have some that wrap around the
16 practice too, and as you heard earlier, they'll
17 go out to the laundromat and meet them, or they
18 go to the home and meet them, and those are
19 unlicensed but trained professionals that go
20 out and do that. And so it's varying the
21 levels of expertise in that model.

22 The other thing that we do that we -
23 - that I think has been a differentiator,
24 because one of my issues has been, even for our
25 -- my previous network, is that from a doctor's

1 standpoint, you're working all year long.

2 You really have very little line of
3 sight of how well you're doing. And then at
4 the end of the year, the end of the year
5 closes, and then you're at another eight
6 months, and you cross your fingers and see if
7 you're going to get any shared savings.

8 So after a while, that becomes a
9 little demotivating, particularly if you go
10 some years where you're not creating shared
11 savings. So in an UpStream model, they're
12 confident enough in their model that they know
13 they're going to make shared savings. So
14 they're actually paying the physicians up
15 front, but we don't pay them for shared
16 savings. We pay them for quality.

17 So we actually have a star rating
18 system for quality, based on all the typical
19 metrics you would think of, and as their
20 quality improves, then we pay them more. So
21 they get paid a certain PMPM for this level of
22 quality, but as their star ratings go up, they
23 can actually see their monthly income going up.

24 And so that motivates them to
25 participate in a team, to close those gaps, to

1 drive quality. It's not about utilization.
2 It's about driving quality. The team is
3 addressing utilization by managing those
4 referrals, managing the hospitalizations,
5 managing the post-acute, but that encourages
6 the doctors to work with that team.

7 And so the docs see immediate
8 reward, we're seeing great returns on the back
9 end with this, with this model. So we take all
10 the downside risk, and we guarantee the upside
11 risk, and that clinical embedded team is what
12 drives all the outcomes. It's amazing that
13 just a handful of embedded team members
14 compared to a telephonic model, drives dramatic
15 improvements in quality and shared savings,
16 okay.

17 Next slide. So again you've heard a
18 lot about data and analytics, and obviously
19 it's important. Most people don't have the
20 access to kind of data you've heard today. We
21 had a fairly sophisticated data system at the
22 previous organization I worked for, but even
23 that was relatively unusual. And so but you do
24 need that. I mean that is the ultimate goal, is
25 to develop that level of data integrity and

1 data abilities, because you've got to
2 aggregate.

3 Again, it goes back to one of the
4 problems is in our network, we had 83 different
5 EMRs⁴⁹, and so developing the processes to get
6 that data, to centralize it, to aggregate it,
7 to scrub it, to normalize it, to match it with
8 claims, to do all that is a huge, huge
9 undertaking. Then to use all that to risk
10 stratify patients, both from a cost standpoint
11 and a clinical quality risk standpoint, and
12 we're now rebuilding that at UpStream, a
13 similar model.

14 So that is a very difficult task,
15 and something that's very expensive. Again, I
16 think relying on hospitals is probably one of
17 the disservices that most organizations do,
18 because they're depending on that kind of data,
19 and hospitals just aren't equipped to do the
20 things that I just mentioned.

21 So you've really got to either build
22 your own, or reach out to a partner or some
23 other data company to help bring that data to

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1 the table. If you do that, then I think many
2 more primary care practices can get into the
3 value-based arena than we've seen get into it
4 in the past. You know, the barriers have been
5 that upfront expense, you know. It's just too
6 expensive for primary care docs to get into the
7 value-based arena.

8 They don't have the capital to take
9 downside risk. Even \$5 million organizations
10 don't want to take that much downside risk,
11 because that hurts their bond rating. They
12 could afford to lose it, but it hurts their
13 bond rating, and then the data and analytics.
14 Those three things really are barriers.

15 So next slide. So again, as I think
16 through what the barriers have been that I've
17 been exposed to that have really prevented us
18 as a country for moving more rapidly into
19 value-based care, has been, you know, a
20 reliance on hospitals to help drive this.
21 Again, it's not that they don't necessarily
22 want to; it's just not their business model if
23 they don't have enough patients in their system
24 for it to become important for them to make the
25 appropriate investments that they need to do,

1 again with notable exceptions.

2 We all hear about the great
3 organizations that are doing this well, but I'm
4 talking about through rural Southeast United
5 States. That just doesn't happen very often.
6 Lack of the upfront investment. Physicians
7 don't receive real-time incentives, unable to
8 take the downside risk, not enough volume.
9 Those are the barriers.

10 So next slide. And my last slide
11 was just really, so how do we get past this? I
12 think developing enablement resources or
13 partnering, and I think the good thing that I'm
14 seeing in the market is that more of these
15 companies are developing, that can at least
16 bring data to the table that's appropriate data
17 the practices and networks can use.

18 I think there's opportunity to make
19 those upfront investments if we educate our
20 practitioners. How do you build chronic care
21 management, transition care management, you
22 know, educate them on the importance of the
23 annual wellnesses, et cetera? All of that are
24 huge drivers to success, and they pay for
25 themselves if you learn how to manage those

1 correctly. The real-time incentives is a
2 problematic thing. There's not many companies
3 that pay up front, real-time, but I think
4 that's becoming more recognized as a need to do
5 that.

6 And then enough to embrace enough
7 risk, and what I hear constantly in
8 conversations is that we've got to move the
9 downside risk. That's a little bit of a
10 negative tone for me, because it's not that I -
11 - I want to go to -- all of a sudden I want to
12 start taking downside risk. What I want is I
13 want lots of upside potential, and to do that,
14 it will take some downside risk.

15 And so but you're never going to
16 have the money to invest in the things you need
17 to invest in unless you're willing to take that
18 upside risk, and the odds are that you're not
19 going to have to pay on the downside. Scale
20 does matter, and so you know if you're managing
21 15,000 patients, your year-to-year variability
22 is significant.

