PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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

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THURSDAY, MARCH 2, 2023

PTAC MEMBERS PRESENT

LAURAN HARDIN, MSN, FAAN, Co-Chair
ANGELO SINOPOLI, MD, Co-Chair
LINDSAY K. BOTSFORD, MD, MBA
JAY S. FELDSTEIN, DO*
LAWRENCE R. KOSINSKI, MD, MBA*
JOSHUA M. LIAO, MD, MSc
WALTER LIN, MD, MBA
SOUJANYA R. PULLURU, MD*
JAMES WALTON, DO, MBA
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS NOT PRESENT
TERRY L. MILLS JR., MD, MMM

STAFF PRESENT

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

*Present via Webex

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1 P-R-O-C-E-E-D-I-N-G-S
2 9:30 a.m.
3 * CO-CHAIR HARDIN: Good morning, and
4 welcome to this meeting of the Physician-
5 Focused Payment Model Technical Advisory
6 Committee known as PTAC. My name is Lauran
7 Hardin, and I'm one of the Co-Chairs of PTAC,
8 along with Dr. Angelo Sinopoli. As you may
9 know, PTAC has been looking across its
10 portfolio to explore themes that have emerged
11 from proposals received from the public over
12 the years.
13 Topics the Committee has covered
14 include telehealth, social determinants of
15 health, and care coordination. In 2021, the
16 Innovation Center at the Centers for Medicare &
17 Medicaid Services released its strategy refresh
18 for the next decade. One of CMS's objectives
19 is to drive accountable care with the goal of
20 having all Medicare beneficiaries in a care
21 relationship with accountability for quality
22 and total cost of care by 2030.
23 To support that goal, PTAC's public
24 meetings last year examined key issues related
25 to developing and implementing population-based
26 total cost of care models. We will release our

1 report to the Secretary with our findings from
2 that series this month. One theme that emerged
3 from those discussions was how to integrate
4 specialists into population-based models, which
5 PTAC has decided to explore further.
6 * **Liz Fowler, JD, PhD, Deputy**
7 **Administrator, Centers for Medicare &**
8 **Medicaid Services, and Director,**
9 **Center for Medicare and Medicaid**
10 **Innovation Remarks**
11 We appreciate that CMS has engaged
12 with us on this important topic. This morning
13 we are honored to have opening remarks from Liz
14 Fowler, the Deputy Administrator of CMS, and
15 Director of the Center for Medicare and
16 Medicaid Innovation. Dr. Fowler previously
17 served as Executive Vice President of Programs
18 at the Commonwealth Fund, and Vice President
19 for Global Health Policy at Johnson & Johnson.
20 She was special assistant to
21 President Obama on health care and economic
22 policy at the National Economic Council. From
23 2008 to 2010, she also served as Chief Health
24 Counsel to the Senate Finance Committee Chair,
25 where she played a critical role in developing
26 the Senate version of the Affordable Care Act.

1 Welcome Liz.
2 DR. FOWLER: Thank you Lauran, thank
3 you Dr. Sinopoli, and others on PTAC. It's
4 really a privilege to be here and provide
5 opening remarks at your quarterly public
6 meeting, and just great to be in person. First
7 off, I want to share our excitement that
8 specialist integration within population-based
9 total cost of care models is the focus of the
10 March 2023 PTAC public meeting.
11 The CMMI specialty care integration
12 team will be live streaming the public session,
13 and I see Dr. Jake Quinton, our medical officer
14 who is leading this effort, is here in person.
15 As well as Linda [Lebovic], who supports this
16 work as well. So, we are here because we firmly
17 believe that this is going to be a really
18 exciting set of discussions today and tomorrow.
19 And I look forward to hearing a
20 report of the robust and informative
21 discussions, even though I won't be able to
22 stay for the entire meeting. The theme of your
23 meeting is clear evidence that we're very well
24 aligned in our areas of focus, and many of the
25 themes and topics you're set to discuss are
26 questions that we're also grappling with in our

1 own work.
2 And looking at the list of speakers
3 you've invited, I see some familiar names, so
4 we're talking to some of the same experts, so
5 this is a really good sign. 2023 is shaping up
6 to be an exciting year for the Innovation
7 Center. Already we published a report last
8 month in response to the Executive Order on
9 lowering prescription drug costs for Americans,
10 and launched the new ACO REACH[1] cohort.
11 In the drug pricing report, we
12 identified three new prescription drug models
13 to consider testing, and three areas for
14 additional research. And this year, if all
15 goes according to plan, the Innovation Center
16 plans to announce three to four new models on
17 advanced primary care, population- and
18 condition-specific accountable care models, and
19 a state total cost of care model.
20 In terms of what you can expect from
21 these models, in our continued focus on
22 addressing health equity, they'll include a
23 focus on underserved populations, and make it
24 more possible for more safety net providers to

1 Accountable Care Organization Realizing Equity, Access, and Community Health

1 participate. We will also continue to focus on
2 strategies to drive better integration of
3 primary and specialty care to serve those with
4 chronic or serious conditions through our
5 models.
6 And by keeping a focus on patients
7 in the Innovation Center models, we can improve
8 the way care is delivered, align payment
9 incentives across the system, and ultimately
10 improve outcomes. Given the topic of today's
11 meeting, I'd like to speak a bit more about our
12 specialty care strategy.
13 In June last year, CMS published a
14 paper titled Pathways for Specialty Care
15 Coordination and Integration in Population-
16 Based Models. And in November 2022, we
17 published another paper, the CMS Innovation
18 Center's Strategy to Support Person-Centered,
19 Value-Based Specialty Care.
20 Since the release of our specialty
21 care paper, we've been conversing with many
22 interested parties both internal and external
23 to CMS, and digesting a lot of information,
24 identifying challenges, and brainstorming about
25 possible model design approaches. As part of
26 the specialty care strategy shared in the paper

1 in November 2022, we're exploring ways to
2 increase data transparency, and expand the data
3 provided on specialists to facilitate and
4 better encourage engagement in referral
5 decisions.
6 We recently conducted a survey of
7 ACO and primary care group practice
8 participants, organizations in the Medicare
9 Shared Savings Program, ACO REACH, and Primary
10 Care First, to solicit feedback on their
11 interest in receiving new forms of data to
12 support specialty engagement. We'll use these
13 survey responses to guide our plan to expand
14 data sharing.
15 Our first objective in offering
16 better information on specialists is by
17 providing shadow bundle data to ACO
18 participants. This data, including claims data
19 constructed into episodes of care, and provided
20 alongside target prices for attributed
21 beneficiaries, will allow an ACO to analyze
22 spend and care patterns for specialists, as
23 well as offer a new way to engage with
24 specialists.
25 In February we released the Bundled
26 Payment for Care Improvement Advanced, or BPCI

1 Advanced, requests for applications, and opened
2 the application portal for participation during
3 a two-year extension in 2024 and 2025. We'll
4 be accepting applications until May 31, 2023,
5 and actively encouraging Medicare providers,
6 suppliers, and ACOs to apply.
7 Additionally, we're thinking about
8 the future of episode-based payment models with
9 a focus on creating a model that is
10 complementary to ACOs. We intend to engage
11 interested parties for their input of a future
12 model with a request for information during the
13 third quarter this year.
14 As we refine our thinking and
15 consider questions to pursue in the RFI, as we
16 call it, the request for information. It
17 really comes back to the basics. What are the
18 current challenges related to specialty
19 integration in advanced primary care models in
20 ACOs? What are the barriers to integration?
21 What strategies and approaches would best
22 support increasing specialty care provider
23 engagements in ACOs where specialists share
24 accountability with primary care providers for
25 high-value care, and bearing appropriate
26 financial responsibility for patient outcomes?

How should high-value specialty care be defined? And what are the appropriate performance measures for assessing specialty integration?

We hope that our partnership with PTAC will help inform the answers to these questions. And maybe with that I'll stop, and I wish you all a very productive meeting, thank you.

*** Welcome and Co-Chair Update - Discussion on Improving Care Delivery and Integrating Specialty Care in Population-Based Models Day 1**

CO-CHAIR HARDIN: Thank you so much for joining us today, Liz. We really appreciate your comments, and we really appreciate working together with your team, thank you. So, for today's agenda, we will explore a range of topics, including best practices for structuring coordination between primary care providers and specialists.

How advanced primary care models and ACOs can improve specialty integration. Structuring financial incentives and performance measures, and how to address the

1 unique challenges that safety net providers and
2 rural providers face. We have background
3 materials online on these topics, and over the
4 next two days we will hear from many esteemed
5 experts on these topics.
6 We've worked very hard to include a
7 variety of perspectives throughout the two-day
8 meeting, including the viewpoints of previous
9 PTAC proposal submitters who addressed relevant
10 issues in their proposed models. I want to
11 mention that tomorrow afternoon, we'll include
12 a public comment period. Public comments will
13 be limited to three minutes each.
14 If you would like to give an oral
15 presentation tomorrow, but have not yet
16 registered to do so, please email
17 PTACRegistration@NORC.org. Again, that's
18 PTACRegistration@NORC.org. The discussions and
19 materials, and public comments from the March
20 PTAC meetings will all feed into a report to
21 the Secretary of HHS[2] on how to improve
22 specialty integration in population-based total
23 cost of care models.
24 The agendas for today and tomorrow
25 include time for the Committee to discuss and

2 Health and Human Services

1 shape our comments for the report. Before we
2 adjourn tomorrow, we'll announce a Request for
3 Input, which is an opportunity for stakeholders
4 to provide written comments to the Committee on
5 today's topic. Thanks for joining us, Liz.
6 Lastly, I'll note that as always, the Committee
7 is poised and ready to receive proposals on
8 possible innovative approaches and solutions
9 related to care delivery, payment, or other
10 policy issues from the public on a rolling
11 basis. We offer two proposal submission tracks
12 for submitters to provide flexibility depending
13 on the level of detail about your payment
14 methodology. You can find information about how
15 to submit a proposal online.
16 *** PTAC Member Introductions**
17 At this time I would like my fellow
18 PTAC members to please introduce yourselves,
19 share your name, your organization, and if you
20 would like, a brief word about your experience
21 you have with our topic. First, we'll go
22 around the table, and then I'll link to our
23 members that are on Webex.
24 So, I'll start. I'm Lauran Hardin.
25 I'm a nurse. I'm Vice President and Senior
26 Advisor for National Healthcare & Housing

1 Advisors. I spent the last 20 years engaged in
2 care management innovation and value-based
3 payment for underserved and vulnerable
4 populations.

5 CO-CHAIR SINOPOLI: Thanks, Lauran.
6 So, I'm Angelo Sinopoli. I'm a pulmonary
7 critical care physician by training, presently
8 the Chief Network Officer for UpStream, which
9 is a company that provides support for primary
10 care physicians engaging in value-based care.
11 Prior to that, I had several decades of
12 experience building very large networks.

13 Prisma Health was my last employer,
14 a very large network, and developed a
15 freestanding enablement company called Care
16 Coordination Institute that housed all of the
17 care coordination process improvement
18 expertise, et cetera.

19 DR. WILER: Good morning, I'm
20 Jennifer Wiler. I'm the Chief Quality Officer
21 for UCHealth Metro, one of the largest health
22 care organizations in the Rocky Mountain
23 region. I'm a tenured professor at the
24 University of Colorado School of Medicine, and
25 I am trained as an emergency physician.

26 I'm also the co-founder of

1 UCHealth's Care Innovation Center, where we
2 partner with digital health companies to grow
3 and scale their solutions focused on high-value
4 care. I'm also a co-author of an Alternative
5 Payment Model that was reviewed by this
6 Committee and considered by CMMI.
7 DR. LIAO: Good morning everyone. My
8 name is Josh Liao. I am an internist
9 practicing in Seattle at the University of
10 Washington, where I'm also an Enterprise
11 Medical Director, working on payment strategy,
12 population health, and value-based care, and
13 covering a range of topics, including specialty
14 integration that we'll talk about today.
15 Outside of that, I'm also fortunate
16 to lead a national group evaluating payment and
17 care delivery policy research.
18 DR. WALTON: Good morning, my name
19 is Jim Walton. I'm a retired internist.
20 Recently started a consulting firm after
21 retiring as CEO of Genesis Physicians Group,
22 which is a 1,500 member IPA[3] in Dallas, Texas,
23 and started an ACO there that's been working
24 with CMS. Prior to that, I was the Chief
25 Health Equity Officer for the Baylor Health

3 Independent physician association

1 Care System, and I'm just glad to be here.
2 DR. LIN: Good morning, Walter Lin.
3 I'm an internist and founder of Generation
4 Clinical Partners. We are a medical practice
5 specializing in care of the frail elderly
6 living in senior living, particularly nursing
7 homes, and assisted living facilities. And I
8 have a special interest in specialty
9 integration and engagement in end-of-life care.
10 DR. BOTSFORD: Good morning, I'm
11 Lindsay Botsford. I'm a Market Medical Director
12 with One Medical. I am also a family physician
13 with Iora, together with One Medical, which is
14 our Texas practices that care for older adults
15 on Medicare. We care for older adults in full
16 risk contracts with Medicare and Medicare
17 Advantage plans, including our ACO REACH
18 products.
19 CO-CHAIR HARDIN: And now I'll turn
20 to our members who are joining remotely.
21 Chinni, please go ahead.
22 DR. PULLURU: Good morning, Chinni
23 Pulluru. I'm a family physician by trade. I
24 serve to lead clinical operations within the
25 Walmart Health business. I also -- I'm the
26 Chief Clinical Executive of the Walmart Health

1 Enterprise. I previously ran and sort of led a
2 large medical group through a value-based care
3 transformation, and led all things care
4 delivery.
5 Value-based care transformation
6 included taking a group through all risk
7 patterns, a multi-specialty group of the entire
8 risk spectrum, into total cost of care
9 programs. And so, I have a particular interest
10 in specialty integration, because it was a
11 large part of our value-based care work in my
12 previous world.
13 CO-CHAIR HARDIN: Thank you, Chinni.
14 Larry, please go ahead.
15 DR. KOSINSKI: Good morning everyone.
16 I'm Larry Kosinski. I'm a gastroenterologist
17 and spent the majority of my career in private
18 practice in the northwest suburbs of Chicago,
19 and helped build the largest single specialty
20 gastroenterology practice in Illinois.
21 Currently, I am the founder and Chief Medical
22 Officer of SonarMD, a value-based care company
23 focusing on specialty care in the digestive
24 disease space.
25 And it was started as an offshoot of
26 a successful PTAC proposal back in 2017. So, I

1 am heavily engaged in specialty care
2 integration into risk-based contracts, and look
3 forward to these next two days. This should be
4 good.
5 CO-CHAIR HARDIN: Thank you, Larry.
6 And Jay, please go ahead.
7 DR. FELDSTEIN: Good morning
8 everyone. My name is Jay Feldstein. I'm
9 currently the President and CEO of Philadelphia
10 College of Osteopathic Medicine. I'm trained
11 as an emergency medicine physician, and prior
12 to this role, I spent 15 years in the health
13 insurance world in both the commercial,
14 Medicare, and Medicaid space, and the last
15 three years running five Medicaid plans in five
16 states.
17 And I'm very familiar and interested
18 in integrated and value-based purchasing
19 models.
20 * **Presentation: Improving Care**
21 **Delivery and Integrating Specialty**
22 **Care in Population-Based Models**
23 CO-CHAIR HARDIN: Thank you, Jay.
24 And one of our members couldn't attend today,
25 Lee Mills, who has been very key with the
26 development of the materials for our session

1 today. He's a physician that leads an ACO in
2 Oklahoma. So, we have a very rich meeting
3 today. Let's turn now to our first
4 presentation. Five PTAC members served on the
5 Preliminary Comments Development Team, or PCDT,
6 which has worked closely with staff to prepare
7 for this meeting.
8 Jennifer led the PCDT with
9 participation from Larry, Chinni, Jim, and Lee.
10 I am very thankful for the time and effort you
11 all put into organizing, preparing, and really
12 thinking deeply about this topic, and the
13 materials for this agenda. We'll begin with
14 the PCDT presenting some of their findings from
15 background materials.
16 These are available on the ASPE PTAC
17 website. PTAC members, you will have an
18 opportunity to ask questions and follow-up
19 comments after the presentation. So, now I'll
20 turn it to the PCDT team lead, Jen.
21 DR. WILER: Thank you so much for
22 the opportunity for us to tee up what we think
23 is going to be a really interesting and
24 important two days. As was described, I had a
25 phenomenal group who helped to develop the
26 materials in front of you. And really, what

1 we're hoping to do is to give a brief overview
2 and background about what is the current state,
3 and what are some challenges related to this
4 topic.
5 And then we're really looking
6 forward to the next two days of having our
7 experts come and discuss with us some of their
8 theoretical approaches, or the practical
9 application of these principles, where there
10 have been successes, and where there may have
11 been some challenges. Before I start, not only
12 do I want to thank our work group, again,
13 Larry, Lee, Chinni, and Jim, but I really would
14 like to thank on behalf of our group, the ASPE
15 staff, PTAC staff, and NORC, who were
16 instrumental in putting our presentation
17 together today.
18 So, the objectives of our theme-
19 based meeting are to really focus on how do we
20 increase specialty care provider engagement in
21 population-based total cost of care?
22 Where specialists share
23 accountability with primary care providers in
24 providing high-value care and bearing
25 appropriate financial responsibility for
26 patient outcomes. What we hope to do is

1 examine issues related to improving care
2 delivery and specialty integration in these
3 population-based models.
4 What we will consider is structuring
5 and improving the coordination between primary
6 care and specialty care providers within
7 existing advanced primary care models, and also
8 within the construct and outside of the
9 construct of Accountable Care Organizations.
10 We'll look to identify best practices for
11 defining, and where appropriate, nesting
12 specialty episodes in these population-based
13 models.
14 We'd like to talk about determining
15 attribution, the structuring, and financial
16 incentives, selecting appropriate performance
17 measures, and also we think it's important over
18 these next two days to think about how do we
19 increase the participation of safety net and
20 rural providers, and also those who are not in
21 large group practices, but in small,
22 independent practices.
23 So, the background for this theme-
24 based meeting includes in September of 2022, we
25 had a public meeting that covered payment
26 issues related to population-based total cost

1 of care models. Our Committee has deliberated
2 on the extent to which 28 proposed physician-
3 focused payment models, or PFPMs, have met the
4 Secretary's 10 regulatory criteria.
5 And that includes integration and
6 care coordination, which we believe will be a
7 key theme throughout this meeting. Many of
8 these proposals that this Committee has
9 reviewed and evaluated raised issues and
10 challenges with regards to specialty
11 integration. And ultimately our goal for this
12 meeting is to better understand these
13 challenges, and how various experts and
14 providers have sought to address them.
15 We'd like to offer a preliminary
16 working definition of the characteristics of
17 specialty integration in the context of value-
18 based care. And we think this asterisk is
19 actually the most important point on this
20 slide, and that's that we think that this
21 should be a working definition, and that based
22 on our conversations over the next two days,
23 we'd like to refine this recommendation.
24 So, specialty integration is a
25 desired characteristic of population-based
26 total cost of care models, that's why we're

1 here today. And what we believe are
2 characteristics include that primary specialty
3 care provider roles and responsibilities
4 individually and collectively are clearly
5 delineated throughout a patient's care journey
6 for a given condition or episode of care.
7 It assumes that specialty care
8 includes a continuum of responsibilities for a
9 patient or condition that includes, but is not
10 limited to a single consultation, co-
11 management, and primary management, which we'll
12 talk a little bit more about. Primary and
13 specialty care providers should coordinate to
14 provide patient-centered care using bi-
15 directional, synchronous, and asynchronous
16 communication.
17 Specialists should provide
18 consultations and/or ongoing care through multi
19 modes, including those I just previously
20 described, and those should be provided in a
21 timely manner. And we believe that primary and
22 specialty care providers have access to use
23 shared real-time data to inform care and
24 decisions.
25 And why we think these
26 characteristics are so important is because

1 we're also interested in how do we incentivize
2 these types of activities to occur. We'd like
3 to offer up the refinement of this model that
4 has been previously developed around what the
5 design elements should be for consideration of
6 specialty integration into population-based
7 models.
8 So, briefly, let's start over on the
9 left with regards to management. I just
10 mentioned a couple of these potential
11 characteristics, but in the domain of
12 management, the considerations are a
13 consultation or a referral, what the
14 relationship looks like from a co-management
15 perspective, where there may be shared
16 management or co-management with principal care
17 either by the primary care provider, or the
18 specialist, or a specialist principal
19 management. The other element for a model
20 design is attribution. We hope that our
21 experts will help us to dive deeper into this
22 topic of attribution, but briefly attribution
23 could be patient-described or self-reported.
24 It could be based on visits for
25 preventative care or wellness. It could be
26 based on primary care visits, prescription

1 data, E&M codes, or other methodologies that we
2 hope our experts will help us to better
3 understand. Data sharing and communication is
4 another important characteristic and element.
5 I talked a little bit about that before.
6 And then another consideration that
7 we think is important is financial
8 accountability. There are a number of
9 different models, again, over the next two days
10 we hope to dive deeper into this. But these
11 include the current fee-for-service mechanisms
12 where there is no accountability that is
13 shared. There are models where a non-
14 specialist model entity has voluntary, or
15 mandatorily shares risk with participating
16 specialists.
17 A specialist model entity assumes
18 risk in voluntary or mandatory models. And
19 there's many other options, but those are just
20 a representative example. Now, what we think
21 is important is to call out in each of these
22 elements, there are additional characteristics
23 that may affect these model elements that are
24 important, and may also impact their
25 interrelationship.
26 One that we think is the most

1 important are patients with multiple chronic
2 conditions. According to a 2018 report, almost
3 70 percent of Medicare beneficiaries have two
4 or more chronic conditions, so how do we take
5 that into consideration when we're talking
6 about nesting of specialist models? The
7 condition or procedure type, and severity of
8 the patient's condition is a consideration.
9 Where a provider is located and care
10 is delivered, urban or rural. Cooperative
11 agreements between entities potentially under
12 or outside of an ACO umbrella. An organization
13 type, ACO, or other. What the financial
14 viability is of the practices that are
15 participating. The provider employment status
16 we think is an important characteristic for
17 consideration, what the prevailing market
18 conditions are.
19 And then specifically with regards
20 to data, the data quality, and infrastructure
21 for sharing. So, what we noted is that there
22 are specialist roles in delivering care in
23 coordination with primary care providers that
24 may differ. And so, we thought this was an
25 easy way for us to start considering what are
26 the different types of care delivery models,

1 and then ultimately how payment policy may be
2 affected by these care models.
3 So, we want to propose this as a
4 recommendation for the Committee to consider.
5 The first is the duration of the specialist
6 involvement, which may be brief and limited or
7 extend into comprehensive, continued
8 management. And also, but different,
9 importantly different, is the extent with which
10 a specialist is involved.
11 So, if we are to think about this as
12 a continuum, we may think first about a pre-
13 consultation exchange, where physicians
14 interact to discuss the care of the patient,
15 which then could escalate into a traditional
16 consult, where a patient is evaluated by a
17 physician. As this progresses, there could be
18 co-management with shared care of either an
19 acute condition or a chronic condition.
20 But the principal management is by a
21 non-specialist, and typically this is a primary
22 care provider. In other conditions, patients
23 may require co-management for either an acute
24 or chronic condition, but really there is a
25 shared responsibility for the care of a patient
26 both by the specialist and a primary care

1 provider.

2 And then there are disease states or
3 conditions where the principal management for
4 the duration of care, maybe a care episode, is
5 primarily driven and performed by a specialist,
6 as opposed to the primary care provider. We
7 thought an example of this may be helpful to
8 show what a continuum may look like, and the
9 example that we give is a patient with renal
10 disease.

11 So, in a pre-consultation exchange,
12 again, physician to physician, potentially a
13 primary care provider would discuss with a
14 nephrologist advice on the diagnosis, and care
15 of a patient who has both diabetes and
16 hypertension, which as we know, are conditions
17 that place a patient at high risk for chronic
18 kidney disease and end-stage renal disease.

19 It may then escalate that there is a
20 need for a traditional consultation where the
21 patient sees the specialist. A primary care
22 provider, for instance, would request this
23 consultation from a nephrologist for a patient
24 whose estimated GFR indicates that they are now
25 progressing to chronic kidney disease.

26 Should the patient's clinical

1 condition continue to escalate, or in this case
2 deteriorate, what might be appropriate next is
3 the specialist has co-management
4 responsibilities, and shared management with
5 the primary care provider. So, let's assume
6 the primary care provider provides episodic
7 assessments of a patient with stage three, or
8 higher kidney disease.
9 And the nephrologist continues to
10 follow up on the GFR, or eGFR, which
11 unfortunately in our example continues to
12 decline. And then finally as the patient's
13 clinical condition continues to deteriorate,
14 the nephrologist may oversee dialysis treatment
15 and management of the patient who progresses to
16 end-stage renal disease.
17 Where the primary care provider is
18 still coordinating screenings, and preventative
19 care, and manages other conditions, but the
20 nephrologist is the person who is primarily
21 responsible for the kidney treatment. And so,
22 in this case, the specialist co-management is
23 really for principal care of a chronic
24 condition.
25 And I think this is an example
26 that's familiar to many. So, what are the

1 potential criteria for categorizing specialty
2 conditions, or disease conditions by
3 appropriateness for episode-based payments? We
4 think that there are a couple of important
5 ones. The first is the criteria for
6 identifying specialty conditions that may be
7 more appropriate for bundled episode payments.
8 These may include specialty driven,
9 or conditions that are generally managed
10 procedurally, or those where there is low
11 variation in spending. And I think if we look
12 across the Medicare portfolio, and the CMMI
13 portfolio currently of programs, those
14 conditions cross-walk to these characteristics.
15 The second criteria for identifying
16 specialty conditions that may be more
17 appropriate for a per member per month, or
18 PMPM, chronic disease management payment may be
19 those that are generally managed cognitively,
20 or non-procedurally, and may involve shared
21 management with a primary care provider.
22 Again, we think these are important clinical
23 and care management distinctions that we then
24 should consider how they correlate to payment
25 policy.
26 We thought we would provide here,

1 again, a clinical example where this may be
2 germane, and actually show even within one
3 medical subspecialty, the variety of disease
4 conditions, their occurrences, and then how
5 this might relate to payment policy. And I'd
6 like to turn it over to Dr. Larry Kosinski, who
7 is expert and going to give us an example from
8 the gastrointestinal disease space. Larry?
9 DR. KOSINSKI: Thank you, Jen. This
10 slide was created to represent as a single view
11 the results of a study we ran with the
12 assistance of a major commercial health plan to
13 demonstrate the differences between, the major
14 differences in one specialty, gastroenterology.
15 It was published in 2020 in the Journal
16 Gastroenterology.
17 To generate the data for this study,
18 we provided the health plan with the ICD-10
19 codes for the major GI conditions, and the
20 health plan then calculated the total cost,
21 disease-specific cost, and cost per decile for
22 each condition. If you look at the figure, the
23 disease-specific cost compared to the total
24 cost is represented on the horizontal axis as
25 the percent disease-specific cost.
26 The vertical axis represents what we

1 call the beta rating for each condition. This
2 beta rating was calculated in a similar fashion
3 to how a beta rating is created in the
4 financial industry for the analysis of the
5 volatility of a stock portfolio. In this case,
6 it is the standard deviation of the cost per
7 decile, and represents the variation of each
8 illness against the index for all GI
9 conditions.
10 Just as individual stocks in a stock
11 portfolio have different tendencies to change
12 their value against a stock index, so also do
13 diseases when compared against an index for a
14 portfolio of specialty-specific diseases. In
15 our case, this represents the variation in cost
16 per patient for the specific condition as
17 compared against the variation of cost per
18 patient for the entire GI index.
19 We thus create a beta rating for
20 each condition, which is represented on the
21 vertical axis. The bubbles for each condition
22 are thus displayed on the figure as a plot of
23 their beta rating against their percent
24 disease-specific cost. Those conditions that
25 are clustered in the lower left have lower
26 disease-specific cost and lower volatility.

1 Those in the upper right have higher
2 disease-specific cost and higher volatility.
3 We further add depth to the analysis by varying
4 the size of each bubble by the actual disease-
5 specific cost for each condition so that the
6 overall cost per patient can be compared by
7 disease.
8 Finally, we profiled each condition
9 with respect to how much of their cost was
10 driven by cognitive services versus procedural
11 services, so that we can create a payment model
12 for each. This is reflected by the level of
13 shading of each of the bubbles. The analysis
14 demonstrates the following conclusions. Number
15 one, the overwhelming majority of disease-
16 specific costs and variability of costs for the
17 GI space is driven by the two inflammatory
18 bowel diseases, Crohn's disease, and ulcerative
19 colitis.
20 The remainder of the GI conditions
21 cluster around the GI index. Inflammatory
22 bowel disease should therefore be a major focus
23 for specialty payment models for
24 gastroenterology. This analysis can also be
25 used to determine payment methodology.
26 Conditions like colon polyps, which are mostly

1 procedural and have minimal disease-specific
2 costs and a low beta rating, are best managed
3 through bundled payments.
4 Conditions like irritable bowel
5 syndrome and celiac disease, which are
6 cognitive, but also have low disease-specific
7 cost and beta rating, are best managed through
8 PMPM payments. Conditions like IBD will
9 require a blend of per member per month
10 payments for cognitive services, and bundled
11 payments for the occasional procedures that are
12 necessary.
13 Finally, we believe that GI is not
14 unique, and that this same methodology can be
15 used in most other disease categories and
16 specialties. Thank you, and I'll turn it back
17 to you, Jen.
18 DR. WILER: Great, thank you, Larry.
19 So, we think this is an exceptional example,
20 again from a specialty that manages a broad
21 variety of diseases, both that are treated and
22 evaluated through cognitive work, and then also
23 evaluated and treated through procedural work,
24 and how to think about both again, care model
25 and payment model.
26 So, thanks, Larry, for allowing us

1 to use this excellent example, and again, as
2 Dr. Kosinski said, we think it's an analysis
3 that may lend itself well to other specialties
4 for which to make a consideration. There are a
5 number of payment design features that help
6 support specialty integration that are
7 currently within the Innovation Center
8 portfolio.
9 These models use nested specialty
10 care and payment, and include, as Larry was
11 just describing, a couple of different payment
12 tactics. Those are bundled payments, per
13 beneficiary per month payments, and then
14 ultimately capitated payments. The bundled
15 payments appear to be best applied to
16 conditions that have low variability, as we
17 just discussed.
18 And here's a list of a number of the
19 current models in the innovation portfolio.
20 Again, thanks to staff in our landscape
21 assessment in the appendices, there's a lot of
22 important detail supporting this information.
23 The per beneficiary per month payments may be
24 more appropriate for chronic conditions.
25 They can cover care management and
26 coordination activities without adding separate

1 fee-for-service-based charges for non-
2 procedural services. Again, the number of
3 different models in the portfolio, including
4 the Next Gen ACO models, which are
5 representative examples. And then capitated
6 payments, which to date, research has tended to
7 focus on chronic conditions and oncology care.
8 But what we noted is that the
9 results are currently mixed with respect to the
10 efficacy of these types of programs. So, what
11 we'd like to do now is summarize what we
12 believe to be a representative list, and
13 certainly not a comprehensive list, of the care
14 delivery challenges related to improving
15 specialty integration in population-based total
16 cost of care models.
17 How we chose to break these out are
18 things that our Committee talks about often,
19 and that is the important interplay between a
20 care model and a payment model, which are
21 different, but obviously intricately aligned.
22 And so, we thought we would specifically call
23 out some of those challenges first in the care
24 delivery model.
25 The first is defining the roles of
26 primary and specialty care providers at various

1 stages in the patient's disease progression,
2 and including potential overlap between
3 specialists. We already gave you a
4 representative example of a renal disease
5 patient, but another example where overlap may
6 occur is advanced heart failure, where a
7 patient may be a heart transplant candidate,
8 for instance. And there is a lot of overlap if
9 the patient ultimately is escalated to
10 transplant.
11 Number two, defining and measuring
12 high-value care. We'll talk about that more in
13 upcoming slides. Number three, clinical care
14 pathways to support patient-centered care.
15 What we note is the challenge is around
16 availability, what is the existing evidence
17 around what is best practice from a care
18 delivery perspective that is condition-
19 specific.
20 Number two is around timing, so when
21 a primary care provider should engage a
22 specialist or make referrals. And again, there
23 are those environmental factors which come into
24 play, availability of resources for instance.
25 The care management continuum, the extent, and
26 duration of co-management between primary care

1 providers and specialists.
2 And then again, overlaying all of
3 this are resources. So, what are the existing
4 assets, or what is the access to assets that
5 help support the provision of evidence-based
6 care? It may be evidence-based to obtain an
7 MRI for a certain condition for instance. But
8 if in a rural community, they don't have access
9 to that advanced imaging, then there need to be
10 different considerations.
11 So, number four is not only limited
12 access from a clinical care pathway
13 perspective, but ultimately limited access to
14 certain specialties. Again, this may be in
15 rural communities, but there may be actually a
16 depravation of resources within urban
17 communities, and that may be -- availability
18 may also be impacted by a patient's insurance
19 status.
20 And then number five, another
21 challenge from the care delivery model
22 perspective is data, both sharing and quality
23 of data. So, there is varying levels of data
24 access, and coordination between primary and
25 specialty care providers, and across various
26 care settings, and there are high resource

1 needs that this Committee has previously heard
2 about, and I think over the next two days we
3 will hear more about.
4 But with regards to developing not
5 only the infrastructure for data sharing and
6 the relationships for sharing, but also really
7 definitions, and understanding about what high-
8 value data exchange looks like. So, the
9 challenge is really ultimately defining what is
10 ideal care, or as I like to say, perfect care
11 that is high-value.
12 So, there were two other
13 considerations that we thought were important
14 to surface here in terms of our landscape
15 assessment. And that's first, the specialty
16 visit duration. One of the challenges is in
17 the fee-for-service environment, it may
18 encourage specialty providers to increase their
19 patient volume, seeing more patients per day,
20 and spending less time with patients at each
21 visit.
22 I think we all know that that is a
23 current incentive. However, it may be true
24 that in contrast, for a specialist to see fewer
25 patients and spend more time with each patient
26 could ultimately support measurable care

1 improvements. So, these longer visits may
2 support improvements in diagnostic decision-
3 making, the patient-provider relationship,
4 ultimately patient engagement, trust, care
5 management.
6 And then ultimately lead to an
7 improved outcome. And one example may be in a
8 procedural space, like an orthopedic surgeon,
9 who may be incented to do procedures and
10 surgery in the current fee-for-service
11 environment, however, not as encouraged to
12 spend time coordinating care with an athletic
13 trainer or a physical therapist to really try
14 to create a non-operative optimization of the
15 patient to prevent, or avoid, or delay surgery.
16 Another challenge is front-loading
17 of care. It may be that higher-frequency or
18 higher-intensity visits, medical or surgical,
19 earlier in a care episode may prevent
20 escalation of disease. And then ultimately
21 utilization and cost. So, one example we
22 wanted to highlight is that research shows that
23 cost and utilization, and quality outcomes over
24 time for end-stage renal disease patients.
25 When dialysis is required, it may be
26 high-value to just place a fistula or a graft,

1 as opposed to starting with the interim state
2 of placing a catheter for instance.
3 CO-CHAIR HARDIN: Jen, I'm just
4 going to give you a five minute.
5 DR. WILER: Perfect, thank you. So,
6 there are considerations with regards to data
7 sharing that we think are important. And one
8 of the most important to highlight is the
9 variation in how providers use and share data.
10 Ultimately providing patients with price
11 transparency is something we'd like to hear
12 more about over the next two days.
13 How do we create policies that help
14 to incent data transfer, and what are those
15 current challenges? And how do we ensure that
16 the appropriate data is transferred with
17 regards to our consultation process? I've
18 summarized briefly what are the opportunities
19 from a care model perspective, and now I'm
20 going to transition into payment model.
21 The first is currently, there is
22 insufficient financial incentives for
23 encouraging specialists to move into value-
24 based care. We heard about this at our last
25 meeting. Liz Fowler talked a little bit about
26 this in her opening discussion about where

1 there are opportunities, and we really think
2 this should be the focus of our next two days.
3 How to think about incentives,
4 financial or not, to incent participation of
5 specialists into total cost of care models. We
6 recognize that identifying attribution models
7 that are most appropriate for both primary care
8 and specialists is important, and a big
9 challenge. There's also a challenge around the
10 amount of flexibility that accountable entities
11 should have in deciding which conditions and
12 episodes should be nested.
13 And then how to structure
14 incentives, including financial incentives.
15 There's also a challenge identifying
16 specialists and conditions that are most
17 appropriate for nesting within these models,
18 and whether certain specialties should or
19 should not be included in total cost of care
20 models. Which I think we'll be interested to
21 hear more about those groups, maybe that should
22 be excluded.
23 The arrangement for structuring
24 payment models, we will be interested to hear
25 more about provider-level risk and entity-level
26 risk, and what those incentives may look like.