23 But if you're scaled and you're
24 managing a million patients, then that, that
25 kind of evens out over the years, and you may

1 have one network that does poorly but another
2 one that does well, and so your risks even out.
3 And so I think, you know, scaling across the
4 country with various organizations is another
5 important aspect of how we're going to spread
6 this across the U.S. more quickly than we have
7 in the past.

8 So I think that was my last slide.
9 So it's really open for questions.

10 VICE CHAIR HARDIN: Go ahead, Bruce.

11 MR. STEINWALD: Thanks. It's a two-
12 part question, so wait for the second part
13 please. I guess you mentioned, I was thinking
14 of volume. What's the minimum that you can get
15 something going in the direction of value-based
16 care in a given market? Is it based on the
17 number of patients?

18 DR. SINOPOLI: That's a great
19 question. So we look at it in two ways. We
20 look at it per practice, and we look at it per
21 micro-geography. So in a micro-geography, we
22 need 4,000 patients, and in a single individual
23 practice, it doesn't make sense for us to embed
24 pharmacists and care management staff if they
25 have under 200 patients.

1 And the way that we do that, so we
2 use that 4,000 patient supports an entire team.
3 That includes a clinical pharmacist, a nurse
4 care manager, and a concierge team of non-
5 licensed people that surround, surround those
6 three individuals, and they cover 4,000
7 patients. And so if you've got two practices,
8 each that have 2,000 patients apiece in them,
9 then they're splitting half of their time
10 between those patients, those practices.

11 But they're available to those
12 practices 24-7, and they're available to those
13 patients 24-7. But when it gets down to a
14 single practice that has under 200 patients,
15 it's not very productive to have that model in
16 place. But we do that sometimes, because we
17 may have a network that has 50,000 patients,
18 and there's a few rural practices in there that
19 have 200. And so in the bigger scheme of
20 things, we provide that service anyway.

21 VICE CHAIR HARDIN: I'm going to
22 jump in.

23 MR. STEINWALD: As I was listening
24 to Dr. Khan, and some of the statistics he
25 cited where it seems like they're in many, many

1 markets, but the market penetration in any
2 given one is pretty low. And even to the point
3 of saying well, there's no specialist
4 organization that derives more than 10 percent
5 of their income through their presence there.
6 Would you pursue a strategy like that? It
7 sounds like it's successful, but is that the
8 exception rather than the rule?

9 DR. SINOPOLI: Yeah. We actually
10 take the opposite strategy, in that we -- and
11 there have been a lot of delivery systems that
12 are trying to move towards senior clinics, you
13 know, that kind of model. After talking to us,
14 they're reversing their strategy, and they're
15 going to go with us because it's, it's -- our
16 strategy is to allow patients to see the
17 practitioners they want to see, you know.

18 Don't take patients away from
19 doctors who have long-standing relationships.
20 Let's embed the resources. Let's give the
21 doctors the time, the resources, the patients,
22 the resources, and we've proven that we can --
23 we can drive utilization down 45 percent a
24 year, year over year, and create, you know,
25 savings of 10 percent a year with this embedded

1 model.

2 And so -- so yeah. So ours is a
3 much broader footprint, more scalable than
4 trying to create, you know, individual
5 practices.

6 VICE CHAIR HARDIN: I have a
7 question for you about social determinants and
8 addressing equity. So you have the perfect
9 scenario. You're not only with one payer or
10 one population, you've got everyone. So I'm
11 curious. What have you found to be the most
12 impactful investments for addressing health-
13 related social needs, and then in relation to
14 that, what partnerships or revenue shifting are
15 you needing to build in order to meet the
16 demand that you're finding as you're
17 proactively addressing that with large
18 populations?

19 DR. SINOPOLI: From a social
20 determinant standpoint?

21 VICE CHAIR HARDIN: Yeah.

22 DR. SINOPOLI: Yeah, yeah. You're
23 right. Since we do all -- all of our contracts
24 are global risk, and even on the fee-for-

1 service side, either a DC⁵⁰ model and now REACH
2 going into this coming year and MA global
3 contracts, and what we're finding is -- so I'll
4 start from the top -- huge educational
5 opportunities.

6 Patients come in, and they don't
7 know how to access the system. They're on
8 multiple medications. They don't understand
9 their medications. One of the things that we
10 do is that we synchronize their prescriptions,
11 so that they're getting all their prescriptions
12 filled on the same day of every month, because
13 otherwise they're trying to get to the
14 pharmacies multiple times a month, and they
15 miss them.

16 Because the number one driver has
17 been transportation. They cannot get to their
18 doctor's office, they can't get to the
19 pharmacist. They can't -- even if you refer
20 them to a community-based organization, they
21 can't get there to talk to them. And so the
22 transportation's the issue, and we have
23 partnered with cab services, with EMS⁵¹, with

50 Direct Contracting

51 Emergency medical services

1 others to help drive those outcomes.

2 That solves the vast majority of
3 problems, because if you can transport them
4 somewhere, you can get most of their issues
5 taken care of. It's just the transportation.

6 VICE CHAIR HARDIN: Thank you. I
7 wasn't paying attention because I was so
8 excited about my own question. Who was first?

9 DR. MILLS: We'll just say it was
10 me. So first of all, Angelo, I'm going to say
11 fantastic and hip-hip hooray. In a fit of
12 convergent evolution, I had exactly the same
13 experience in private practice in Kansas that
14 came with the very same lessons learned, which
15 was such modest investment in primary care of
16 about half an FTE⁵² nurse care manager, one
17 extra medical assistant per physician, one LPC⁵³
18 per clinic site, and a tiny smidge of a
19 clinical pharmacist, you can get what you need
20 done, and you laid out the revenue sources that
21 cover it.

22 DR. SINOPOLI: Yeah.

23 DR. MILLS: It makes perfect sense.

52 Full-time equivalent

53 Licensed professional counselor

1 These are two follow-up questions just to see
2 what your experience was in parallel to my
3 experience, which was first, two parts.