1 And then ultimately there's a challenge of
2 participation, of safety net and rural
3 providers, or low-volume providers. And then
4 there's a challenge around creating meaningful
5 benchmarks for evaluation of high-value care.
6 In each of our subsequent slides, we
7 go into details of each of these challenges,
8 but I think with respect to time, I'll skip
9 over some of those details, because I know we
10 had those materials available to us before.
11 But again, to summarize, challenge one is that
12 there's insufficient financial incentives for
13 encouraging specialists to move into value-
14 based care.
15 And these are a lot of the drivers
16 that we've identified related to that
17 challenge, and what currently exists, in
18 current state. Challenge two, with regards to
19 attribution models, including timing and
20 duration for instance, there are already, we
21 will note, the use of beneficiary-level
22 attribution models that currently exist.
23 But however, there have been some
24 challenges with their implementation within the
25 current Medicare and Innovation Center
26 portfolio. With regards to challenges three

1 and four, really, this is where I think a lot
2 of our discussion will be over the next two
3 days, and that's how much flexibility should
4 accountable entities have in deciding both what
5 conditions and episodes should be nested, and
6 what the structure of those financial
7 relationships should look like.
8 And again, what clinical conditions
9 are most appropriate for model nesting. Here
10 is just one summary that we think is a nice
11 rubric for us to be thinking about specifics
12 around specialty nesting models. And on our
13 horizontal axis is overall utilization. The
14 vertical axis is spending per episode, and this
15 just shows the variability across different
16 disease conditions.
17 So, briefly on the left, there are
18 highly specialized, but low utilization
19 services, and the example we gave is transplant
20 surgery. There are other conditions where
21 there is low specialist utilization with
22 chronic management, and I think we've given
23 some previous examples here in the
24 presentation.
25 Next are some conditions that are
26 high utilization, but just during an acute

1 management phase, and stroke is an example, I
2 think, that others are familiar with, and that
3 previous APMs[4] have considered. There are also
4 high utilization subspecialty services with a
5 moderate amount of spend, our example here is
6 cardiology.
7 And then there are highly
8 specialized, high utilization services, and a
9 clinical condition might be pulmonary
10 hypertension, for instance, and the total cost
11 may be related to drugs. I'm not going to go
12 into too much detail about what the definition
13 is of -- excuse me, what is the rubric for
14 defining a nested model. We actually have some
15 experts who have developed this previously.
16 But essentially for condition
17 episodes, there is a trigger, usually a billing
18 code to define an episode, and then there's an
19 accountable period, which typically is around
20 one year. And for procedures, again, there is
21 a trigger of a code, and then there is a pre-
22 defined end for that clinical condition.
23 Again, I won't go into the details of each of
24 our challenges that we've identified.
25 I think our speakers are going to

4 Alternative Payment Models

1 ultimately extract some of those opportunities,
2 but we did want to mention briefly around
3 creating meaningful benchmarks for high-value
4 care. And although there are a number of
5 programs currently that do this in the Oncology
6 Care Model and others, we think that there is
7 an opportunity for us to better define how we
8 evaluate and create benchmarks, either
9 thresholds or targets for the participation.

10 And ultimately the care delivery of
11 specialists in total cost of care models. So,
12 our recommendation for the areas of focus for
13 this meeting are how should we increase
14 specialty care provider engagement in total
15 cost of care models where specialists share
16 some or a lot of accountability with primary
17 care providers for providing high-value care,
18 and again, bearing appropriate responsibility,
19 including financial responsibility for patient
20 outcomes.

21 The issues related to specialty
22 integration both within the current Medicare
23 payment programs and advanced primary care
24 models, and within ACOs. What are our
25 approaches for structuring coordination between
26 primary care providers and specialists? Which

1 we acknowledge from a care delivery perspective
2 is value-added, but how do we create those
3 incentives?
4 How do we monitor them, potentially
5 how do we collect data around that? What are
6 the options for defining and embedding
7 specialty episodes within a population-based
8 model, including patients who have multiple
9 chronic conditions? The role of HIT[5], and
10 health care information, and analytics in
11 specialty integration, and what is necessary,
12 both from an infrastructure perspective, and
13 then ultimately from a data sharing
14 perspective.
15 Again, we want to focus on how do we
16 have safety net providers and rural providers
17 included in these models, and what are the
18 specific challenges? And then ultimately,
19 which may be a discussion in and of itself, and
20 may be worth us having an additional meeting,
21 but that's around appropriate performance
22 measures for specialty integration.

5 Health information technology

1 And with that, I'd like to again,
2 thank my colleagues, the NORC staff, and PTAC
3 staff for helping us put together this
4 landscape assessment of what we believe the
5 current state and challenges are.
6 CO-CHAIR HARDIN: I want to
7 acknowledge this PCDT, this was an incredibly
8 valuable and rich presentation with some really
9 wonderful visuals as well to summarize complex
10 concepts. Members, I'd like you to jot down
11 your questions and comments, because we're
12 going to go right to the break. But please
13 write those down. We'll have an opportunity to
14 discuss later in the day.
15 So, at this point we will take a
16 break until 10:30 a.m. Eastern. Please join us
17 then. We have a great lineup of guests for our
18 first panel discussion on strengthening
19 advanced primary care and improving specialty
20 integration.
21 (Whereupon, the above-entitled
22 matter went off the record at 10:24 a.m. and
23 resumed at 10:32 a.m.)
24 * **Panel Discussion 1: Strengthening**
25 **Advanced Primary Care and Improving**
26 **Specialty Integration**

1 CO-CHAIR HARDIN: Welcome back. Jen
2 and the PCDT helped us level set with our goals
3 and our starting point for this public meeting.
4 I'm excited to welcome our first panel
5 discussion. At this time, I ask our panelists
6 to go ahead and turn on video if you haven't
7 done so already. In this session we have
8 invited three esteemed experts to discuss
9 strengthening advanced primary care and
10 improving specialty integration.
11 After each panel offers a brief
12 overview of their work, I'll be asking them
13 questions. PTAC members, you'll have an
14 opportunity to ask our guests follow-up
15 questions as we go. The full biographies of
16 our panelists can be found on the ASPE PTAC
17 website, along with other materials for today's
18 meeting. I'll briefly introduce each of our
19 guests and their current organizations, and
20 give them a few minutes each to share an
21 overview of their work.
22 First, we have Ms. Ann Greiner, who
23 is the President and Chief Executive Officer of
24 the Primary Care Collaborative. Ann, welcome,
25 please go ahead.
26 MS. GREINER: Well, thank you so

1 much. It's wonderful to be here, and I very
2 much appreciate the invitation. As you heard,
3 I'm President and CEO of the Primary Care
4 Collaborative, and we are a nonprofit multi-
5 stakeholder organization that brings together
6 about 70 members from all different sectors.
7 Patient groups, all kinds of primary
8 care clinicians, and behavioral health folks,
9 purchasers, health plans, pharmaceutical
10 organizations, tech firms, et cetera. Very
11 diverse, but the common thread is a commitment
12 to strengthening primary care as the foundation
13 of a high-performing health system. I'm
14 thrilled to be talking about this topic about
15 primary care and specialty care, and improving
16 coordination.
17 It is very important to patients
18 when the National Partnership for Women and
19 Families, a member of PCC, did focus groups,
20 and asked patients to define patient-centered
21 care, they said care that's coordinated. More
22 recently, the Community Catalyst did focus
23 groups with patients that are 50 and above in
24 underserved communities, and asked them, what
25 are you seeking in primary care?
26 And they said a navigator, an

1 ongoing relationship, and one-stop shopping.
2 So, I think it really is a very important
3 topic. The PCC has defined advanced primary
4 care with seven different principles. One of
5 them is care coordination, but we've broadened
6 that a bit. It's coordination and integration,
7 and that's really what patients want -- they
8 want their care to be integrated, and for
9 someone to help them navigate.
10 But care coordination is getting a
11 lot more complicated. A 2022 study by Michael
12 Barnett and Asaf Bitton found that in 2000, 19
13 percent of Medicare beneficiaries had five or
14 more physicians. That grew to 35 percent by
15 2019. We also know that the clinicians are
16 having to coordinate with a lot more
17 physicians. In 2000 they were coordinating with
18 52 other physicians.
19 That grew to 95 by 2019. And this
20 is resulting in a lot more fragmentation. Four
21 out of 10 Medicare beneficiaries report highly
22 fragmented care. So, what's driving all of
23 this enhanced coordination burden? Lots of
24 things. Patients are less healthy under fee-
25 for-service arrangements, which most of primary
26 care is still under.

1 Primary care visit time is not
2 adequate to meet expanded patient needs.
3 Consolidation is also a factor. 70 percent of
4 primary care clinicians work for hospitals or
5 other corporate entities. Many hospitals think
6 of primary care really as referring partners,
7 as opposed to providing the kind of time to
8 really manage patients in the primary care
9 setting.
10 And finally, patients can't locate
11 or retain primary care. We look at usual
12 source of care. PCC put out a report in 2022
13 last year, and we saw a 10 percent increase in
14 loss of usual source of care; about 74 percent
15 of patients have a usual source of care that
16 varies widely across states. There's a 27
17 percent swing across states in usual source of
18 care.
19 The solution that we believe, and
20 that we are working on at the Primary Care
21 Collaborative, taking a page from the recent
22 National Academies of Sciences, Engineering,
23 and Medicine report, is to pay primary care
24 differently, and to pay primary care more. A
25 scorecard that came out last week from the
26 Milbank Memorial Fund found that we continue to

1 under-invest in primary care.
2 In fact, investment has gone down in
3 the last 10 years. It was 5.8 percent in 2010,
4 it was 4.6 percent in 2020, capitation levels
5 are in the single digits, and also declined
6 during that period. Not to pick on our friends
7 in the dialysis realm, but we spend six percent
8 on dialysis patients, and less than five
9 percent on primary care.
10 So, what we focus on is changing how
11 much we pay, and how we pay, and we can point
12 to a lot of innovators who are investing in
13 primary care, building out primary care teams
14 that are able to manage the multiple needs that
15 patients have with care coordinators, community
16 health workers, NPs[6], and other members of the
17 team, social workers. Care is less fragmented,
18 you're reducing your care coordination burden.
19 And most importantly of all, you're
20 enhancing patient outcomes, reducing
21 inequities, and beginning to bend the cost
22 curve. So, thank you so much for giving me the
23 opportunity to provide those opening remarks.
24 CO-CHAIR HARDIN: Thank you so much
25 Ann. Next, we're excited to welcome back one

6 Nurse practitioners

1 of the past Chairs of PTAC, Dr. Paul Casale,
2 who is Vice President of Population Health at
3 New York Presbyterian, Weill Cornell Medicine,
4 and Columbia University. Paul, it's great to
5 see you, please go ahead.
6 DR. CASALE: Thank you, Lauran, and
7 thank you to all the PTAC for inviting me to
8 come back. Having been a long-standing member
9 of PTAC for a number of years, I know how
10 important the work is, and look forward to the
11 discussion we're going to have on improving
12 specialty integration and strengthening primary
13 care.
14 So, I lead Population Health
15 initiatives at New York Presbyterian, Weill
16 Cornell, and Columbia, which includes an MSSP[7]
17 ACO, which has approximately 40,000
18 beneficiaries. We have about 5,500 clinicians
19 who are part of our ACO, of which approximately
20 20 percent are primary care, and over 50
21 percent are specialists. So, in fact, engaging
22 with specialists is something we think a lot
23 about in our ACO. We have been fortunate --
24 our ACO has been successful.
25 We've earned shared savings for the

7 Medicare Shared Savings Program

1 last five consecutive years. Our quality scores
2 have consistently been over 90 percent. But
3 having said that, I look forward to the
4 discussion we're going to have around, in
5 particular, engaging specialists. We've had
6 experience both in the Oncology Care Model
7 through the two medical schools, as well as CJR[8]
8 at a variety of sites at New York Presbyterian.
9 So, I look forward to further
10 conversation around how that has worked, or the
11 challenges around that within an Accountable
12 Care Organization. The other comments I'd make
13 is some of the other work I do, which is, as a
14 cardiologist, I am actually quite active in the
15 American College of Cardiology. I lead a lot of
16 their population health initiatives, chaired
17 multiple task forces and workgroups.
18 And we've done a lot of thinking
19 about how to engage specialists in accountable
20 care. And we convene a forum every year, and
21 the last two years that has been the topic,
22 specifically around engaging specialists. So,
23 some of the takeaways and conversation have
24 been, in these arrangements, it's important to
25 think about how do you identify a high-value

8 Comprehensive Care for Joint Replacement

1 specialist, or in this case, a cardiologist
2 continues to remain a challenge, and I'm sure
3 we'll be talking about some of that today. And
4 how do you structure risk-sharing when in fact
5 currently, specialty care and cardiology in
6 particular is primarily RVU[9]-based?
7 And then when we think about things
8 like performance measure selection, and
9 attribution, and accountability, how do we
10 define that, what is the level of
11 accountability, and how do we cascade that
12 accountability from primary care to
13 specialists? Other areas that we've talked
14 about in particular is the need for
15 flexibility.
16 Not just due to geographic
17 variation, but also thinking about innovation
18 and disruptors, and how that is going to
19 continue, and how do you incorporate that into
20 thinking about how to engage specialists? And
21 I guess a few final comments, and I know we'll
22 be talking about this further, is really
23 there's a need to think about how to move from
24 an RVU-based contracts for specialists.
25 And then I'm sure we'll be talking

9 Relative value unit

1 today about what are the payments. The current
2 sort of retrospective attribution and shared
3 savings models really doesn't clearly show the
4 specialist a path forward, and what other
5 payments to think about. And then really
6 thinking about the balance. You want the
7 clinicians to be busy, but you don't want to be
8 paying them piecemeal for activity.
9 So, how best to manage that? And
10 then when you delegate care to the specialist,
11 which Ann brought up, and I heard a bit in the
12 PCDT conversation, how do you define those
13 relationships, and how do you define who is
14 primarily going to be responsible for the care?
15 So, I'm going to stop there, and look forward
16 to the conversation.
17 CO-CHAIR HARDIN: Thank you so much
18 Paul, that was very helpful. Lastly we have
19 Dr. Adam Weinstein, who is Chief Information
20 Officer at DaVita Kidney Care. Adam, welcome,
21 please go ahead.
22 DR. WEINSTEIN: Thank you, and thank
23 you guys for having me back. And I actually
24 think it's very opportune to have gone third
25 here, because as Ann and Paul pointed out, some
26 of the high-level questions that are, I think,

1 on all of our minds, nephrology is, I think, a
2 great example of how some of these problems
3 have manifested, and some of the solutions have
4 become more evident.
5 If you could go to the next slide
6 for me please. So, I'm not only the CIO at
7 DaVita, which is one of the two largest vendors
8 of dialysis in the United States, but I'm a
9 nephrologist from Maryland, and I come to you
10 representing my colleagues in nephrology.
11 I do a lot of work with the Renal
12 Physicians Association, which is an advocacy
13 organization for nephrologists worried about
14 payment and relationships between
15 nephrologists, patients, and the greater
16 structures in which health care delivery is, I
17 guess, delivered. Anyway, I think taking a few
18 moments of my introductory time to illustrate
19 what has been now probably a 15- to 20-year
20 endeavor within nephrology to help manage the
21 cost that Ann rightly pointed out.
22 Which is six percent of Medicare
23 payments go to dialysis, and advanced chronic
24 kidney disease patients is, I think, a good way
25 to start what questions and discussion will
26 happen next. So, when we think about chronic

1 kidney disease, I think of really complex
2 chronic disease management. More often than
3 not, the kidneys are a final common pathway of
4 so many comorbid conditions.
5 And when we think about our
6 patients, we start in this population of about
7 30 million people who are identified as having
8 chronic kidney disease, only about half a
9 million at any given time end up on dialysis.
10 We stage this with lab data, which is very
11 handy, since it's objective, measurable,
12 reproducible.
13 And what happens is that in our
14 patient population, there is a shift, that is,
15 as their kidney function declines, we, the
16 nephrologists, take over a more intense
17 relationship with the patient, and there is a
18 point of hand-off where we become more of the
19 primary coordinator of care than other folks in
20 the patient's panel of providers.
21 We also know that there's a window
22 of time, as you can see, where there's the
23 greatest opportunity to mitigate potential
24 costs, and deal better outcomes. And after
25 that window, it gets very expensive and very
26 complex for the patient. And our goal, as

1 nephrologists, ideally, and doubly so in the
2 various payment models that we've been working
3 with and working in for the last 15 to 20
4 years, has been to get people through that
5 period, such that we mitigate whatever high-
6 cost events there are.
7 You can see that there's lots of
8 work to be done, and a lot of it comes in terms
9 of patient education. It comes in identifying
10 patients that are at highest risk for
11 progression, and then doing what we can with
12 evidence-based and other kinds of activities
13 that would result in mitigating both the cost
14 and quality curve.
15 And then you can see we become the
16 accountable provider, especially as kidney
17 disease advances, but we are not the only
18 provider. Our patients typically touch
19 numerous, numerous specialties, and ultimately,
20 I view myself as basically a project manager in
21 complex care coordination. If you could go to
22 the next slide, please.
23 I think it's also worth pointing out
24 that there are numerous variables that happen.
25 And while that idealized model that I showed on
26 the previous slide is what would be true under

1 the best of circumstances, the reality is that
2 all health care is local. And so, urban,
3 suburban, rural communities all have their own
4 challenges.
5 We have workforce challenges within
6 nephrology, as I know we do throughout all of
7 health care. As a chief medical information
8 officer, I'm acutely aware of the tech and the
9 data problems that exist, especially in
10 specialties like nephrology, where we have
11 dialysis organizations, transplant centers, and
12 independent nephrologists.
13 Some of whom are employed by
14 hospital systems, some of whom are not, all
15 trying to coordinate across multiple systems.
16 The practice transformation elements of value-
17 based care are critically important, and yet
18 also underappreciated in many nephrology
19 practices. And then lastly, we too suffer
20 from, I think, a dearth of opportunity to
21 really share responsibility across the multiple
22 needs that our patients have.
23 I have included an appendix that I
24 will not go through with you guys, but those
25 are slides that I tend to use when talking
26 about this, given the, I think long-standing

1 relationship that nephrology has in the value-
2 based care community. So, with that, I will
3 stop, and look forward to further discussion,
4 thank you.
5 CO-CHAIR HARDIN: Thank you so much,
6 Adam, this is going to be a really rich
7 discussion. So, next we're going to dive into
8 some questions we have for you. And then time
9 permitting, Committee members, you'll be able
10 to ask questions if we have time before noon.
11 So, let's get started. First, we want to
12 understand care coordination for different
13 types of providers.
14 What approaches are currently being
15 used to facilitate coordination between primary
16 care and specialty care providers? And what
17 challenges exist related to improving specialty
18 integration? Let's start with Ann.
19 MS. GREINER: Thank you. So, I
20 think you raised one of the challenges that I
21 think many of the speakers alluded to. We
22 really don't have sufficient data to really
23 understand not only the cost, but also the
24 quality of specialists that primary care has
25 the opportunity to refer to.
26 So, we obviously need to enhance the

1 data that we have available, and that needs to
2 be available in real time for primary care to
3 be able to leverage so that they can make the
4 best possible recommendations in terms of
5 specialty referrals. We, I think, have seen
6 that some organizations are using tools to help
7 specify what kind of information should be
8 transferred when there is a referral.
9 And I think we can appreciate those
10 kinds of tools, and look to see them become
11 standard practice, because I think that will
12 really help to get the right information in a
13 standardized way when a referral is being made.
14 It's going to be good for the patient, it's
15 good for the receiving specialist.
16 And I think the other challenging
17 issue we need to work on is just the
18 opportunity for primary care clinicians to
19 really know the specialist network that they're
20 referring to, beyond data that they may have
21 about them, but begin to deepen their
22 relationships. I know I'm returning to an era
23 when those relationships existed, but they are
24 absolutely critical.
25 Because when you're thinking about a
26 patient referral, you really want to bring in

1 both the quantitative information you may have,
2 and also the qualitative. I'll stop there.
3 CO-CHAIR HARDIN: Thank you. And
4 Adam?
5 DR. WEINSTEIN: So, I think the best
6 answer probably comes from the years of
7 experience we've had across multiple payment
8 structures that have existed for nephrology.
9 It's been a sore point, because you do need
10 what I call a data wrangler, and then a care
11 coordinator to adequately keep track of and
12 then help coordinate the various things that
13 patients need to do.
14 One of the pithier things that I
15 find myself saying a lot is that for
16 nephrologists, every patient is a project, and
17 every project needs a good project manager.
18 Care coordinators need to be funded, they need
19 to be part of these events, and only with the
20 most recent models, which are the KCC[10] and KCF[11]
21 models, which were CMMI demonstration models
22 currently in practice as of the beginning of
23 2022, do we have, I think, the right financial
24 arrangements to have care coordinators provided

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10 Kidney Care Choices
11 Kidney Care First

1 usually by the value-based entities that roll
2 up across the nephrology practices, and the
3 transplant centers. In those instances, it is
4 great, because now we have people focused on
5 essentially the Gantt chart, similar to the one
6 I showed, that says where is a patient in this
7 pathway, what are the next steps, what are the
8 gaps and outliers? The struggles continue to
9 be, however, patients don't like to pick up the
10 phone for people they don't know, that there
11 needs to be a relationship between the
12 coordinator and the patients, as well as the
13 coordinator and other specialists.
14 The funding that we have is helpful,
15 but you're talking about a ratio where a
16 coordinator might have a panel of three or 400
17 patients across numerous communities, often
18 they're centralized, and those folks may not
19 know the local conditions that any patient is
20 experiencing.
21 We have had challenges getting the
22 attention and time of other specialists who
23 don't understand why there is a care
24 coordinator for something specific like kidney
25 disease as well. Nevertheless, it is probably
26 the most hopeful I've been, given the fact that

1 we now have a role, and people doing these
2 activities, and we are better defining what
3 those tasks are, in addition to what software,
4 and other data tools they need to perform those
5 tasks.
6 CO-CHAIR HARDIN: Thank you. And
7 Paul?
8 DR. CASALE: Yeah, I would say in my
9 experience, a couple things, I would certainly
10 echo what Adam said around care management. We
11 have certainly leveraged, we have built a large
12 care management team within the organization,
13 and we have been leveraging their expertise and
14 their ability to help with care coordination,
15 as well as in our organization, we have quite a
16 large number of advanced practice providers in
17 the system.
18 And they also, I think, have been
19 very helpful. For the specific communication
20 between primary care and specialty, I would say
21 we really worked hard on e-consults as a way to
22 really start that conversation early, so that
23 primary care may have questions anywhere from
24 is this an appropriate consult, to what tests
25 should I order before they come see you?
26 Those kinds of things have really

1 enhanced sort of some of that efficiency. We,
2 I think like many organizations, still have a
3 tremendous access problem. The demand for both
4 primary care and specialty care really
5 continues to grow. And so, being more
6 efficient, and again, using sort of the e-
7 consults within our organization, I think, have
8 been helpful not only for initiating the
9 reasons for the consult.

10 But then the decisions around how
11 sort of involved the specialist needs to be in
12 an ongoing way, versus sort of making an
13 opinion, and sending them back to primary care.
14 So, I would say that we continue to work on
15 that, that has been particularly helpful. In
16 terms of the challenges, and I'm sure we'll be
17 going back to this.

18 It's still, we're in a fee-for-
19 service RVU-based system where that is how
20 physicians generally and clinicians are paid
21 within the system. It’s already been brought
22 up. And it makes it hard to have the time for
23 the clinicians themselves. So, we think of
24 ways even within the current system, so that
25 the time they do have, they can really focus on
26 the clinician work, and then provide others to

1 do the other work around coordination.
2 And then how do we move that, as
3 you're thinking about new payment models, where
4 all of that would occur together?
5 CO-CHAIR HARDIN: Very interesting,
6 technology accelerators, and continuity, and
7 relationship connectors. PTAC is particularly
8 interested in advanced primary care models, and
9 Accountable Care Organizations. Can you tell
10 us how advanced primary care models and ACOs
11 can encourage specialist engagement? Adam,
12 let's start with you.
13 DR. WEINSTEIN: Yeah. So, I think
14 the disconnect for nephrology has been that
15 there's not been, outside of organizations that
16 are vertical, like hospital systems where Paul
17 is operating, to connect independent nephrology
18 practices with ACOs without some sort of
19 contracting mechanism. And so, the way the
20 world has evolved for nephrology is largely
21 separate from ACOs, for the most part.
22 Having said that, I think sharing
23 the risk across the disease spectrum ultimately
24 results in what you're looking for. It's hard
25 though, the challenge that I've seen is that at
26 some point, as in the chart that I've shown in

1 my introductory slides, there's a point where
2 you're beyond what I think a typical primary
3 physician would feel either responsible for, or
4 appropriately managing.
5 And that hand-off has to be the
6 moment. There's probably opportunities upstream
7 from where that hand-off moment is to use
8 things like e-consults, and a more informal
9 kind of process of engagement around risk
10 reduction and risk mitigation to offer some
11 sort of financial relationship between an ACO
12 and specialty physicians.
13 If, however, they're all employed by
14 the same organization, it becomes a lot easier,
15 probably for all the reasons you can imagine.
16 CO-CHAIR HARDIN: Thank you. Paul?
17 DR. CASALE: Yeah, I'll just add a
18 few comments. One is the point about sharing
19 the risk, I think, is important. And also, as
20 these relationships are developed or
21 established, it can't be overly complicated or
22 burdensome in terms of understanding the
23 relationship, because I think that would be a
24 particular challenge. So, I think particularly
25 understanding who the patients are, who you're
26 accountable for, or attributed to collectively.

1 And then defining either through
2 care pathways, guidelines, et cetera, who will
3 be sort of managing -- what the specialist will
4 be managing, what primary care would be
5 managing. I'll stop there, thanks.
6 CO-CHAIR HARDIN: Thank you, Paul.
7 And Ann?
8 MS. GREINER: When I think about
9 ACOs, and the MSSP program, the largest ACO
10 program that we've got in the country, we're
11 still paying primary care on a fee-for-service
12 basis. And I think that we are not then
13 leveraging what primary care could do if it was
14 paid on a capitated basis.
15 And we are advocating right now for
16 a capitated option within MSSP to be able to
17 build out that team that would include a care
18 coordinator, and be able to manage more of the
19 care at the primary care level, with a team. I
20 appreciate, and this is not at all to denigrate
21 the absolute importance of specialty care, and
22 its relationship within the ACO, and the like.
23 But I do think, and I know I've been
24 making this point a couple of times, that we
25 are really so under-investing in primary care
26 that it is perpetuating a lot of the problems

1 that we have with our fragmentation and the
2 challenges with care coordination. A report
3 that some actuaries did at Wakely examining
4 data from the MSSP program showed that ACOs
5 that have more primary care physicians have
6 more utilization of EM[12] services.
7 And the low revenue ACOs, which we
8 have seen in the past, do much better with
9 respect to reducing costs. So, I think when we
10 think about the MSSP program, and we know CMS
11 is very interested in growing this program, I
12 think there's a lot of data that suggests we
13 need to strengthen primary care.
14 I completely agree about e-consults,
15 and we used to have that more informally, and
16 now we can use technology to help support that
17 kind of dialogue. It helps also to reduce
18 perhaps the patients in the specialty waiting
19 room that don't need to be there, that really
20 could be taken care of in the primary care
21 setting to free up the specialist to see folks
22 that really need to be seen, and allow for that
23 management.
24 Patients like it too, because they
25 would prefer not to be going to lots of

12 Emergency medicine

1 different specialists, but getting their care
2 in one setting that is more coordinated and
3 integrated. So, clearly, I see the MSSP program
4 as, with some changes, really being able to
5 enhance our ability to coordinate care. I
6 think we can also look at lessons that are
7 emerging from the ACO REACH program.
8 CO-CHAIR HARDIN: Thank you so much,
9 Ann. I'm actually going to turn it to the
10 Committee next. I know you have great ideas and
11 questions, so if you have a question, please
12 put your name tent to the side, and for our
13 colleagues that are on Webex, please raise your
14 hand. And I see Larry has a question. Larry,
15 please go ahead.
16 DR. KOSINSKI: Thank you, great
17 presentations. Something we heard last year
18 repeatedly was that primary care is best
19 provided proactively. High-touch proactive
20 primary care, and I think this applies to the
21 specialty space as well, when they're
22 participating in the cognitive side. In
23 reference to your care coordination comments, I
24 am not hearing anything in the proactive role.
25 So, early detection of disease is
26 more cost effective, less morbidity to the

1 patient. What are you doing in care
2 coordination to build proactive, high-touch
3 care?
4 MS. GREINER: I think that question
5 is directed at me, so I'll give it the first
6 shot anyway. Could not agree with you more,
7 and the earliest advanced primary care models,
8 like the patient-centered medical home was very
9 focused on proactive care. So, analyzing your
10 population to understand what conditions they
11 have, and proactively reaching out to manage.
12 And I think the ACO models help to
13 incent that, as do these other primary care
14 models. We know that practices to be able to
15 do that successfully need the data and
16 infrastructure to manage, and so what we
17 observe is a lot of aggregation of practices to
18 avail themselves of that data and the like.
19 We also see aggregators coming into
20 the marketplace, like Agilon and the like, that
21 can provide that data to independent, small
22 primary care practices, so that they can
23 actually manage patients proactively. So, I
24 think your comment is spot on, and I agree with
25 you. And we need additional support for those
26 practices that are providing care to the safety

1 net, that may be in rural areas, that really
2 are not well set up to provide that kind of
3 care.
4 CO-CHAIR HARDIN: Paul, did you want
5 to comment on that as well?
6 DR. CASALE: Yeah, so I was just
7 going to add, thank you for that question,
8 Larry. When I think about proactive care, I
9 really think around the virtual, how do you
10 manage some of this through technology?
11 Because everybody has very busy practices, it's
12 hard to do a lot of touches, or challenging
13 around doing more, and more touches in person.
14 Two examples, one around
15 hypertension. So, we provide through primary
16 care blood pressure cuffs with Bluetooth
17 capability to the patients, their blood
18 pressures are brought into our EHR[13], and those
19 where it's out of control, the primary care
20 physician or clinician will look at it, and if
21 they need help from the nephrologist, or the
22 cardiologist, they reach out.
23 So, again, an example of how to
24 proactively have high touch for a very common
25 condition, which we're really not that good at

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13 Electronic health record

1 in terms of managing overall, in terms of
2 control of blood pressure. And then at sort of
3 the more specialty level, I think heart failure
4 is a good example. Where again, we leverage,
5 and I know many organizations do remote patient
6 monitoring to really proactively touch
7 patients.
8 And that has led, at least in our
9 organization, we have less ED[14] visits, less
10 hospitalizations, less readmissions. Again, I
11 think those are examples of how you do high
12 touch both in primary care and in specialty to
13 better manage these patients.
14 CO-CHAIR HARDIN: Thank you, Paul.
15 Adam, did you want to also comment on that, or
16 should I go to the next question?
17 DR. WEINSTEIN: No, actually I think
18 I have some value to add here. I would say
19 that for nephrology, and for the work that I'm
20 seeing done throughout the nephrology
21 community, that the proactive care really comes
22 in the form of the project management I made
23 reference to. That is, we generally understand
24 the trajectory of high-risk patients, which are
25 typically identified through risk models that

14 Emergency department

1 have been borne out in medical literature.

2 And then once someone gets into a
3 nephrology practice, and they're part of one of
4 these programs, the idealized version of the
5 story is that the care coordinator screens
6 across the at-risk population looking for
7 patients who have not had the events that you
8 would expect. So, frequent office visits, the
9 appropriate lab measurements.

10 And in nephrology at the practice
11 level, that is when you're walking in the exam
12 room as a nephrologist, there really is a
13 checklist of items that needs to be considered,
14 irrespective of whatever else the patient is
15 bringing to that appointment. So, is the
16 patient on an ACE[15] inhibitor, an SGLT2[16]
17 inhibitor, et cetera?

18 So, there's this tension in my mind
19 with how do you support the necessary time and
20 space for practices and physicians to do the
21 value-based care work between the fee-for-
22 service appointments? And right now, in
23 nephrology, that accounts for maybe 10, 15
24 percent of the revenue. And so, to ask a

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15 Angiotensin-converting-enzyme
16 Sodium-glucose co-transporter 2

1 nephrologist or any physician to say I'm going
2 to block an hour or two a week to look at my
3 patient panel to make choices about them
4 between office visits, is the struggle that I
5 see. But you're absolutely right, that
6 proactive, sort of iterative management of
7 patients with a known disease progression is
8 absolutely the only way to mitigate the cost
9 and the outcomes.
10 CO-CHAIR HARDIN: That's so
11 interesting, the anticipatory management piece,
12 so important with disease, but also social
13 determinants as well. We have Angelo, then Jim
14 and then Chinni, just wanted to let you know I
15 see you all. Angelo, please go next.
16 CO-CHAIR SINOPOLI: Yes, thank you.
17 So, there's been a lot of discussion about
18 increasing primary care payment. And so, I'm
19 interested in, maybe starting out with Ann, but
20 in everybody's opinion, how would you structure
21 that? And would it be just an increased fee-
22 for-service payment, or would you link that to
23 some PMPM for some function for becoming a
24 project manager, and how would you link that to
25 helping integrate care for the patients?
26 MS. GREINER: Well, thanks so much for that

1 question. I don't think the answer is higher
2 fee-for-service payment. I mean, I think what
3 we need to do is move to prospective payment,
4 and a preponderance of prospective payment. A
5 study by the Harvard Center for Primary Care
6 demonstrated that a primary care practice needs
7 to have at least 60 percent of their revenue
8 coming through a capitated model before they
9 feel comfortable enough to build out that
10 comprehensive team that can provide a more
11 comprehensive set of services, that could
12 actually do the proactive management of folks
13 with congestive heart failure, asthma,
14 diabetes, hypertension, whatever it is. And it
15 takes a team, not a teamlet, not just a doc,
16 and an MA[17].
17 It actually takes a team to
18 successfully manage patient needs, because
19 there's not one need. There's multiple
20 conditions, you need to be also focused on
21 mental health. If we're really going to meet
22 patients where they are, there are many, many
23 needs that they have. And I think project
24 management is a really good definition, I often
25 say general contractor, quarterback, whatever

17 Medicare Advantage

1 it is.
2 That's a lot of data, and that's
3 even before you get into all of the data that
4 could be coming in through remote monitoring,
5 which is wonderful, but also, it's a lot of
6 data, and it's not yet information that's
7 turned into a dashboard that can really help
8 the primary care team manage.
9 So, I think there are innovators out
10 there that are doing this, and we can look to
11 them, and now we just need to figure out what
12 are the policies to bring that innovation to
13 scale. And payment is a critical lever.
14 DR. CASALE: I just had a couple of
15 comments on that, just to follow up. So,
16 certainly prospective payment, I think, is
17 where we need to go. Again, I'm old enough to
18 have lived through the HMO[18] and capitated days,
19 which I bring that up only to say you need
20 primary care or whoever to be prepared. I'm
21 not sure many were back then.
22 All of sudden moved to capitation,
23 and the sort of gatekeeper model, and it led to
24 a lot of challenges that we don't certainly
25 want to repeat. So, Angelo, you mentioned for

18 Health maintenance organization

1 some, the PMPM, and we saw in a lot of the PTAC
2 models that were brought before PTAC over the
3 years, a way potentially to enhance payment to
4 primary care, understanding that they will be
5 responsible for the management.
6 And there were different ways that
7 those were constructed, whether it was based on
8 complexity, et cetera, but a way for them to
9 start supporting the teams, as Ann has brought
10 up, that are needed. As well as the innovative
11 technology that's likely needed, as well as the
12 data infrastructure.
13 So, for many though, there may need
14 to be sort of an interim before getting to a
15 full prospective, and having sort of the PMPM
16 may be a pathway for that.
17 CO-CHAIR HARDIN: Adam, would you
18 like to comment?
19 DR. WEINSTEIN: Yeah. I think the
20 only addition I would add, because I agree with
21 Ann and Paul totally, is that it's important to
22 bear in mind that many of the physicians who
23 are the spearhead of these events are part of a
24 practice that has a certain business structure.
25 And to Ann's point, there needs to be some sort
26 of magnitude of reimbursement that's coming in

1 the form of these PMPMs really to shift how the
2 practice operates.
3 And so, within the nephrology
4 community, one of the struggles we see is that
5 you as a practice sign up, but any individual
6 nephrologist or advanced practitioner in the
7 practice is still under what is essentially a
8 contract for fee-for-service work. And as a
9 result, there's a disconnect between what the
10 practice is now doing, or trying to do, and
11 what the physician is incentivized to do within
12 their work world.
13 And again, this gets easier,
14 perhaps, in certain organizations where you
15 have flexibility around that, but even employed
16 physicians in large hospital systems have work
17 contracts that have dictates largely around RVU
18 generation. So, at the end of the day,
19 whatever you decide to do in terms of a payment
20 model, you do have to, I think to Paul's point,
21 expect a transition period of reasonable time
22 frame.
23 Because the thought of rewriting
24 every practice employment agreement is a
25 nightmare, though I'm sure there's lots of
26 lawyers who would be very happy with that

1 activity.