4 One with your providers. The
5 biggest sticking point is often just getting
6 the time and attention of the individual docs
7 to engage, and trust their team to do the
8 amazing stuff behind the scenes while they're
9 in an exam room. So what did you find to be
10 the magic tipping point for your docs, doc by
11 doc?

12 And secondly was we actually had
13 more resistance in the management level of most
14 of the clinics than the docs. Managers, of
15 course, being trained to maintain homeostasis
16 and keep the bus moving smoothly, as opposed to
17 a leadership mindset of what's the potential
18 for the future. So we actually had some
19 retraining at a management leadership level to
20 make huge difference. So if you can comment on
21 those two aspects.

22 DR. SINOPOLI: Yeah. No, I would
23 agree with you. I think -- and one of the ways
24 that we train our staff is we tell them. So
25 your primary responsibility is to the patient.

1 Your secondary responsibility is to the doc in
2 that clinic, and you're not there to disrupt
3 his workflows. You're there to partner with
4 him, to help make his workflows more efficient.
5 Even with that to your point, it takes about
6 four months before the doc begins to trust that
7 these staff know what they're doing, that
8 they're not there to disrupt his day and make
9 his day, and it's interesting.

10 You know, as we're talking to
11 potential new partners, that's always the
12 number one things that comes up. They're
13 saying what kind of abrasion am I going to get
14 when you embed your team in my practice, and
15 we're going, this is your team, you know.
16 We're training them, we're hiring them, but
17 they're your team and this is what they're
18 going to do for you, and you've got to be
19 willing to work with them to let them do that.

20 But even with that, there's that
21 tension and resistance. But typically after
22 about three or four months, they're like, oh
23 yeah. In fact, I had one of the -- so this is
24 a country doctor. You've got to understand his
25 language. So I had a doc call a primary care

1 practice out in a rural area to describe the
2 lack of abrasion that you're talking about.

3 He called me up afterwards, and he
4 said yeah, I talked to Doctor such and such,
5 and he said, he said I'm glad my office staff
6 wasn't in the room. I'm like uh-oh. I said
7 well, what did he say? He said if my office
8 staff had been in the room, they would have
9 wrestled me to the ground and put a choke hold
10 on me until I signed the contract with you,
11 because they took so much of the administrative
12 burden off the staff, and that's what gets the
13 staff bought in.

14 Because all of the sudden now
15 they're freed up to spend time with the
16 patients too, and they're not answering all
17 these pharmacy calls and all these other
18 things. And so it takes a number of months for
19 them to kind of recognize that's what's
20 happening. So good question, thank you.

21 VICE CHAIR HARDIN: Jay.

22 DR. FELDSTEIN: Angelo, do you hire
23 -- does your company hire the team for the
24 doctors' office?

25 DR. SINOPOLI: We do, we do.

1 DR. FELDSTEIN: Do they have any
2 input into those decisions?

3 DR. SINOPOLI: Yes. They have
4 hiring and firing rights. We train the teams.
5 We bring the teams to them, but they get to
6 meet them, make sure they're a fit culturally,
7 and if at any time during the course of their
8 employment there they get sideways with the
9 docs, the docs can fire them, and we have to
10 bring in another, another team. But they do,
11 they do participate.

12 DR. FELDSTEIN: And are they on the
13 physicians' payroll, are they on your payroll?

14 DR. SINOPOLI: They're on our
15 payroll.

16 DR. FELDSTEIN: And is it part of
17 the package?

18 DR. SINOPOLI: Part of the package.
19 So we cover all the costs for all the teams, as
20 well as paying the docs that monthly PMPM.

21 DR. FELDSTEIN: And when you say
22 "embedded," do you mean face-to-face action, or
23 just it's owned by the physician practice? So
24 if they have to do telephonic, it's still part
25 of the practice, or it just has to be face-to-

1 face? I'm very curious about that.

2 DR. SINOPOLI: So we have both of
3 those. So we have actually physical bodies in
4 the office. We have a clinical pharmacist and
5 a nurse care manager actually in the practice,
6 and they may not both be there the same day.
7 You know, the scenario I gave you where they
8 might be covering two practices, and one may be
9 in one and one in the other.

10 But somebody's there most every day,
11 and they're interacting with the docs. They've
12 got a space where they can see the patients.
13 They do the intake, so to speak, of those
14 patients and meet with them and manage them.
15 We also have a -- we do have some telephonic
16 care management services. We found that
17 they're really only useful for follow-up
18 issues. We don't like to use them as a primary
19 resource for care management.

20 It's if somebody just needs to be
21 checked on to see if something happened or if
22 they got their prescription, then we can call
23 them, and we can call them from a central
24 office. But we want them to have that
25 relationship with that pharmacist and that

1 nurse care manager, that they feel like that's
2 my pharmacist and my nurse care manager so --

3 We also, you know, those that we are
4 seeing so intently, it averages to be about 30
5 percent of the entire Medicare population.
6 Those are the ones that we're really seeing in
7 the office and intently. That other 70, we
8 have a team that's outside the office just
9 following up on those, because what you heard
10 from somebody earlier today, that 70 percent is
11 actually what drives a lot of the gaps in care,
12 because we're paying attention to those top 30
13 percent and trying to fill those gaps.

14 There's 70 percent with rising risk
15 and those quote, you know, "well patients,"
16 they aren't getting their colonoscopies done,
17 but they're not sick, and they're not utilizing
18 you yet. So we've got another team that
19 addresses those, and make sure that those gaps
20 are being filled.

21 DR. FELDSTEIN: Thanks.

22 VICE CHAIR HARDIN: Jennifer.

23 DR. WILER: Thank you for
24 describing your organization and your previous
25 experiences. I think there's a lot of themes

1 that we continue to hear, not only today but in
2 our other sessions. So it strikes me that in
3 fee-for-service, a balancing measure that was
4 created out of that system, is utilization
5 management, right, to restrict access.