2 CO-CHAIR HARDIN: That's a great

3 point. Jim, please go ahead.

4 DR. WALTON: Thank you. I'm

5 intrigued by this, the larger overarching

6 concept of relationships between numerous

7 stakeholders. The relationship between the

8 patient and the primary care doctor, the

9 relationship between the patient and the

10 specialist. In our market, a large PPO[19]

11 market, by and large patients will see both

12 relationships as vitally important to them.

13 And then we've kind of pushed an ACO

14 model in the middle there. And so, we're

15 trying to, so to speak, mediate a relationship

16 between the primary care doctor and the

17 specialist because there are a lot of factors

18 that have been kind of breaking us down into

19 silos. I agreed with the comment that somehow

20 the increase in PCP[20] payments, if we did that,

21 whether it was through a PMPM, or some other

22 mechanism, oftentimes the PCPs were being less

23 compensated than their colleagues in the

24 specialty space, and would not necessarily

19 Preferred Provider Organization
20 Primary care provider

1 reflexively put that additional payment into
2 services for the patient to create patient-
3 centered care with the key elements that you've
4 mentioned, Dan.
5 Which were navigators, coordinators,
6 relationship builders, SDOH[21] interventions,
7 behavioral health coordination, things like
8 that. So, I think that some of the new payment
9 structures, I'm curious about whether or not
10 some of the new payment structures would be,
11 again, what was commented on earlier, tied to
12 new services from primary care.
13 But the question I really wanted to
14 ask was to Paul, because I thought Paul,
15 because of your comments with regards to 5,500
16 MDs, physicians, and mid-levels and such in
17 your system, 20 percent were PCPs, and a five-
18 year history of the performance financially in
19 quality.
20 My question to you was really, what
21 came to my mind when you said that was how
22 might your MSSP financial performance and
23 quality performance improve with successful
24 specialty engagement and integration, and could
25 you kind of give the Committee a guestimate,

21 Social determinants of health

1 estimate, or maybe some practical experience
2 that y'all have done something up in New York
3 that is meaningful.
4 Where this opportunity for growing
5 the savings and the quality occurred because
6 you did something specific around a disease
7 condition, where you intentionally integrated
8 primary care, and specialty in a new way inside
9 of your ACO. Because you have kind of a
10 captive, employed network. I think that's a
11 unique opportunity, and I just haven't heard
12 anybody talk about that in a while.
13 DR. CASALE: Sure, happy to, and
14 thank you for that question. So, a couple of
15 comments I'll make is when we look at our data,
16 again, we're in metropolitan New York.
17 Although you may view us as sort of this
18 encapsulated provider network, when we look at
19 our claims, half of the care for our ACO
20 patients is outside of our organization.
21 They're going to the other large
22 systems, and there's a lot of reasons for that,
23 they may live closer to there, so if they call
24 an ambulance, they may end up at a different
25 institution. But having said that, it was
26 clear when I began this work several years ago,

1 where the high-cost areas are, we already know
2 what they are: being in the hospital, being
3 admitted to the hospital, going to the
4 emergency room, post-acute care.
5 And we know there's opportunity if
6 we really -- a place to start is on
7 coordinating care, so that patients aren't
8 reflexively going to those, particularly the
9 ED, and to the hospital, when there are other
10 places where that care can be provided in a
11 better setting, as well as more efficient.
12 So, we focused on a couple of --
13 when we started, we started on a couple of high
14 costs. So, one is ESRD[22]. ESRD patients are
15 high-cost, they represent, out of our 40,000,
16 they're a relatively small group, but
17 tremendously high-cost. So, we looked at where
18 they were going, why were they ending up in the
19 emergency room, why were they hospitalized?
20 Again, in our center, a lot of
21 patients, before they got to dialysis, they
22 were ending up in the hospital, where then they
23 were going on dialysis in an emergent way. We
24 know that's a high-cost way for that to occur.
25 So, we started -- there were already education

22 End-stage renal disease

1 programs in place. We worked with the
2 nephrologists at both schools.
3 They've done a lot of work. Weill
4 Cornell has the Rogosin Institute. They've been
5 very proactive in early education, referring
6 patients to transplant, but there were still
7 many opportunities. So, again, engaging
8 between primary care and the nephrologists
9 around not just managing the patients before
10 they're moving towards dialysis.
11 But then working with the
12 nephrologist on how best to manage the dialysis
13 patients so that they don't end up in the
14 hospital. So, that was one, and the other was
15 particularly around heart failure. I know I'm
16 a cardiologist, and I focus a lot on
17 cardiology, but heart failure is a high-cost
18 condition in Medicare overall.
19 And we found that patients were
20 ending up again, in the ED and the hospital
21 where we could potentially manage them better
22 through an outpatient setting. So, at any
23 rate, so those were two particularly high-cost
24 clinical conditions where we started, and we've
25 expanded since then. And then I'll finally say
26 that we focus on any Medicare patient who is

1 discharged from the hospital.
2 Any Medicare patient that's been
3 hospitalized is what I'd say a higher-risk
4 patient, beneficiary, and they're obviously at
5 risk for readmission. And again, unfortunately
6 things are still somewhat highly fragmented.
7 And so, really helping coordinate and do high-
8 touch, as Larry was referring to, for those
9 patients, we found a lot of opportunity to
10 reduce readmissions in coming back to the ED.
11 And then I'll finally say about
12 post-acute, again, there's a tremendous number
13 of post-acute facilities within the
14 metropolitan New York area, and identifying
15 partnerships and better care coordination in
16 that area has also been particularly helpful.
17 CO-CHAIR HARDIN: Thank you, Paul.
18 Adam, I saw you shaking your head, did you also
19 want to comment?
20 DR. WEINSTEIN: Yeah, I'm actually
21 quite familiar with the Rogosin folks, and they
22 are as good as Paul says. But it's a great
23 example of where when you have organizations
24 that are, I would say more vertical, and more
25 integrated, you have the opportunity to agree
26 on common standards. When do you refer a

1 patient, what is it that the specialist would
2 expect of the primary care physician, versus
3 what would the specialist want to handle?
4 And this is where the local
5 relationships really do matter. And so,
6 unfortunately, there's no one universal way to
7 apply this just through payment, but also
8 through the education and the encouragement of
9 developing those kind of standards within a
10 geography, or within a set of institutions.
11 CO-CHAIR HARDIN: Thank you. And
12 Ann, are you okay if we go onto the next
13 question, or did you have something? Okay, I
14 have next Chinni, and then Jen, and Walter.
15 Really rich dialogue. Chinni, please go ahead.
16 DR. PULLURU: Hi, everyone. Thank
17 you for speaking, and being on the panel. This
18 has been great. My question is to Paul, Adam
19 specifically around specialty compensation.
20 Paul, you had mentioned the e-consults that
21 you're using in your ACO, and one of the things
22 we struggle with is on the -- if it's not
23 entirely a total cost of care payment
24 mechanism, how do you envision compensating
25 specialists for e-consults?
26 Or having that be -- introduce

1 parity to what specialists get compensated
2 outside, right? And so, not incentivizing in-
3 person care, or other sort of procedural
4 interventions.
5 DR. CASALE: Yeah, a great question,
6 Chinni. So, a couple things. There are some
7 codes available for e-consults, but certainly
8 not a lot. We structured some funding
9 internally to help promote that. Sort of
10 working within our enterprise with the hospital
11 and the physician groups, again as an interim.
12 Now, that's not going to work for
13 everyone. We wanted to do that, because we
14 wanted to message the importance of gaining
15 experience, and understanding around what works
16 or what doesn't around e-consults. But I'd say
17 right now, quite a bit of that is sort of
18 within internal funding.
19 But even in our last forum with the
20 ACC[23], CMMI is there, and we had quite an
21 extensive conversation around how Medicare
22 should think about, in the physician fee
23 schedule, where e-consults can be supported to
24 help support this work.
25 CO-CHAIR HARDIN: Adam, or Ann?

23 American College of Cardiology

1 DR. WEINSTEIN: Yeah, I'm happy to
2 chime in a little bit too. So, I think as Paul
3 pointed out, there is accommodation in the
4 current fee schedule for telehealth
5 appointments. I know there's active work
6 ongoing about what happens, for instance audio
7 only, and patients that are not able to do
8 video-based calls. I would hope that as the
9 world develops, that this will be now standard
10 of care.
11 The pandemic, if there's any good
12 things that came out of it, certainly the
13 broadening of telehealth was one of those good
14 things. And I hope that as we move down the
15 path with payment around these that will
16 reflect that, probably the somewhat increased
17 burdens that telehealth brings, I believe that
18 it is less efficient in certain ways, and often
19 best used as a supplement.
20 But absolutely critical in terms of
21 getting patients who often have transportation,
22 other issues to the specialist they need to get
23 to in a more timely fashion.
24 CO-CHAIR HARDIN: And Ann, did you
25 want to comment as well? No, okay. Chinni, go
26 ahead.

1 DR. PULLURU: Sorry, just as a
2 follow-up, the question I had wanted to
3 actually sort of clarify was thinking through
4 how you would compensate a specialist for
5 primary care to specialist consultation in
6 order to be able to better provide sort of that
7 care coordination. Because currently there
8 really isn't a huge incentive for specialists.
9 Particularly if they're not getting
10 that in-person care, and downstream revenue, to
11 partake in that outside of some sort of
12 internal compensation mechanism.
13 DR. CASALE: Well, that's -- sorry
14 Chinni, I'm sorry if I wasn't being clear, but
15 we fund that internally. So, we understand
16 that takes time. The specialist is taking time
17 to do this e-consult, and not seeing a patient
18 where they can do an E&M. So, we have a pool
19 of funds internally to compensate for that
20 time.
21 And again, it's not a perfect
22 system, but we needed to start somewhere, we
23 had to recognize that there's time and
24 expertise that we're asking from the
25 specialist, and communicating back sort of in a
26 shared role in managing these patients.

1 CO-CHAIR HARDIN: Chinni, were you
2 asking if things could go the other direction?
3 So, primary care to be consultation to the
4 specialists holding that continuity of care?
5 DR. PULLURU: It could go both ways.
6 My question was more around if you're -- the
7 construct of if I'm a primary care physician,
8 and I wanted to have some sort of -- oncology
9 does this with the tumor board, but I wanted to
10 have some sort of coordination between myself
11 and say, a nephrologist, or a hematologist, and
12 I created that. How can we better envision
13 payment constructs that support that?
14 CO-CHAIR HARDIN: Got it.
15 DR. WEINSTEIN: There were some
16 recent CPT[24] codes that reflected that
17 professional-to-professional consultation, but
18 these things are not well reimbursed, they're
19 certainly not universal in their reimbursement.
20 And I think between a time that we're sharing
21 risk in a way that would incentivize these kind
22 of conversations.
23 You're really left with a fee-for-
24 service piecemeal slash documentation-level
25 need for reimbursing those conversations

24 Current Procedural Terminology

1 between two providers, be them specialists, or
2 whomever.
3 DR. CASALE: Yeah, that's where I
4 think this transition, the PMPM, or whatever.
5 You need to have some dollars that are
6 available in a more global fashion, not the
7 piecemeal in order to encourage and enhance
8 that collaboration and communication. Sorry
9 Ann, I didn't mean to cut off.
10 CO-CHAIR HARDIN: Ann, please go
11 ahead.
12 MS. GREINER: No, I was just going
13 to say, I mean let's not make it more complex,
14 right? We have 8,000 codes, more codes that
15 quite frankly some of these new codes aren't
16 being used for lots of different reasons. So,
17 how can we get to that pot of money that Paul's
18 organization is putting up, because they
19 understand it improves care, and we would hope,
20 also reduces costs.
21 How do we move and transition more
22 rapidly so that we can avail ourselves of more
23 creative ways to deliver care? Because I think
24 that's what we're also all trying to do here.
25 If we pay differently, we're going to unleash a
26 lot of creativity for people to use technology,

1 use different kinds of team members, think
2 about other modalities to meet patient needs,
3 and at the same time reduce costs.
4 I did want to make one comment
5 following up on Paul's comment about what
6 happened when we moved to capitation some time
7 ago. And I think a lot of primary care
8 clinicians have PTSD about that, because you're
9 right, it didn't work well. We didn't have
10 much in the way of data and analytics. We
11 didn't have really good performance measures.
12 We still have a lot of work to do in
13 terms of performance measures, but I hope now
14 we have more of the infrastructure that can
15 provide guardrails and accountability, and if
16 we're going to be -- and we need to invest more
17 in primary care, we can't be taking the same
18 amount of money going from retrospective
19 payment to prospective.
20 We need to enrich that payment, at
21 the same time, we need good measures to make
22 sure that -- and a definition of what services
23 will be provided as a result of that enriched
24 payment.
25 CO-CHAIR HARDIN: Thank you. I want
26 to go to Jen next.

1 DR. WILER: I also want to say thank
2 you to our presenters for an excellent
3 discussion.
4 I'd like to summarize some of the
5 things that I've heard and dovetail off of the
6 discussion that Chinni has sparked, and
7 ultimately what I'm going to be asking you is
8 what's missing and what would be helpful from a
9 payment or payment policy perspective?
10 So, what I heard was that RPM, or
11 remote patient monitoring, is the way for us to
12 perform high-touch, potentially primary care or
13 specialty care that, with that high-touch focus
14 that is potentially creates proactive activity
15 as opposed to retrospective activity as a
16 patient progresses with disease, which may or
17 may not be inevitable but can be slowed.
18 There’s then high-touch that starts to
19 transition to a specialist -- and Chinni
20 mentioned this and I agree, I think it's a good
21 model, and it's this idea of a multi-D
22 approach. We have multi-D clinics.
23 They work really well in oncology
24 for instance, and it sounds like, Adam, that
25 that could be, you know, an approach in the
26 renal care space and others.

1 But that really requires that
2 provider-to-provider discussion and
3 consultation, and that ultimately, it sounds
4 like we need a project manager for the patient
5 in their care journey, and we need a project
6 manager for the physician or the practice
7 across their panel, and my team that would be
8 listening today -- I love project managers, and
9 we do a frequent portfolio review.
10 And so, like you've described, this
11 would be a panel review or a portfolio review.
12 So again, my question for you all as I think
13 about what are the costs associated with
14 standing this up, infrastructure, what are the
15 payments needed, either prospectively and/or
16 retrospectively to engage this work?
17 And lastly, what are the levers
18 needed to incent these behaviors, and how do we
19 know it works? How do we prove value? What
20 does measurement look like? So, in that model,
21 tell us what's missing and what would be
22 helpful.
23 CO-CHAIR HARDIN: Either one of you
24 can go first.
25 DR. CASALE: Thank you. Ok, yeah.
26 CO-CHAIR HARDIN: It's a really rich

1 question.
2 DR. CASALE: Yeah, it is. So
3 Jennifer, let me just show you -- you asked
4 three things about what is the cost, and what
5 was the second? I heard the levers.
6 DR. WILER: I want to give you a
7 chance to talk about cost because practices
8 have to cover their cost, maybe that's
9 infrastructure, the technology. I've heard
10 about technology-enabled care or virtual health
11 or telehealth, that's a cost.
12 Then there's the provider-to-
13 provider interaction that you've all talked
14 about. What are the incentives?
15 There may or may not be a cost, but
16 it sounds like, Paul, you've created an
17 internal process because currently from a
18 payment policy perspective, it's not either
19 adequately reimbursed or there's not the right
20 incentives.
21 And then, Adam, I heard you talk
22 about a project manager, and maybe that's
23 covered in care coordination, but it sounds
24 like in your personal experience and that of
25 your specialty, it's been inadequate to do what
26 you believe is right, and again that's high-

1 touch, as Larry asked a question, and
2 complicated but important work that's not
3 currently being valued.
4 So, thinking a little bit again
5 about payment policy, I wanted to expand the
6 conversation beyond just virtual telehealth
7 waivers. Talk to us a little bit more about
8 where there are opportunities.
9 DR. WEINSTEIN: So, I'm happy to
10 talk on this. I feel like, there's a lot of
11 things going on in my space that might be
12 applicable.
13 So that the first cost, I think as
14 you pointed out, are the FTEs[25] that are
15 required. At the moment the folks that are
16 paid for are the ones that are managing our
17 high-risk populations that are covered by the
18 capitated contracts, either through a
19 commercial entity or through the CMMI
20 demonstration projects.
21 Certainly scaling that to an entire
22 practice where the patients would have some
23 cost associated with it.
24 I would say another cost that needs
25 to be considered is time. None of these things

25 Full-time equivalents

1 can happen in two- or three-year increments.
2 If we're going to do this right as a country,
3 then we really do need to think in terms of
4 decades.
5 It talks about bringing new people
6 into the practice, restructuring practices in a
7 way that's not disruptive to the way physicians
8 expect to be paid and expect to conduct
9 themselves in a health care environment.
10 Those things are very, very
11 challenging and take time, which I know is
12 often not on our side with regards to these
13 payment models. People want to see results
14 very quickly.
15 The other opportunity I see is
16 similar to the HITECH[26] Act. We really have
17 missed the boat with regards to population
18 health tools, so practices, you know, beyond
19 simply an EHR need the appropriate data
20 aggregation and interoperability tools.
21 A lot of the data is out there, but
22 bringing it in, turning it into discrete data
23 elements, turning it into something that is
24 then actionable and aggregatable using things

26 Health Information Technology for Economic and Clinical Health

1 like natural language processing -- and God
2 forbid I'm going to use sexy tech words like
3 AI[27], that would aggregate information and
4 potentially offer that up in a way that a human
5 in the form of a care coordinator or someone
6 else whose job it is to monitor that Gantt
7 chart of patient progression can use in a
8 proactive way.
9 For instance, right now we have
10 nurses looking at 4,000 pages worth of PDF
11 documents to pull out the most relevant
12 information. That's just not sustainable or
13 scalable.
14 And then in terms of measures, I
15 mean, you know, it very much depends on the
16 disease state for heart failure patients,
17 hospitalizations, and ultimately appropriate
18 use of end-of-life services.
19 For nephrology it's going to be
20 things around, you know, the timeline to
21 progression to end-stage renal disease, and
22 whether or not you get patients listed for
23 transplant, and sort of the volume of expected
24 versus outcomes in a chronically ill patient
25 population.

27 Artificial intelligence

1 Again, these things take multiple
2 years to develop, right? Nobody gets
3 identified with chronic kidney disease and ends
4 up on dialysis four months later. It's a multi-
5 year process, and so you have to be respectful
6 of that time.
7 And then lastly, I would say the
8 opportunity is figuring out how to get
9 practices and physicians to restructure their
10 business relationships amongst themselves so
11 that you are compensating physicians within the
12 existing business structures to do the things
13 we want them to do in terms of value-based care
14 management.
15 DR. CASALE: Yeah. Adam, that's
16 great. I'll just add a few things, I'm sorry.
17 That was great, a great answer.
18 The other things I would add,
19 Jennifer, to your question is, you know, really
20 in terms of payment, you really want to move to
21 prospective payment, and as Ann brought up - I
22 mean, that's really where they want to go, but
23 to do that we really have to be sure we
24 understand attribution, accountability. I
25 mean, the clinicians need to understand who are
26 they responsible for, and for, you know, what

1 period of time.

2 And really risk-adjustment,
3 including SDOH, has got to be part of that.
4 You know, whenever you think of prospective
5 payment, you do worry about sort of unintended
6 consequences if it isn't done well.

7 And so, I think those areas really
8 need to be improved, and again that's going to
9 take time, but I think that that's certainly
10 missing.

11 And then in terms of levers and
12 incentives, you know, we know clinician burnout
13 is high, there's a lot of reasons for that.
14 When I talk to my primary care physicians, they
15 talk about their inbox. You know, they're
16 spending hours and hours and hours, and again,
17 you know?

18 So again, in a more global world
19 where, you know, where that's important because
20 that's, you know, communication, asynchronicity
21 with the patient to help manage the care,
22 that's really important.

23 You know, I know there's a lot of
24 conversations around sort of, you know, billing
25 for that, but that's the piecemeal approach. We
26 need to have a more global approach.

1 And for the specialists, you know,
2 one of the biggest pain points is prior
3 authorization, right? It just takes so much to
4 do this.
5 So again, some of the levers, if
6 some of the payment -- if moving closer to the
7 premium dollar for those who are caring for the
8 patients, they can think more creatively around
9 some of this and remove some of those pain
10 points which are sort of incentives levers,
11 levers to enhance that primary care, specialty
12 relationship and move away from sort of the
13 piecemeal mentality.
14 CO-CHAIR HARDIN: Ann, would you
15 like to comment? Please go ahead.
16 MS. GREINER: Sure. I think Paul
17 raises a lot of technical issues that are
18 really important to solve for: attribution,
19 risk-adjustment, adjusting for social
20 determinants.
21 I mean, these are very tough issues
22 and, you know, there's a lot of progress we
23 need to make here.
24 Having said that, you know, where I
25 sit, I see a primary care platform that was
26 really hit hard during COVID. Estimates of

1 losing $15 billion in 2020, money that, you
2 know, primary care doesn't really have.
3 And so, when I think about where
4 should we prioritize additional investment to
5 try to address this issue of fragmentation, I
6 think it is primary care.
7 And the Europeans pay twice as much,
8 you know, they invest twice as much as we do in
9 primary care or more. Not that we don't have
10 access issues in specialty care, we certainly
11 do.
12 And this is not -- you know, there's
13 difference of course in the salaries, but I'm
14 really talking about the infrastructure support
15 and the teams that need to be built out to
16 truly provide the kind of care we're looking
17 for.
18 So, it's a comment about, you know,
19 there's many competing demands and everything
20 is costly in our system, but we clearly are
21 spending a lot more downstream and that
22 increases, and a lot less upstream.
23 And look at our outcomes. You know?
24 We were four years behind the Europeans in
25 terms of life expectancy before COVID, you
26 know, and now we're even falling further

1 behind.

2 CO-CHAIR HARDIN: Paul, did you want

3 to comment a follow on there? I saw your light

4 go on.

5 DR. CASALE: You're asking me, or?

6 I'm sorry.

7 CO-CHAIR HARDIN: Yeah, I thought I

8 saw your light go on.

9 DR. CASALE: No.

10 CO-CHAIR HARDIN: That's okay.

11 Let's go to Walter next.

12 DR. LIN: Thank you for our

13 panelists for such a rich discussion so far and

14 adding so much value to our discussion on

15 specialty integration.

16 Now, I think we all know the goal,

17 right? The goal is to move 100 percent of

18 Medicare beneficiaries into some sort of value-

19 based relationship with a focus on total cost

20 of care.

21 The current state is -- and I've

22 heard this not just from our panelists, but

23 also from our subject matter experts last year

24 as well -- specialty care in large part today

25 is compensated still via fee-for-service RVU

26 mechanisms.

1 And so, I think the really tough nut
2 that we've been trying to crack through this
3 public meeting is how do we construct payment
4 models that appropriately incent specialty
5 providers to participate in a total cost of
6 care-based world?
7 And I guess I'd just like to try to
8 get some specifics of maybe best practices our
9 experts have seen out in the industry in the
10 respective organizations or industry groups.
11 So, for instance, Adam, what kind of
12 payment mechanisms have you seen out there that
13 will incent a nephrologist from delaying
14 progression of, or maybe even preventing
15 progression of chronic kidney disease to end-
16 stage renal disease requiring dialysis?
17 Paul, you mentioned in your ACO that
18 you're using Bluetooth-enabled blood pressure
19 cuffs to enable better control of blood
20 pressure, largely under the purview of the PCP,
21 but they're reaching out to specialists, the
22 nephrologists, cardiologists as needed.
23 How are the nephrologists,
24 cardiologists being compensated for their
25 participation? Is it just kind of a fee-for-
26 service payment that you refer to, or do they

1 somehow get increased payments if the patients
2 have decreased cost overall?
3 I'm looking for more kind of
4 specific examples of payment structures that
5 have worked to incent and engage specialists in
6 the total cost of care world.
7 CO-CHAIR HARDIN: And colleagues,
8 we have lost our video feed, but we're still
9 connected, so I'm going to leave it to the
10 three of you to decide who answers first.
11 Paul, Ann, or Adam, please go ahead.
12 Paul, would you answer first?
13 (Audio interference.)
14 CO-CHAIR HARDIN: And panelists, can
15 you indicate if you can hear me? Either
16 verbally or try the thumbs-up symbol on Zoom.
17 And we are checking the technology. Please
18 hold on.
19 We are working on the connection.
20 And if you can hear this, we are actively
21 working on reconnecting with the panelists.
22 (Audio interference.)
23 CO-CHAIR HARDIN: I think that we're
24 reconnecting it. It sounds like you are having
25 a really interesting discussion, I'm very sad
26 we missed that. Can you hear me, Paul?

1 DR. CASALE: Oh, we're back.
2 CO-CHAIR HARDIN: It sounds like
3 not.
4 DR. CASALE: Can you hear us?
5 CO-CHAIR HARDIN: We can hear you.
6 Can you hear me? Working on the technology, one
7 moment.
8 MS. SHATS: Paul, can you hear us?
9 It says no microphone is detected on your
10 system.
11 DR. CASALE: They apparently can
12 hear us, but if they're speaking, we can't hear
13 them right now. Okay. Yeah.
14 CO-CHAIR HARDIN: Paul, we could
15 text you questions and then you could answer
16 them.
17 MS. SHATS: Should we just have them
18 restart their answers? Where did we stop?
19 CO-CHAIR HARDIN: Checking one more
20 time. Can you hear me, Paul? Can you hear us
21 now? You can hear us, Ann?
22 DR. CASALE: Now we can.
23 CO-CHAIR HARDIN: Oh. Oh, that's
24 great.
25 DR. CASALE: Yep.
26 CO-CHAIR HARDIN: That's wonderful.

1 DR. CASALE: We're back.

2 CO-CHAIR HARDIN: Well, it sounds
3 like you had a really interesting conversation
4 while we were connecting, we're very sad that -
5 - we heard that.

6 Walter asked a very good question.
7 Do you want to do a very quick summary of that
8 question, Walter?

9 DR. LIN: Yeah, sure.

10 CO-CHAIR HARDIN: And then we'll go
11 to the panelists to answer.

12 DR. LIN: Sure, yeah. Kind of the
13 premise of the question was specialists are
14 still in a fee-for-service RVU world. We're
15 trying to move to engage them in a value-based
16 payment world, especially since they account
17 for the majority of the cost of care.

18 And I'm looking for specific
19 examples that have worked to kind of promote
20 this payment transition, so I asked Adam, for
21 example, how does a nephrologist get incented
22 to prevent progression of a chronic kidney
23 disease patient to dialysis when the
24 nephrologist gets paid more for dialysis?

25 And I asked the same about
26 oncologists and prescribing chemotherapy

1 infusions on a kind of fee-for-service basis,
2 and how do you incent that oncologist to have
3 end-of-life discussions, or how do you -- like
4 for Paul, I asked for his ACO, the hypertension
5 Bluetooth-enabled sphygmomanometer device where
6 blood pressure control is still mainly under
7 the purview of the primary care, but the
8 primary care would reach out to cardiology,
9 nephrology as needed for improved control.
10 How does the specialist there get
11 paid? Is it just kind of a fee-for-service
12 payment for their consultation, or do they
13 actually get additional payment if the patient
14 controls their blood pressure better and has
15 lower costs?
16 DR. WEINSTEIN: So, I'm happy to
17 start the answer for nephrology. So that the
18 current CMMI models, the CKCC[28] model in
19 particular is a great example of how this is
20 working.
21 So, the first piece of it is that a
22 preponderance of the patients in a nephrology
23 practice are usually Medicare patients, though
24 increasingly it's Medicare Advantage.
25 But having said that, the model, you

28 Comprehensive Kidney Care Contracting

1 know, allows you to have some sort of incentive
2 payment for patients that are appropriately
3 landed in a home dialysis modality PD[29], start
4 dialysis with a fistula -- which is superior to
5 a dialysis catheter -- and then of course
6 getting patients to transplant.
7 There's total cost of care dollars
8 thrown in there as well, so there's, you know,
9 sort of a true-up at the end of each
10 performance period.
11 But really has been most eye-opening
12 to me is that practices that assign a clinical
13 lead and an administrative lead to help rally
14 the troops within the practice, and to I think
15 to what Paul is doing, create some sort of
16 artificial payment structure within the
17 practice to incentivize people's behavior in
18 the way you want, is where we're seeing the
19 greatest uptake of success.
20 And so, the CKCC model as the years
21 go on -- we're entering I think payment year
22 two --it's a strangely structured timeline
23 because of the overlapping measurement years.
24 But having said that, as you start
25 to see the data roll out, you'll see that

29 Peritoneal dialysis

1 practices that have done more toward
2 transformation, more toward organization, more
3 toward internal incentivization are probably
4 going to be more successful on the whole.
5 DR. CASALE: Yeah, I'll just add on,
6 you know, Walter, you know, I mean, the idea to
7 what Ann was saying about moving upstream,
8 right, I mean we are trying to move upstream,
9 we know if you control hypertension, you know,
10 obviously over a number of years you're going
11 to prevent complications.
12 So for us it's not really
13 incentivizing like an outcome, saying well, you
14 know, if you control blood pressure -- I mean,
15 I think everyone, you know, all the clinicians
16 are interested in better, you know, blood
17 pressure control for their patients and how to
18 leverage this.
19 So really part of it is when is the
20 right time to refer to the nephrologist or the
21 cardiologist, you know, when, you know, based
22 on control or lack of control, and you know,
23 what medicines the patients are currently on.
24 And so, creating some of those care
25 pathways and guidelines to help has helped some
26 of that. And again, we do have sort of some

1 internal funding to try to encourage that
2 communication. And again, that's trying to
3 work within the current fee-for-service.
4 And then there's opportunity even
5 with chronic care management fees. I mean,
6 there's small areas in fee-for-service that can
7 help, you know, enhance some of this work.
8 And similarly for heart failure. I
9 mean, we know our guideline-directed medical
10 therapy, you know, the number of patients who
11 are truly on the right dosing and the right
12 combinations in general is relatively low, and
13 I think there's opportunity, and we've seen
14 opportunity there by leveraging the higher-
15 touch remote communication and monitoring.
16 CO-CHAIR HARDIN: And Ann, do you
17 want to add any comments to that?
18 MS. GREINER: No thanks.
19 CO-CHAIR HARDIN: Any other
20 questions from our Committee members?
21 So, I want to thank our three
22 panelists for joining us this morning. It's
23 been a tremendously rich discussion. We
24 appreciate your expertise and all of your
25 dialogue. We've covered a lot of ground in
26 this session, and you're welcome to stay and

1 listen to as much of the meeting as you can.
2 At this time we have a break until
3 1:00 p.m. Eastern. Please join us then. We
4 have a great lineup of guests for our second
5 panel discussion of the day, and we look
6 forward to seeing you at 1:00 p.m. Thank you.
7 (Whereupon, the above-entitled
8 matter went off the record at 11:54 a.m. and
9 resumed at 1:00 p.m.)
10 * **Panel Discussion 2: ACO Perspectives**
11 **on Specialty Integration and**
12 **Improving Care Delivery**
13 CO-CHAIR SINOPOLI: Good afternoon,
14 welcome back, everybody. I'm Angelo Sinopoli.
15 I'm one of the co-chairs of PTAC.
16 We had great sessions this morning
17 with a lot of experts and a lot of robust
18 conversations. So, I'm really looking forward
19 to this afternoon's session as well.
20 I'm pleased to welcome three experts
21 who have experience in different types of ACOs
22 for our second panel on Specialty Integration.
23 You can find their full biographies
24 posted on the ASPE PTAC website along with
25 their overview slides.
26 I will briefly introduce our guests

1 and give them a few minutes each to share an
2 overview of their work and perspectives.
3 First, we have Emily Brower, who is
4 the Senior Vice President, Clinical Integration
5 and Physician Services at Trinity Health.
6 Welcome, Emily.
7 MS. BROWER: Thank you.
8 Thanks so much for inviting me, so
9 glad to join you all for this discussion and
10 share a little of Trinity Health's experience,
11 yes, as an ACO, but also as an integrated
12 delivery network with a significant investment
13 and broad geography in value-based care.
14 So, if we could go ahead, I'll just
15 give a little bit of that overview.
16 I always start conversations about
17 population health and value-based care with our
18 Trinity Health mission, vision, and values
19 slides.
20 And that is because this work is
21 right at the core of our mission to be a
22 compassionate, transforming, healing presence
23 within our community to lift the health of the
24 communities that we are called to serve.
25 And so, yes, we, I think, are the
26 leading health system in value-based care. But

1 that's simply because we are trying to
2 transform the health care delivery system in
3 order to improve the health of the communities
4 we serve.
5 So, not sort of an end in itself,
6 but in a means to get to that end.
7 And so, I often get questions about,
8 you know, what drives the level and breadth of
9 investment we've made in this work. And it's
10 because of this. We just don't think we'll be
11 able to really transform the health of the
12 communities we serve under a fee-for-service
13 payment model.
14 So, payment model transformation and
15 service of care delivery, transformation and
16 service of community health.
17 Next slide?
18 And so, in this work, we are trying
19 to move all payments from the lower left
20 quadrant to the upper right quadrant. So, from
21 traditional fee-for-service all the way up to
22 fully integrated total cost of care payment
23 models.
24 We are the second largest PACE[30]
25 provider. And to us, that's sort of like the

30 Program for All-Inclusive Care for the Elderly

1 original population health value-based payment
2 model because it fully integrates all the
3 payment and the services and really leverages
4 the depth of relationships in the communities
5 we serve that we have.
6 So, by integrating, including long-
7 term services and supports and behavioral
8 health really, the full breadth of services for
9 the population.
10 And so, we just keep trying to move
11 things from the lower left to the upper right
12 where we have the opportunity to deliver the
13 most integrated care and, hopefully, change the
14 payment model.
15 Next slide?
16 And in terms of our portfolio today,
17 two million attributed lives, as we like to say
18 in value-based care, or people that we serve
19 and $11 billion in cost of care accountability.
20 You'll see here the breakdown which
21 I think is helpful for today's discussion. A
22 lot of Medicare, 50 percent of Trinity Health's
23 business, fee-for-service business is Medicare.
24 So, trying to transform the payment
25 model, right, we're very much sort of each and
26 every day trying to make sure all Medicare

1 beneficiaries have that accountable home,
2 either by being attributed to a Medicare ACO
3 or, if they so choose, Medicare Advantage. We
4 have our own Medicare Advantage plan, and we
5 take total cost of care accountability there as
6 well.
7 I mentioned PACE. Up until
8 recently, we were one of the largest
9 participants in the bundled payment program.
10 And I include it in my slides today, just some
11 of our -- the value that we saw from
12 participating in both as a way to sort of start
13 a conversation about integration and alignment.
14 So, a lot of good experience there.
15 And then, of course, we have
16 accountability for the health and well-being of
17 our colleagues and their dependents. So, we
18 have first dollar accountability there for our
19 colleague health plan.
20 And then, we participate in
21 commercial and Medicaid plans. And one of our
22 systems is in Maryland. So, there we've also
23 have gotten some experience with all-payer
24 global budgets.
25 So, lots of different programs. We
26 sort of will raise our hand where we feel like

1 we can get anywhere further up that diagonal
2 and participate if the terms are reasonable.
3 On the next slide, just teeing up
4 some, you know, this is some of our thoughts
5 specific to -- and we often get a lot of
6 questions because we have such an extensive
7 participation in both population-based payment
8 models and, until recently, episodic-based
9 payment models.
10 So, why, you know, what was our
11 hypothesis around that?
12 And that was really an ability to
13 align and integrate at the moment where
14 patients are -- it was really a critical period
15 for people that are in the hospital that shift
16 to next site of care, is one that is fraught
17 with possibilities for falling through the
18 cracks or poor integration, poor alignment.
19 And so, wanting to specifically
20 align at that moment and make sure that
21 patients are getting that extra touch and
22 services to get them to the most appropriate
23 next site of care with the supports and
24 services to take care of them during that
25 critical period and then return them to primary
26 care.