6 And yet we had a number of speakers,
7 including yourself, today talking about number
8 of touches being a process measure, to validate
9 interactions, which improve outcomes. So we
10 heard today about a ratio of a PCP to
11 specialist/consultant, and one of our speakers
12 said a one to one ratio was where they were,
13 they were focusing.

14 And if I took notes appropriately,
15 Dr. Zimmerman said that the goal was to have 95
16 percent of patients being seen once per week,
17 which is obviously really high. So again, you
18 just described high touch and also 24-7 access.
19 So can you talk a little bit about how to
20 operationalize that, especially as we're
21 thinking about workforce issues and folks who
22 are, you know, leaving the specialty because of
23 emotional stress?

24 And yet we're, you know, this is
25 creating potentially an unintended consequence

1 of unfettered access of patients to resources.
2 Are you finding it difficult to find staff who
3 want to have 24-7 accessibility to patients,
4 number one, and then number two, what are the
5 metrics that you're following around validating
6 that there's a high touch?

7 DR. SINOPOLI: So we've not found it
8 difficult to recruit staff. So there's an
9 abundance of pharmacists out there right now,
10 and a lot of new graduates who are having
11 difficulty finding jobs, and then because of
12 this model, a lot of the pharmacists are tired
13 of counting to 30 every day.

14 So they are looking for these kind
15 of jobs, and so -- and we pay very well. And
16 so for every open spot we have, we typically
17 have at least five great applicants for them.
18 We have to decide between those five which ones
19 to put in a practice. So nurses are a little
20 bit harder to find, but this is such a unique
21 job again, that we've not had problems so far
22 of finding enough good nurses. But just
23 because of the nature of the work. It's what
24 they went to nursing school for, and so, so
25 we've not. They love the interactions, they

1 love being available, and they don't really get
2 that many calls at night.

3 You know, they are available 24-7,
4 but if they're doing their job, those things
5 are taken care of during the day, and there's
6 not many night time calls. And so -- and we
7 are measuring touches. We measure how much
8 time each of our staff spends with patients.
9 They average about 7-1/2 hours per year
10 actually, you know, directly conversing or
11 meeting with the patient.

12 It doesn't sound like a lot, but
13 that's actually a lot of time compared to
14 nothing, and that intense structured time with
15 them is really what's driving the outcomes. So
16 we do measure that, and we measure patient
17 experience and get feedback from patients about
18 it too.

19 VICE CHAIR HARDIN: Walter.

20 DR. KOSINSKI: Walter?

21 VICE CHAIR HARDIN: I mean Larry.

22 (Simultaneous speaking.)

23 DR. KOSINSKI: Angelo, I can't tell
24 you how much I enjoyed listening to you and how
25 much I relate to the environment you're

1 building, because it's so similar to what we're
2 doing. Touches. Touches are such an important
3 concept. They supersede the difference between
4 PCPs and SCPs⁵⁴, because really what you're
5 doing, what you're calling primary care is
6 proactive engagement with patients, and we call
7 it touches because it can be in multiple
8 different fashions.

9 But a specialist managing a
10 condition that has a very high ratio of
11 disease-specific cost to total cost, those
12 touches are equally as important, and I think
13 we heard that in the renal disease piece
14 earlier today. So one of the things we've done
15 with touches is we've -- I hate the word
16 "automate," but I'm going to use it.

17 But we automated them. They are,
18 they're a part of the technology platform, and
19 we're in an environment today with patients
20 where patients want to engage in the way they
21 want to engage, and we have to adapt to that.
22 We can't retrofit it. I know we heard a story
23 about trying to find a gray Celica, you know,

54 Specialty care providers

1 to get a diabetic patient. That's obviously
2 the extreme, but you know, you have to figure
3 out a way of engaging with those patients where
4 you can proactively avoid the deleterious
5 effects that happen with poor engagement.

6 You're right. We found out that 200
7 patients was the minimum. But on the other
8 side, that nurse care manager or care manager,
9 it doesn't have to be a nurse, but that care
10 manager can handle a lot more than the 200. So
11 you build a lot more efficiencies as you bring
12 in more patients.

13 We really don't have an upper end to
14 that established yet because there is a lot of
15 elasticity there in how many patients you can
16 encounter there. So you're doing great things,
17 and I think there's a science. We've heard
18 some things today that have permeated multiple
19 presentations.

20 To me, what I'm coming away with is
21 that engagement is so critical, because we
22 heard that in just about every successful story
23 up there, and whether that engagement's being
24 done by a PCP, an under-appreciated PCP I
25 should say, or a specialist, I think we have to

1 get to the patient before the patients need,
2 realize that they need to be encountered.

3 DR. SINOPOLI: Thank you.

4 DR. KOSINSKI: Oh, one more point,
5 one more point.

6 VICE CHAIR HARDIN: Okay. Only one.

7 DR. KOSINSKI: I forgot. My team, I
8 emailed my team because you mentioned CCM⁵⁵ and
9 PCM⁵⁶ codes. One of the things that's a problem
10 today, these are not first dollar codes. A
11 patient gets a deductible every time we use
12 them. So if they're, if they're realizing that
13 we're doing something for them, they can accept
14 the fact that they have a hit to their
15 deductible and their copay.

16 But if we're using it proactively,
17 and maybe they don't realize they're getting
18 that much benefit, it would really accelerate
19 the use of these if they were first dollar and
20 --

21 (Simultaneous speaking.)

22 DR. SINOPOLI: So if I can make a
23 comment about that, is that so when we reach

55 Chronic Care Management

56 Principal Care Management

1 out to patients, we always describe that to
2 them so that they're aware of that. We only
3 get about a 70 percent uptake, because they're
4 worried about their copay. Of the 70 percent
5 who decide to take it, and sometimes their
6 copay is covered by their supplemental or
7 whatever, that's where we have a less than one
8 percent attrition rate.

9 But as we move into REACH, REACH
10 actually has a waiver, so that as long as you
11 do it for everybody, you can you waive the
12 copays for these client care management fees?
13 So that's our intent, is just to waive the
14 waiver because it's so valuable to get those
15 patients in so --

16 VICE CHAIR HARDIN: So fantastic
17 presentation.

18 DR. SINOPOLI: Thank you.

19 * **Stakeholder Responses to PB-TCOC**
20 **Request for Input**

21 VICE CHAIR HARDIN: It's really
22 great to see you weaving together the themes
23 and the depth of knowledge and experience from
24 having done this and best practices. We've
25 heard some fantastic themes today, really great

1 dialogue and discussion, and now we're going to
2 turn it over to Victoria, an analyst with ASPE,
3 to update us on the request for information and
4 input that we issued in March. Victoria,
5 please go ahead.

6 MS. AYSOLA: Hello, excellent.
7 Thank you so much. So I'm here to give a quick
8 plug that PTAC has released a Request for
9 Input, or RFI. The RFI is an important part of
10 the Committee's work on population-based total
11 cost of care models, and the RFI is still open.
12 So members of the public are asked to submit by
13 July 20th for the Committee's consideration as
14 part of the series.

15 And as a quick disclaimer, I'm not
16 speaking on behalf of PTAC, and right now I am
17 also not endorsing specific comments or policy
18 positions. So if we could go to the next
19 slide, please. Excellent. So throughout the
20 Committee's history, at least 10 of the
21 physician-focused payment models that
22 stakeholders have proposed discussed the use of
23 total cost of care measures or other related
24 elements, which led the Committee to plan and
25 hold this theme-based discussion series.

1 The purpose of the RFI is to gain
2 additional stakeholder insights that can then
3 inform the Committee's review of proposals, as
4 well as recommendations provided to the
5 Secretary.

6 I think the Chair noted this morning
7 that the Committee is going to draft and
8 release a report to the Secretary of HHS on
9 this topic after the series concludes in
10 September. So this RFI is a great source of
11 stakeholder input to lead to those
12 recommendations.

13 So if we could go to the next slide,
14 please. Great. So seven different
15 organizations have responded so far, and I'll
16 leave this up for a moment so that our audience
17 can get a sense of who has submitted. The
18 public comments that have been received so far
19 are available on the ASPE website, and as you
20 can see, we've heard from a few different parts
21 of the health care system.

22 Next slide, please. Great. So here
23 are some of the topics that the Committee asked
24 about in the RFI. I do want to share some
25 brief highlights of what has come in so far,

1 but note that this is not a comprehensive look
2 at the responses. I think a lot of these will
3 sound familiar, based on what you have all been
4 hearing throughout the day.

5 So I'll note that for defining total
6 cost of care, there has been a variety of ideas
7 about which services should be included when
8 calculating total cost of care. In terms of
9 the design and implementation of these models,
10 several respondents suggested incorporating a
11 wide array of providers and entities that can
12 potentially contribute to reducing total cost
13 of care.

14 That was also a care delivery best
15 practice that people wrote in about. Some
16 respondents also said that using clinical
17 workflows and data analytics can help
18 facilitate innovative care delivery. In terms
19 of accountability, respondents tended to favor
20 setting accountability for total cost of care
21 at the entity level, rather than at the
22 individual provider level.

23 And for provider participation,
24 stakeholders who responded shared that being
25 able to manage total cost of care does vary by

1 many factors such as specialty, data
2 availability, provider's history of prior
3 participation with value-based care
4 arrangements, patient's health status, and so
5 on.

6 Respondents said that to improve
7 coordination between primary and specialty care
8 providers, there are several factors that tend
9 to be important, including access to timely and
10 accurate data, expanding payment opportunities
11 to all necessary services in real time, as well
12 as expanding regulatory flexibility when
13 possible.

14 And for that last category, I'll
15 note that some respondents wrote in that while
16 incorporating and embedding episode-based
17 payment models into or within a population-
18 based total cost of care model can be useful,
19 this requires a very clear definition of the
20 episode, as well as transparent rules about the
21 accountability.

22 Great, and next slide, please.
23 Great. So that was just a sample, and the full
24 RFI and stakeholder responses are available
25 online, and members of the public are welcome

1 to submit by July 20th for the Committee's
2 consideration as part of the series. Thank
3 you. Back to you, Lauran.

4 VICE CHAIR HARDIN: Thank you so
5 much, Victoria. At this time, we're going to
6 take a short break. The PTAC Public Meeting
7 will resume at 3:30, with Committee discussion
8 about themes and things noted from today. So
9 from 3:15 to 3:30, we'll take a break. Thank
10 you all so much for joining.

11 (Whereupon at 3:14 p.m., the above-
12 entitled matter went off the record and resumed
13 at 3:30 p.m.)

14 * **Committee Discussion**

15 CHAIR CASALE: Welcome back. So now
16 the Committee members and I are going to
17 discuss what we've learned throughout the day
18 from the various presentations and Q and A
19 sessions. We still have more presenters in a
20 panel discussion tomorrow, but I want us to
21 reflect on what we heard today.

22 After we conclude this series in
23 September, we will submit a report to the
24 Secretary of Health and Human Services on
25 population-based total cost of care models.

1 Our reflections at these meetings will help
2 shape our findings in that report. So for
3 Committee members, I'm going to ask you to find
4 the Potential Topics for Deliberation document.
5 It's in the left front pocket of your binder.

6 To indicate that you have a comment,
7 again just please flip your name placard. So
8 we're now going to open it up for comments for
9 the Committee members. The potential topics
10 are listed on the slide, but you can also see
11 those in your handout. So I'll turn it over to
12 the Committee for comments. Larry.