1 So, and so, I've got a few points on
2 here that I thought might be fun to touch on
3 during the discussion.
4 So, with that intro, I will pause
5 for our next subject matter expert.
6 CO-CHAIR SINOPOLI: Thank you,
7 Emily.
8 Next, we have Ms. Cheryl Lulias, who
9 is the President and Chief Executive Office at
10 Medical Home Network.
11 Cheryl?
12 MS. LULIAS: Hello, thank you.
13 And thank you for the opportunity to
14 participate in this discussion with this
15 esteemed panel. I'm really grateful.
16 So, I'm Medical Home Network CEO and
17 President. We call ourselves MHN. We're a
18 not-for-profit, Chicago-based.
19 And we have a vision to redesign
20 care delivery in the safety net. And like
21 Trinity and everybody else on this panel,
22 improve the health of the communities we serve.
23 So, I'm going to talk to you a
24 little bit about our model and our approach.
25 So, we've created a standardized
26 whole-person model of care that we practice

1 across our federated networks.
2 And for us, that means a team-based
3 care management at the primary care practice
4 with the care team employed by the primary care
5 practice, and that care team coordinates care
6 across the continuum.
7 So, today, I'm going to share an
8 example from the Illinois ACO we created. It
9 was a Medicaid ACO.
10 The composition is 13 FQHCs[31] and
11 three hospital systems. This group is
12 completely delegated for care management and
13 has global risk for 175,000 Medicaid lives.
14 And my hope today is that this
15 example proves relevant to our ensuing
16 discussion.
17 So, next slide, please?
18 Great, so, what is the problem we
19 were trying to solve?
20 We identified a subset of our
21 membership who are high-risk, high-cost. And
22 namely, those who went to the ED or were
23 frequently hospitalized for severe mental
24 illness in substance abuse diagnosis.
25 And so, we analyzed our utilization

31 Federally qualified health centers

1 and our cost data from the sub-population, and
2 the goal was really to understand potentially
3 avoidable costs and what was contributing to
4 them.
5 So, this slide shows that, it's a
6 little bit of a busy slide, but during the six
7 months post-discharge from the ED or inpatient
8 setting, how many people for our focus subgroup
9 had at least one claim in each of these
10 categories?
11 So, we had a cohort of 699 patients,
12 and let me run through this.
13 So, the top yellow line, the first
14 yellow line, what that's saying is 30 days
15 post-discharge, only 50.5 percent of our
16 population filled -- had an Rx claim for psych
17 or substance abuse.
18 You go to the next yellow line,
19 that's saying that only two-thirds of our
20 patients had follow-up with a behavioral health
21 provider.
22 You go to the next line, that's
23 saying only 40 percent of our patient
24 population with these diagnoses saw their
25 primary care physician within 30 days post-
26 discharge.

1 And then, things that aren't
2 highlighted, readmission rate was 19.2 percent.
3 We've had it as high as almost 30 percent. And
4 a third were back in the ED.
5 So, sort of the punch line was, over
6 time, things were getting even worse. And so,
7 clearly, we had a problem with our members not
8 taking their meds and not getting engaged in
9 ambulatory care with behavioral health or
10 primary care post-discharge.
11 So, let's go to the next slide.
12 So, this slide is the cost view.
13 And this slide takes the population and breaks
14 down different categories of severity based on
15 CDPS[32] Rx-defined categories, and tracks the
16 average monthly costs for the population that
17 we were -- the sub-population we were looking
18 at.
19 And the line in yellow shows, you
20 know, it's actually most expensive. It shows
21 somebody admitted for alcohol abuse was $2,556,
22 you know, in costs the first 30 days post-
23 discharge.
24 So, again, we had a significant
25 segment of our population with the diagnosis we

32 Chronic Illness and Disability Payment System

1 were looking at that were really expensive,
2 that were in the ED, and getting hospitalized,
3 not taking meds, and not getting the
4 appropriate ambulatory care.
5 So, this slide is what we use as the
6 baseline measure for our target value-based
7 program and construct, which I'll go through in
8 a minute to support the model we did.
9 So, this was our baseline that we
10 used for our VBP program.
11 So, let's go to the next slide.
12 So, what did we do with this
13 information, and what did we do in terms of
14 creating a nested model of care?
15 So, we looked at our data. We said,
16 our management model is, you know, with care
17 management at the primary care level, but you
18 can see only a fraction of our members were
19 going to their PCP post, you know, ED or
20 inpatient discharge.
21 So, we needed a new clinical model
22 and a new payment model.
23 So, we found a community mental
24 health partner to develop and implement
25 including community-based behavioral health
26 trained care managers, as well as, you know,

1 access to the clinicians and workflows.
2 So, what we did is we engaged our
3 community behavioral health partner to meet our
4 patients face to face in the community. We
5 used transitions of care and ED visits and
6 inpatient transitions as the triggering event
7 for the care teams to make contact while the
8 patient was in the hospital.
9 And then worked to coordinate
10 follow-up care.
11 So, they were our boots on the
12 ground, so to speak, and they worked as an
13 extension of our primary care-based care teams.
14 So, let's go to the next slide.
15 So, let me talk about -- recap the
16 value-based construct to support the clinical
17 model and then talk a little bit about the
18 outcomes so far.
19 So, the value-based opportunity for
20 our behavioral health partner was that we paid
21 an up-front care management fee to cover the
22 staffing model and tasks in care management,
23 the weekly coordination, everything that we
24 asked them to do to implement this model.
25 And then, we offered the back-end
26 incentive for avoidable costs and utilization

1 based on savings from the baseline I showed in
2 the previous slides. And we split that 50/50.
3 And so, a little bit about outcomes
4 and results, you know, really super promising
5 directional results. We don't achieve values
6 because our numbers to date have been small
7 because we launched this construct a few months
8 before COVID. And it's been difficult for us
9 to enroll patients because our behavioral
10 health care team has not had access to the ED
11 or inpatient facilities because of the
12 pandemic.
13 So, we have some good promising
14 initial results, but we haven't had savings to
15 date, but we do anticipate that that will
16 change in our current performance year.
17 And I just wanted to share this, you
18 know, it's an example of how the nesting
19 thinking helped us innovate in both the
20 clinical and the payment model.
21 So, hopefully, this proves useful.
22 CO-CHAIR SINOPOLI: Yes, thank you,
23 that was very interesting.
24 All right, next we have Emily
25 Maxson.
26 DR. MAXSON: Hello, everyone, I'm

1 Emily Maxson. I'm the Chief Medical Officer of
2 Aledade.
3 And I wanted to first start with a
4 description of who we are so that that will
5 ground who -- what we tried to accomplish and
6 our perspective on integrating specialty care.
7 And before I do, I wanted to say how
8 grateful I am as well to be here and to present
9 alongside Emily and Cheryl. So, thank you for
10 the opportunity.
11 Aledade is the company that brings
12 together independent primary care doctors
13 across the country. And we form and manage
14 risk-bearing contracts and Accountable Care
15 Organizations.
16 So, as of this year, we are the
17 largest independent primary care network in the
18 country. We have about two million lives under
19 management, 5,000 PCPs, 1,500 practices.
20 And we got our start with the
21 Medicare Shared Savings Program, expanded to
22 Medicare Advantage, commercially insured
23 patient populations, and Medicaid.
24 And basically, our rule of thumb is
25 that we want to be able to impact health and
26 wellness across the country. We want to be

1 able to curb excess health care utilization and
2 runaway spend in this country.
3 And we want to be able to eventually
4 be the best in care for our elderly and
5 disabled populations.
6 And independent primary practices
7 are an inspiration to me and to us every day.
8 And that's really who we serve. And we help
9 them provide the best care they can to their
10 patient populations.
11 And so, if you can go to the next
12 slide?
13 We do this through a combination of
14 technology-driven services and an app platform.
15 And we've been exploring ways in which to
16 integrate specialty care and help manage
17 specialty care over the past eight years, and
18 have a number of lessons here that I'll touch
19 on briefly.
20 Again, we operate in independent
21 primary care. And so, we are serving up
22 insights and we're helping them to re-invest
23 and double down on primary care to avoid costs
24 in sites and service and escalations in health
25 and poorer outcomes for their patient.
26 So, by investing more in primary

1 care up front, we can stave off the
2 complications and avoid unnecessary emergency
3 room utilization and hospitalizations.
4 So, when we think about most of our
5 interventions, they are usually things like
6 teeing up the patient populations in need of
7 annual wellness visits.
8 They are things like helping them
9 understand which patients have been released
10 from the emergency room or the hospital or the
11 skilled nursing facility so that they can have
12 the data to embrace their patients in a timely
13 fashion and engage them in care.
14 And as Cheryl had mentioned, it's so
15 important after that acute event to really
16 embrace the patients back into their medical
17 home.
18 So, when we think about specialty, a
19 lot of the time, we have to pause and say,
20 okay, well, what is our effect lever? How can
21 we help our practices’ patients once they are
22 outside of our practices’ walls? How can we
23 help our practices understand the data around
24 specialists in their community? And how can we
25 start to impact practice patterns?
26 So, I'll give you a couple of

1 different lessons that we've learned over the
2 past eight years trying to impact work outside
3 of the primary care arena.
4 One is that we have very entrenched
5 referral patterns in our primary care networks.
6 These relationships are often built off of
7 years of experience. They're built off of
8 community relationships.
9 We have lots of people who refer to
10 their children's friends, parents, or the
11 people they went to medical school with or the
12 people they see at church. And they have a
13 beautiful relationship as long as the patients
14 are getting excellent, timely care.
15 And the primary care offices are
16 getting excellent, timely feedback about that
17 visit.
18 And what we know is that that's not
19 always the case, unfortunately.
20 But even bringing data on specialty
21 patterns and quality, it's still hard to get
22 them to change that entrenched pattern.
23 We have had experience with three
24 different e-consult vendors. So, for those of
25 you who are unfamiliar, an e-consult is when
26 you can use your smart phone or your computer

1 to send a question to a specialist
2 electronically.
3 There are some that are synchronous
4 where you get a response back within 30 minutes
5 to an hour.
6 There are some that they send them
7 out and then you might get it back the next
8 day.
9 And we've had a number of
10 experiences. And in all three of those
11 instances which span synchronous and
12 asynchronous, what we found is that clinicians
13 loved the e-consult platforms, and they almost
14 never used them.
15 And they would cite such learnings
16 as well, it's difficult to remember that this
17 is available to me.
18 They were also learning, and we made
19 sure to do it in a contractor/payer agnostic
20 way so that the service would be available for
21 anyone in their patient panel and not just for
22 a subset of Medicare, for example.
23 And still, it wasn't ingrained in
24 their workflow. It was hard to remember that
25 this was something they could access.
26 And then, I think the other really

1 interesting finding there was that we had
2 robust utilization in our nurse practitioners
3 and physician assistants.
4 And we also had robust utilization
5 for patients who didn't have adequate
6 insurance.
7 Our under-insured or uninsured
8 patients, they were almost using it as an
9 alternative to sending the patient somewhere
10 where they wouldn't be able to afford, and they
11 would get the question answered and try to
12 manage them in primary care.
13 But even that robust utilization
14 relatively wasn't enough for us to sustain any
15 of those pilots, utilization was just too low.
16 I also wanted to mention that we
17 have had great success with highly targeted
18 third-party intervention.
19 So, what do I mean by that?
20 We aggregate data from a number of
21 sources, from the practices' electronic health
22 records, from Medicare claims, and other
23 insurer claims, and pre-adjudicated claims data
24 and the practice from hospital HIEs, health
25 information exchanges, and other sources.
26 And we can use all of that data to

1 try and understand through machine learning and
2 artificial intelligence algorithms which
3 population of patients might be most likely to
4 benefit from a given intervention.
5 The first one we tried was for
6 complete advanced care planning.
7 The data suggests that 98 percent of
8 elderly patients have never had a conversation
9 with their primary care doctor about their end-
10 of-life wishes or their wishes in the event of
11 complex illness.
12 We also know that there's a lot of
13 care that's provided at the end of life that
14 isn't necessarily in concert with what the
15 patient would have wanted.
16 And so, what we tried to do was we
17 tried to say, look, our primary care doctors
18 are extremely overworked, and we know that they
19 can have beautiful conversations about
20 preferences and complex illness.
21 And we also know that they may not
22 have time to chase down the documents and tie
23 the knots and communicate with the sister in
24 California and the daughter in San Diego, both
25 in California, and the son in New York. There
26 we go, different parts of the country.

1 And that it takes an average of two
2 hours to do this right and comprehensively.
3 And our providers, the way that
4 Medicare reimburses, it is for a 16-minute
5 conversation. So, you can get the ball started
6 rolling down the hill, but there's a lot that
7 needs to be done administratively in order to
8 ensure that a patient's wishes are not only
9 understood, but documented and shared with
10 family members.
11 So, we contracted with a company
12 called Iris, and we did a three-year randomized
13 control trial where we took patients at high
14 risk of mortality in the next 12 months, and we
15 assigned them to either have this Iris
16 introduction and have a complete advanced care
17 planning conversation done or usual care with
18 their PCP.
19 And what we found was that, the
20 patients were extremely appreciative. Our net
21 promoter score was extraordinarily high for the
22 intervention.
23 The practices also gave it a high
24 NPS[33]. The patients, their families, the
25 doctors were happy. And, at the end of the

33 Net Promoter Score

1 day, it was cost-effective so that we could
2 fund it at no cost to the patients or
3 practices.
4 So, we ended up acquiring that
5 company, and that just goes to show, you know,
6 you can use the third-party intervention and,
7 as long as they are in collaboration with the
8 primary care practices and don't cut them out,
9 it can be really a successful partnership.
10 We're now doing this with kidney
11 care management for patients whom we've
12 identified to be at high risk for transitioning
13 into dialysis in an unplanned fashion. And the
14 preliminary results are pretty exciting.
15 So, we're excited to do more of
16 this. What kind of intervention can we find,
17 whether it's for COPD[34] or congestive heart
18 failure, for behavioral health, and really help
19 augment the services and the primary care
20 provider’s office.
21 So, that's probably where we've had
22 our most success.
23 We also have tried inviting
24 specialists into primary care ACOs. And what
25 we've found is that, those clinicians often

34 Chronic obstructive pulmonary disease

1 bring attribution of patients in, but without
2 primary care end to end accountability.
3 So, we tried this with cardiology,
4 and we tried this with nephrology. And so, the
5 patients that tend to see those doctors a lot
6 can be very sick patients and may not have a
7 strong relationship with their primary care
8 provider.
9 And so, it just doubled down for us
10 that primary care is still very key and needs
11 to be forefront. And in the future, should we
12 invite specialists to join our primary care
13 ACOs, we would want to guarantee that their
14 patients that they're treating had robust
15 primary care relationships.
16 And then, finally, when we try to
17 partner with an external entity and shared
18 risk, it's very interesting because you have to
19 help understand that there's overlap between
20 initiatives.
21 So, we tried early on in Aledade's
22 tenure to think about how we might delegate
23 cost to a kidney provider, for example.
24 But that doesn't mean primary care
25 stops. The primary care clinicians are still
26 embracing patients after escalation in care,

1 and maybe so are the kidney providers.
2 So, when you think about affecting
3 in a delegated way, you have to have those up-
4 front conversations about cost accountability
5 in order to move forward efficiently.
6 So, those are some of the lessons
7 we've learned. I hope they're helpful as we
8 continue the rest of the discussion.
9 CO-CHAIR SINOPOLI: Thank you,
10 Emily. Yes, that was very helpful and very
11 informative.
12 And I'd like to thank all three of
13 the speakers for sharing their insights and the
14 overviews.
15 We're going to have -- we have some
16 prepared questions that we're going to ask this
17 group. And the Committee members will also be
18 able to ask questions as time is permitted.
19 As you know, we're focusing on
20 specialty integration at this meeting and
21 wanted to hone in on the ACO perspective during
22 this session and different types of ACOs.
23 So, I'm going to start out with the
24 first question and that is, what approaches are
25 most commonly being used to facilitate
26 coordination between primary care and specialty

1 care providers and the different types of ACOs?
2 And I'm going to start out with
3 Emily Brower.
4 MS. BROWER: Sure, thanks, Angelo.
5 So, our ACOs are multi-specialty
6 ACOs. So, back to sort of the reason we're
7 doing this work, we want as much of the
8 community, of the provider community and the
9 ACO.
10 Most of our participants are
11 independent in the neighborhoods we serve,
12 whether they're primary care or specialty care,
13 some subset of those are employed by us. But
14 we're very inclusive in terms of who's in our
15 ACO.
16 So, there are physician-led,
17 physician-governed. It includes both primary
18 and specialty providers in those leadership and
19 governance positions in the committees, in the
20 care pathways, or at the care redesign work.
21 So, because we -- so, I would say,
22 for us, it starts with including the
23 specialists in the ACO. It certainly
24 introduces some of the complexities Emily from
25 Aledade mentioned, right, because we get
26 attribution, but we want that.