13 DR. KOSINSKI: So we heard models
14 described in fully employed situations. We
15 heard about primary care models. We heard
16 about how specialists interact with the primary
17 care models. There's -- to me, there was a
18 single best practice -- if we're talking about
19 best practices, there's a single best practice
20 theme that permeated just about everything, and
21 that's high touch, proactive patient
22 engagement.

23 To me, that's almost a must after
24 listening to everybody today. We have to be
25 proactive. We have to have a lot of touches.

1 Whether it's a primary care doctor or a
2 specialty care doctor doing it, I don't know if
3 that environment is different. So I mean
4 that's, that's I think one of my biggest
5 takeaways from today.

6 CHAIR CASALE: Lee.

7 DR. MILLS: Yeah. A really rich
8 discussion today. I think I was just
9 reflecting on some of the themes we've heard,
10 and some of Angelo's recent comments I think
11 really highlight that. One is the importance
12 of thinking and recasting primary care. It
13 just has to be done differently, and that
14 includes resourcing that is real, but it's not
15 as hugely overwhelming as it sometimes is
16 feared to be.

17 It can be fairly modest. Focused
18 resourcing makes all the difference in the
19 world inside a different model. That model
20 pairs with some compensation changes. Again,
21 you can't keep doing the same thing and
22 expecting different results. I think all of us
23 have lived through that.

24 The centrality of data that has be
25 polysourced, it has to be bigger than any one

1 practice, one doctor, one EMR, frankly even one
2 system or one payer. So I think Dr. Kendrick
3 spoke powerfully to those challenges and
4 opportunities.

5 And then lastly, to take up what
6 Larry just pointed on, that we heard sometimes
7 I oversimplify and say it's just doing the job.
8 But it's just the high touch, get where the
9 patient is and find out what, what they need,
10 and that's not -- that's not rocket surgery,
11 but it is something that doesn't happen in the
12 traditional model of medical practice, and
13 that's the secret sauce to everything we've
14 heard about today.

15 CHAIR CASALE: Yeah, thanks. I mean
16 I'll add to that. Particularly on the data, I
17 thought Dr. Kendrick, I mean that was really --
18 you know, I know the data that I work with, and
19 I think it's okay. I know it's not great, but
20 when I saw that map of the country and Oklahoma
21 and where all the patients are getting their
22 care, I mean that's really powerful, to realize
23 that, you know, how -- you know, we tend to
24 very centered on our either health system or
25 community or state.

1 So the data piece, which is really
2 challenging but so important, is certainly one
3 of the takeaways I was thinking about. And the
4 other thought again around these high touches,
5 which I think you brought up, was around the
6 culture change that's needed. I can tell you
7 my organization, I have, you know, quite a few
8 primary care doctors who sort of want help, but
9 then they want to control.

10 And so I'm sure, Angelo, in your
11 model, I'm sure you've come across that, and it
12 is a culture -- any of these things require a
13 culture change from, to move to a new model and
14 how best to do that.

15 VICE CHAIR HARDIN: I'll just build
16 on that. I think some really interesting
17 themes that I've seen in my work and also in
18 partnership with other sites is really the
19 concept of case finding. So utilizing data to
20 find people with needs or really a longitudinal
21 relationship, where you're looking in your
22 population for people with needs before they
23 have them. And then another theme I thought
24 was really interesting and teased out is the
25 cultural change in the kind of training.

1 So Angelo talked about this, but it
2 was true across the other models as well. It's
3 very different to do a longitudinal
4 relationship and build that sort of full
5 knowledge, comprehensive across settings and
6 EMR. What is that patient's story, and how
7 does it integrate? That's a different kind of
8 work and culture than proactively light touch
9 reaching out in that 70 percent of rising risk.

10 Different people like to do those
11 things, and the training's different. But
12 they're both necessary to get total cost of
13 care, and then I think tomorrow we'll have an
14 opportunity to go even deeper on some of those
15 social determinants of health, investments, and
16 opportunities, and also the populations that
17 aren't intersecting with primary care. So
18 what's happening with them, because they're
19 also in that total cost of care equation.

20 But we did hear some great themes
21 about reaching out to where the people are and
22 the importance of transportation, as well with
23 social determinants. So lots of rich dialogue.

24 DR. SINOPOLI: One other -- sorry.
25 One other point I'd like to make is that either

1 we have to make it easier to migrate to global
2 risk, and/or create a lot more waivers that are
3 easy to get, because we're -- we have our hands
4 tied frequently because of our inability to do
5 things because of regulatory issues.

6 If we can get past those waivers,
7 it'll make things a lot easier. So identifying
8 those and addressing those I think is useful.

9 DR. WILER: I think what struck me
10 most, and this has come out in a number of
11 these sessions that we've done, is that the
12 care delivery itself at the patient level may
13 be a simple intervention. But the incentives
14 and payment programs around it are extremely
15 complicated. I appreciated hearing these
16 disruptions and innovations.

17 But a couple, back to a couple of
18 other themes. There's still a disproportionate
19 amount of employed physician practice where the
20 biggest innovations are happening, which may or
21 may not be replicable. This big data strategy
22 is one that absolutely works, but again the
23 question around feasibility is one that I think
24 I appreciated the comment that, again if I'm
25 remembering correctly, that there's 25 nodes

1 across the U.S. that potentially could be
2 linked, which I think is really an opportunity
3 for CMMI to be thinking about how do we incent
4 leverage of that data.

5 And then I was also struck by
6 multiple examples of how to get care teams to
7 want to participate, either with, you know, a
8 carrot or, you know, balking at it, a
9 disincentive. And so we heard a number of 30
10 to 50 percent of total comp at risk for
11 performance, and a couple of -- and there was
12 all kinds of micro-examples at the clinical
13 staff person or provider level, absent
14 contracting because we heard a lot of, I
15 thought, interesting ideas around contracting,
16 about how to make this work.

17 I'm also struck by the fact that a
18 health system strategy for which I work is
19 unlikely to be the right model, and these
20 private-public partnerships are the ones that
21 appear to be the most successful.

22 DR. LIN: Yeah. So just following up
23 on that comment on incentives, I believe Kaiser
24 lore has it that one of the co-founders of
25 Kaiser, Sidney Garfield, a physician, was found

1 nailing nails down in a construction site to
2 prevent an infection from a tetanus wound from
3 these construction workers, who were seen in
4 clinic.

5 And similarly, you know, we heard
6 Dr. Khan today talk about a really vivid
7 example of going out to, it sounds like a
8 trailer park, looking for a woman with a
9 diabetic foot ulcer in a Celica, along with a
10 social worker by the way, so the care team, to
11 prevent or treat a diabetic infection.

12 What you can say, which I assume is
13 implied, is that he was doing that to prevent a
14 downstream worsening of infection, potential
15 hospitalization with weeks of IV antibiotics,
16 post-acute care, preventing a 15 to 30,000
17 dollar stay in the inpatient and subacute areas
18 of health care. And he was doing that with a
19 simple physician visit along with the social
20 worker.

21 So I think, you know, as I'm
22 thinking about total cost of care, how this
23 Committee can help maybe think about a payment
24 system that incents that kind of really
25 profoundly innovative primary care. How do we

1 -- how do we incent, create the right
2 incentives to substitute low-cost, high-value
3 care for much higher-cost care downstream? I
4 think we had some great examples of that today.

5 And I think we'll have some more
6 tomorrow too, as I look forward to tomorrow's
7 subject matter experts.

8 MR. STEINWALD: May I go?

9 CHAIR CASALE: Other comments?

10 VICE CHAIR HARDIN: Bruce.

11 MR. STEINWALD: Yeah, I have one.
12 You know, as I keep telling you, I've been
13 around a long time, and the notion of being, of
14 doing more and as a result of doing more,
15 spending less has been around for a long time,
16 but it's kind of when you want to have an
17 actuary in your pocket to come out and say, oh
18 yeah, well what's the evidence of that.

19 And I -- actually I guess I'm
20 thinking of in particular the presentations by
21 Drs. Zimmerman and Kendrick, who are now at a
22 decent-looking time series where it does appear
23 that the upfront patient engagement approach
24 yields downstream less spending. I'm going to
25 give them the benefit of the doubt that their

1 methods are up to snuff, but that cynicism
2 about doing more and spending less has got to
3 be still there somewhere. I'm not sure I've
4 done away with it myself.

5 CHAIR CASALE: Thanks, Bruce. Josh.

6 DR. LIAO: Yeah. I think lots of
7 things to chew on and reflect on today, and I
8 think setting aside the data piece others have
9 I think articulated really well, and putting
10 aside high-level actuarial considerations for
11 the moment. I think, you know, I at least
12 quickly kind of found seven things that I'm
13 taking away for today, and what I've --

14 The through line for this is to be
15 thinking about how to me under certain
16 arrangements like Medicare Advantage, people
17 either said or indirectly imply that they don't
18 have to worry about certain things. So I'm
19 cognizant that there are certain activities,
20 delivery activities where they can do it, and
21 not have to mind those things, and I'm thinking
22 how if possible can we translate to a world
23 where people do often mind those things?

24 And there may be some trade-offs
25 there, but how do we do that? So the first was

1 around kind of removing barriers, you know.
2 Angelo talked about the services that can like
3 create the financial proposition for it, take
4 away patient copays. I think he also mentioned
5 waivers as that kind of bridge that's maybe not
6 the end state, but that is one way we could
7 think about operationalizing that.

8 The other is to think about
9 maximizing opportunities to reframing downside,
10 is actually the ability to take upside. I
11 think it's fair to say that as we think about
12 TCOC models, one of the limitations I think
13 historically has been there hasn't been a lot
14 of upside there, and that rationing effect of
15 benchmarks just like further dampens that.

16 So just a very concrete design thing
17 is if we don't expand that some way, I don't
18 think we can get that analog to what Angelo's
19 talking about. The team-based approach and the
20 kind of touches, but maybe not coming from each
21 team member, kind of like distributing the work
22 among team members, is a good idea. Again,
23 under certain models or approaches, you don't
24 need to count those.

25 I think in some fee-for-service

1 arrangements you do, and so I think thinking
2 about how we define eligible professionals for
3 different services and also how we think about
4 access. So for example, in the forthcoming
5 REACH model there is that element around
6 expanded NP⁵⁷ access. So to be determined. But
7 there are, I think, practical things we can do
8 to begin fitting different activities to
9 different people in an incremental way.

10 I really was struck by something
11 Angelo said and Dana Safran said around
12 quality, which is that often I think we
13 incentivize clinicians and physicians in
14 particular to work on utilization. It's not
15 surprising to me and then seeing, you know,
16 letters response about if you engage clinicians
17 in quality, it motivates them.

18 Someone's got to mind the
19 utilization, but it doesn't have to be them,
20 and Dana had that element in AQC where they
21 just pay people on quality like no matter how
22 you did, you know, on the spending. And so how
23 do we think about that? The models that I'm

57 Nurse practitioner

1 aware of in the more restrictive fee-for-
2 service world tend to gate on quality, but they
3 don't reward on quality. So I think there's
4 probably a revisiting there that can happen, to
5 get closer to those things.

6 I'll buzz through the last couple
7 quickly. I think we heard from Dr. Zimmerman
8 about maturity, and I think we say "glide path"
9 a lot. I don't know that our models have had
10 the glide paths that we, you know, can see, and
11 I think it's -- but it's doable in my mind. So
12 I'd love to see more of that.

13 You know, Shari Erickson talked
14 about what is a high-value referral, and there
15 are a lot of bullets there. I think what I
16 took away from that was you do have to mind the
17 details in some ways. And so if some of the
18 codes and the services we're talking about do
19 have those details, and they can be
20 frustrating, but they also help ensure that
21 it's not just like "I coordinated care and that
22 was good."

23 And so I think we'll have to kind of
24 grapple with how specific we want certain
25 things to be, and then finally, you know, what

1 I took away from the kidney model presentation
2 was that there are these other non-primary care
3 realms in which these things can be applied. I
4 do think issues of accountability and culture
5 need to be addressed. But I'm hoping that some
6 of the learnings from this we can use as a way
7 where I think it fits a task in primary care
8 often. Not so much in others, but I'm hoping
9 we can move in that direction.

10 So in each of these, I do think
11 there are little things we can do, but in the
12 spirit of trying to say how do we capture the
13 spirit of all the things we've heard today, but
14 also acknowledge like the reason they're so
15 gripping is because they can be done in a world
16 where there's more flexibility. So --

17 CHAIR CASALE: Yeah, I appreciated
18 all those comments. Just picking up on the
19 quality one, yeah, I was looking at one of the
20 topics around addressing unintended
21 consequences. I always think about that
22 whenever we think about total cost of care, and
23 you know, to the point that if, you know,
24 focusing on quality, there's always worry on
25 the other side, you know.

1 Could you be stinting on care, and
2 so you need to counterbalance measures to be
3 sure, and that's really hard to do, to be
4 honest with you. And so when -- having the
5 physicians or clinicians focused on utilization
6 can sometimes exacerbate some of those
7 unintended consequences around potential
8 stinting of care, where if you really have them
9 focused on quality and quality measures and
10 outcomes, one, it's a scenario they feel, you
11 know, passionate about and very comfortable
12 obviously, and also, you know, I think enhances
13 that relationship with the patient, because
14 it's all about the quality of care that you're
15 trying to get to.

16 DR. LIAO: And I'm going to say in a
17 follow-up, I think many of us are clinicians
18 and, you know, a lot of us think about
19 financial incentives. One thing that also came
20 up about giving trophies, which I don't get
21 many of, Dr. Zimmerman, but that idea of what
22 like motivates people is not all money.

23 I mean that is one thing, but it's
24 not everything, and speaking as a general
25 internist and having many colleagues in primary

1 care, I think people do things and they spend
2 the time and they work on the EHR because it's
3 the right thing, not because they're thinking
4 about that bonus. So I think that the
5 alternate is not like -- there's harms, you
6 know. There's like errors of tying too much I
7 think to utilization. It creates these
8 potentially twisted incentives that we don't
9 want so --

10 CHAIR CASALE: Yeah, and I was also
11 thinking about, and I'm sorry, I forgot which
12 presentation talked about risk adjustment, you
13 know, the problems around our currently doing
14 risk adjustment, which really focuses often on
15 cost but not necessarily on needs. I thought
16 that resonated with -- in my thinking, as well
17 as -- you know, we always think about that as
18 an issue about a current risk adjustment
19 methodology, but where does that need to move
20 so that it really does think about the patient,
21 you know?

22 DR. WILER: Yeah, I agree. I think
23 what I heard in that same comment, we focused a
24 lot on risk adjustment and how to get credit
25 for taking care of complicated patients. But I

1 think what our speaker said today was think
2 about payment adjustments for taking care of
3 complicated patients, all right, rather than
4 trying to create a homogenous benchmark
5 essentially.

6 And I think that's a really
7 interesting way to create incentives, to
8 actually want to focus on that patient
9 population. That said, the other comment I'll
10 make is I do wonder currently many of the
11 models or the innovative care delivery programs
12 that we've heard about it -- from a total cost
13 of care perspective, the winners have
14 disproportionately focused on high-cost
15 utilizers.

16 Which is no surprise, but it assumes
17 a couple of things. One, that the mean will
18 never get better, right? So that you can
19 always beat a rate by just focusing on those
20 patients. And even in the renal care model, it
21 really doesn't incent what we have, you know,
22 what's been described is probably being value-
23 added, and that's back into that preventative
24 care space.

25 And so the question is, you know, is

1 that a sustainable model, only focusing on --
2 and in the renal care model it was broken up
3 into fourths, where basically the patients who
4 had accelerated all the way to the end of
5 transplant, nothing you can do about it. But
6 in that sort of progression of disease space,
7 there was the most opportunity.

8 We're definitely hearing a theme of
9 these groups, right? That's where the biggest
10 revenue generation is. And so it's creating
11 potentially disparities in focusing on these
12 high-cost patients.

13 CHAIR CASALE: Yeah. Yes, Larry.

14 DR. KOSINSKI: It's also assuming
15 that the high-cost patient of last year is
16 going to be the high-cost patient of next year
17 and the year after, and that that is a flawed
18 assumption.

19 CHAIR CASALE: Right.

20 DR. KOSINSKI: And the vice, and the
21 opposite of that, that your low ones are going
22 to be low-cost going forward too.

23 CHAIR CASALE: Yeah. Other
24 thoughts, comments? Bruce, anything else. No,
25 you're okay. Okay, okay.

1 * **Closing Remarks**

2 So I want to thank everyone for
3 participating today, our expert presenters, my
4 PTAC colleagues, and those listening in. We
5 certainly have more to cover as we alluded to
6 related to care delivery for population-based
7 total cost of care models.

8

9 * **Adjourn**

10 So we'll be back tomorrow morning at
11 9:30 a.m. Eastern. Liz Fowler, the CMS Deputy
12 Administrator and Director of the CMS
13 Innovation Center, will deliver opening
14 remarks. So we hope to see you all then.
15 Thank you. This meeting is adjourned for the
16 day.

17 (Whereupon at 3:53 p.m., the above-
18 entitled matter went off the record.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

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