1 We want to get as many people in the
2 community we serve and as many of the providers
3 in the work.
4 So, it does introduce a lot of
5 complexity, but -- and so, how we get at some
6 of that is, as I -- one vehicle is the care
7 redesign and the care pathways work where we
8 involve the specialist and primary care
9 providers in that together.
10 And then, the other piece is just
11 the day-to-day care coordination. So, making
12 sure that for high-risk patients that get our
13 care management, sort of RNs[35], social worker,
14 care management or PharmD care managers that
15 they are in the practices meeting with both the
16 primary and specialty care, particularly those
17 in ACO parlance, attribution-eligible
18 specialist, so, cardiology, nephrology,
19 oncology, pulmonology, that they are offering
20 that same care coordination approach.
21 And with some of those sub-
22 specialists, some of them have their own sort
23 of care coordinator, care manager. So, most
24 typically, a nephrology and oncology, they have
25 members of the care team.

35 Registered nurses

1 So, they are -- we're really
2 flexible about including those folks as
3 authentic members of the care team to have that
4 fully integrated patient-centered care plan.
5 So, it requires a lot more
6 coordination and integration just in our --
7 what I would say is usual work we do in an ACO
8 that may not look much different than what
9 other ACOs might do, except we pull the
10 specialist into that work because they are in
11 the network.
12 They have attribution. They are in
13 leadership in governance. And so, we just do
14 that work together.
15 CO-CHAIR SINOPOLI: Perfect, thank
16 you.
17 Now let's go on to the other Emily.
18 DR. MAXSON: So, I highlighted some
19 of the challenges. I think we do have a number
20 of multi-specialty clinics.
21 And one way that we found we can be
22 helpful is by helping them understand the
23 patterns of their patients.
24 And when we think about the insights
25 that are usually available to our practices,
26 they don't include information from outside of

1 their own clinics' walls.
2 And so, when you get that file of
3 information from CMS and you can see where
4 they've been, regardless, it's an eye-opening
5 moment for the clinic to experience.
6 So, one thing that we've done a lot
7 of, which the multi-specialty clinics are very
8 hungry for, is analyses of when the patients
9 stay in that clinic and when they go elsewhere
10 for specialty care.
11 And if they do, why? How can we
12 follow up and understand what is lacking or
13 what could be made better about the patient
14 experience?
15 And so, what you see is great
16 quality improvement on the part of the multi-
17 specialty clinics and a better patient
18 experience to boot. So, it's very well
19 aligned.
20 And we also think about when can
21 make sure that our patients' chronic diseases
22 are well understood, documented, and attended
23 to on a yearly basis.
24 Specialists often have better
25 insight into some complex conditions in their
26 categorization than the PCPs do, especially if

1 they're the ones managing it.
2 So, we try to help our specialists
3 understand what it means to be as specific as
4 possible in their documentation and communicate
5 back to the primary care practices so that
6 they, too, understand the level of complexity a
7 chronic disease has reached and what they need
8 to attend to as they're attending to the whole
9 person and not just one subset.
10 So, those are a few examples of the
11 ways in which we can work with specialists that
12 I didn't mention in my introduction.
13 Let's see, I think I'll leave it
14 there for now.
15 CO-CHAIR SINOPOLI: Okay, thank you
16 for that.
17 Let's go to Cheryl, would you like
18 to make some comments?
19 MS. LULIAS: Sure.
20 I think the one thing I'll drill
21 down on is, this is a place where we've had
22 some success using e-consult. Emily talked
23 about that.
24 But like she said, you know, it's
25 because it was really ingrained in the
26 workflow. And so, we use e-consult to support

1 our collaborative care model for depression.
2 And we use e-consult to engage
3 psychiatrists to support primary care practice
4 caring for the patients, both in care and
5 medication management.
6 And that's been really effective in
7 putting patients in remission and reducing
8 depression.
9 What we've actually seen is our
10 results mirror everything we've been able to
11 find in literature. So, that was a great
12 example of using e-consult to facilitate
13 specialists.
14 But again, it's because we've very
15 clearly defined workflows. I think e-consult
16 has a lot of promise, but it's challenging on a
17 more global basis.
18 The other thing I'll say is when we
19 have used e-consult, it's really important that
20 primary care take the time to provide detailed
21 explanations of what they want addressed from
22 the specialists.
23 And that's another key imperative to
24 make that type of technology useful for
25 coordination between primary care and
26 specialty.

1 CO-CHAIR SINOPOLI: Thank you.
2 So, obviously, there are different
3 types of ACO models out there from integrated
4 delivery system to freestanding ACOs to purely
5 primary care ACOs.
6 A lot of those are represented right
7 here by this group.
8 So, we're interested in
9 understanding across those variety of ACOs what
10 kind of challenges are you seeing that may be
11 different in terms of improving specialty
12 integrations, and what kind of challenges are
13 you seeing that may be different among the type
14 of ACO you are?
15 And maybe I'll go back to Cheryl
16 again on this one.
17 MS. LULIAS: Okay.
18 So, I'm going to give a specific
19 example with regard to REACH. So, we're a
20 REACH, and one of the -- and it's a new
21 program.
22 So, we're early days but, you know,
23 we have been contemplating this because, you
24 know, we don't have the ability to use any kind
25 of narrow network or prevent use of low-value
26 providers.

1 And so, we're looking to see how we
2 best improve specialty integration in the
3 construct of the REACH without any levers. So,
4 it's not really -- that's a challenge we're
5 focused on addressing.
6 I don't have any answers, but I
7 think that's something I wanted to raise in
8 these types of CMS value-based models. It's a
9 challenge that needs to be addressed.
10 CO-CHAIR SINOPOLI: Thank you.
11 How about Emily Brower?
12 MS. BROWER: Sure.
13 I'm not sure that it's, you know,
14 specific to the kind, you know, the shape of
15 our ACO or the kind of ACO we have.
16 But I would say, for the most part,
17 the specialists in our network like being part
18 of the network. They like the coordination.
19 They like getting the right referrals, right,
20 where they feel like they're sort of highest
21 and best use of their time.
22 We do have, you know, we need to
23 flex on the way we work. If they have care
24 coordination navigators types of services,
25 their practice looks a little different. But
26 we can do that.

1 I would say, we're going a bit
2 deeper on kidney care. It sounds like Emily
3 Maxson is doing that as well.
4 And there, we've gotten way more
5 into what is it going to take to allow the
6 nephrology practice to see more patients?
7 So, if we're referring to them
8 sooner in the disease process, and they're
9 already really full, right, how do we partner
10 them, bring in a nurse practitioner, another
11 member of not just sort of care management, but
12 on the medical management side to support that
13 capacity?
14 So, we're doing some work there with
15 a partner in Chicago that I think is super
16 promising.
17 And then, the other piece is, how do
18 they make time in that busy schedule? And if
19 they're not sort of documenting and submitting
20 RVUs for that, is there some PMPM support? So,
21 we're working that out as well.
22 So, that's where we're looking for
23 greater integration beyond what I would say is
24 sort of typical care navigation, care
25 coordination to do more integrated medical
26 management. And that is requiring some

1 different thinking.
2 I don't know that that's specific to
3 us, and we think it's great. It's like really
4 where we need to be. So, I would say less
5 maybe challenge, more as like a really good
6 opportunity we think we're going to learn a lot
7 from.
8 CO-CHAIR SINOPOLI: Perfect, thank
9 you for that.
10 Emily Maxson, would you like to add
11 some comments?
12 DR. MAXSON: Sure, a couple of
13 things.
14 I think that we're in a similar
15 position to Cheryl with -- we don't command and
16 control any of our practices, right, and
17 especially not the specialists who are not part
18 of the network.
19 But one thing that we can influence
20 is the provision of data to our primary care
21 practices.
22 So, for example, in
23 gastroenterology, we have practices, as
24 everyone does, who are referring their patients
25 appropriately for colon cancer screening.
26 And what we find is that if you take

1 a look in the data, unbeknownst to our
2 practices, there were a number of GI doctors in
3 certain communities who are routinely providing
4 upper and lower endoscopies for every patient
5 referred for a colonoscopy.
6 And so, imagine the power of giving
7 that data to the primary care doctor who sends
8 all their referrals there. And we actually had
9 primary care doctors visit the office of one
10 specialist, for example, and say, look, when I
11 send you my patient, I trust you. I trust that
12 you're going to do what I asked for and not a
13 non-evidence-based procedure that could put my
14 patient at greater risk.
15 And that GI specialist stopped
16 providing those additional procedures unless it
17 truly was clinically indicated.
18 And so, I think that there's a lot
19 of power in the referral relationship in the
20 community. And with data transparency and
21 providing these very patient-centric quality-
22 based assessments, we can empower really
23 interesting conversations so that the pattern
24 of care matches the expectation.
25 So, that's one example. The other
26 example I think is that, just like in primary

1 care, our specialty practices are challenged by
2 insufficient resources to address social
3 determinates of health and other factors that
4 are outside of managing medically a chronic
5 disease with medicine and therapy and
6 treatments and procedures. Right?
7 There is so much more that goes into
8 taking care of a patient. So, where we can
9 bolster up those third-party solutions I
10 mentioned or even just help our practices learn
11 how to do better chronic care management.
12 We can also help the specialists to
13 enrich the quality of their visit to make sure
14 that what they are recommending has a better
15 chance of being implemented in the context of
16 the patient and everything else they're dealing
17 with.
18 And so, I think upskilling care
19 management or providing extra resources for
20 practices who can't do a care management
21 program at home can be really effective and
22 improving both the specialist and the primary
23 care experience and is no-brainer for the
24 patient experience.
25 CO-CHAIR SINOPOLI: Thank you.
26 So, we had a lot of good, robust

1 discussion this morning. So, I'm going to ask
2 one more structured question, but then I'm
3 going to open it up to the Committee members to
4 start asking some questions, too.
5 And we certainly have other
6 structured questions we can ask, too, as our
7 time moves forward.
8 But one of the things that we're
9 interested in is nesting models. And that's
10 become more and more in conversation, how do we
11 think about those? How do we structure payment
12 around those, et cetera?
13 And so, the question is, what do you
14 all think about nesting models, and what
15 support the ACOs need to participate in total
16 cost of care models that might have nested
17 programs within the ACO?
18 Excuse me, let's start out -- let's
19 go back to Emily Maxson for that. I'm sorry.
20 DR. MAXSON: Sure.
21 I think that the most important
22 thing is that, if you nest something, you're
23 inherently providing different services to the
24 same patient population, and you have to tease
25 apart, right, who's accountable for what and
26 when benefits are achieved in a complex model.

1 What is that thanks to? Right? And
2 how do you sort of distribute the return that
3 that provides financially?
4 Because it's expensive to provide
5 value-based care. And practices will not be
6 able to sustain if they don't get to continue
7 to share in some of the savings that they have
8 worked so hard to achieve.
9 And so, I think that if there can be
10 clarity on which programs are accountable for
11 which piece of the pie, that would be helpful.
12 CO-CHAIR SINOPOLI: Great, thank
13 you.
14 Emily Brower?
15 MS. BROWER: Yes, thanks.
16 So, I suppose nesting is sort of
17 very -- it's in the eye of the beholder or
18 whatever the right term is.
19 When I talk about nesting, I see
20 that as rather than have these different
21 models, CMS models, in this case, if we could
22 just use CMMI as an example, right, where you -
23 - where they had next gen in bundles.
24 And those were exclusive, meaning if
25 patients were attributed to the next gen ACO,
26 and I think this is true for REACH as well,

1 they are not included in the bundled payment
2 program.
3 And then, on the Center for Medicare
4 side and the MSSP ACO, you have what people
5 commonly call overlap. Right? You have model
6 overlap.
7 And if you're all one, which is true
8 at Trinity Health, all of our ACOs are in the
9 MSSP model. And we like bundles.
10 So, we like when those come
11 together. And so, when we think about our
12 experience and sort of exclusive models and our
13 experience in overlapping models, we -- that
14 our concept of nesting is that ACO or the
15 population-based model has total cost of care
16 accountability.
17 Let that entity then decide within
18 that total cost of care what episodes or what
19 specialty care they want to deliver as the
20 entity that's accountable for the outcomes of
21 costs and quality for the population, they will
22 make rational decisions.
23 And so, give the ACO the ability to
24 nest those models, make those decisions.
25 You know, an example of that would
26 be to say, I, as an ACO will convey to CMS, I

1 want to participate in the bundled payment
2 program for my population for these episodes
3 with this payer, with this episode initiator or
4 provider at this price.
5 In other words, it's really taking
6 the bundled payment construct and bringing it
7 inside the accountability of the really big
8 bundle of the whole population on all the
9 services they may need.
10 So, that's the way we think of it,
11 as a way to get out of exclusion on one end and
12 overlap on the other and let that ACO make
13 those rational decisions.
14 As an integrated delivery network
15 that has a lot of hospitals, we would also like
16 to be that partner for other ACOs that don't
17 have specialists and hospitals in their
18 network, right, where they could make that
19 rational decision, and we would offer these
20 episodes, these bundles, these providers, this
21 price.
22 So, really to kind of create that
23 marketplace, if you will, for an ACO, again,
24 that has the full accountability to be able to,
25 looking at its data and selecting where they
26 see there's opportunity to improve care and

1 reduce costs, and then making those rational
2 decisions.
3 CO-CHAIR SINOPOLI: Great, thank you
4 for that.
5 Cheryl, you want to make some
6 comments?
7 MS. LULIAS: This is a hybrid of the
8 current question a little bit before.
9 But, you know, one of the challenges
10 is that attribution, piggybacking off both
11 Emilys, is usually to the PCP, even if the
12 plurality of care is done by the specialist.
13 So, you know, we continue to think,
14 you know, so the specialist is an incentive to
15 manage total cost of care.
16 And so, we have been thinking about
17 how to build in care management and, you know,
18 reward for care management and coordination?
19 We've also been thinking about, for
20 select services, the opportunity to attribute
21 specialists when the plurality of ambulatory
22 services provided are by the specialist.
23 And then, again, provide a care
24 management fee in excess to shared savings.
25 So, this is sort of a blueprint
26 we're toying with for, you know, more global

1 thinking of how to integrate specialists in the
2 event that, you know, in cases like ESRD,
3 oncology, really, the preponderance of care is
4 really done with the specialist.
5 So, that would be, you know, the
6 additional thinking. I would build to this,
7 you have to have enough patients to make it
8 feasible. It works best with an integrated
9 group practice.
10 And that's some of what we're
11 thinking at present.
12 CO-CHAIR SINOPOLI: Perfect, thank
13 you.
14 These have been great, great
15 comments, and we certainly, as I've said, have
16 other structured questions. But I can't
17 imagine that my colleagues aren't eager to ask
18 you some questions of their own.
19 So, I'm going to open it up to the
20 Committee members and ask them to pose some
21 questions for you.
22 I can't -- oh, yes, go ahead, Jay.
23 DR. FELDSTEIN: Yes, I have two.
24 One, in terms of using the third
25 party for e-consults, and even though the
26 providers really like them, because they

1 weren't integrated into the workflow, you've
2 got low utilization.
3 Were you also using their network of
4 specialists, or were you using their platform
5 for your network of specialists? And do you
6 think that that may have had an impact on
7 utilization?
8 DR. MAXSON: So, I can take that one
9 first.
10 So, we tried it both ways. We
11 tried, first, a platform that leveraged their
12 own network of specialists, and they
13 prioritized people from highfalutin places, and
14 it was anonymous.
15 And our independent doctors across
16 the country did not like that. They didn't
17 like the anonymity of that platform, and they
18 would have preferred at least to know who they
19 were getting their advice from.
20 So, I think that we, then, that
21 informed our next adventure which was going to
22 be to try to help develop the local network and
23 help enroll the local network as preferred
24 relationships.
25 And in that model, we used two
26 things. The local network would have first go

1 at the synchronous e-consult. But if they
2 didn't answer expediently enough, that question
3 would go out to the broader network.
4 And the providers actually liked
5 both models. But the ability to have access to
6 the local model didn't meaningfully change the
7 integration into the workflow piece.
8 I think if we were to have started
9 with EHR integration and other flags within the
10 point of care tools to advance the workflow, we
11 might have had more success.
12 But we work with over 100 different
13 EHRs across our network, and it wasn't feasible
14 for us in our organization.
15 DR. FELDSTEIN: I don't know if any
16 other members want to take a crack at that.
17 And part two would be for everybody.
18 To what extent are you using virtual
19 specialty care to help to drive integration?
20 Do you use that? Do you leave that up to the
21 specialists themselves? Or do you kind of
22 build incentives in to utilize virtual care to
23 help drive integration?
24 MS. BROWER: So, this is Emily.
25 Other than making a platform
26 available, so, you know, this -- like many at

1 the start of the pandemic, we quickly stood up
2 a virtual visit platform and made it available
3 to our entire network, so including the
4 specialists in our network.
5 Other than that, sort of making it
6 quickly, very quickly and easily accessible
7 without a cost to the network.
8 We haven't done anything systematic
9 in terms of workflows or utilization or
10 anything like that.
11 CO-CHAIR SINOPOLI: Anybody else
12 have any comments for that question?
13 If not, I'm going to move to --
14 MS. LULIAS: To the former question
15 --
16 CO-CHAIR SINOPOLI: Go ahead.
17 MS. LULIAS: To the former question
18 on e-consult, we just used one network, the
19 specialty network of one hospital system. And
20 again, had pretty prescriptive workflows.
21 But also provided access to 43
22 specialists and had SLAs[36] like Emily referenced
23 where we had really, really rigid SLAs to make
24 sure that people had predictability when they
25 went to an e-consult on response.

36 Service-level agreements

1 And it was pretty -- it was a really
2 successful collaborative care model.
3 But in general, we also saw a lot of
4 success with derm, GI, and ortho for quick
5 questions, so for what that's worth.
6 But we had one group focus, we
7 didn't have multiple networks. And adoption
8 has been okay for the general e-consult
9 questions, but much better where we had
10 focused, ingrained workflows, and focused
11 models.
12 DR. FELDSTEIN: Okay, thank you.
13 CO-CHAIR SINOPOLI: Thank you.
14 Larry, you had a question?
15 CO-CHAIR HARDIN: We can't hear you,
16 Larry.
17 DR. KOSINSKI: Got to remember the
18 two buttons, got to put the hand down, and
19 unmute.
20 I've really enjoyed the discussion
21 here. And it's similar to one that we had
22 probably at our June meeting last year where
23 I'm hearing a top-down approach from a couple
24 of you where, from a system level, you are
25 taking full risk and then trying to implement
26 the providers.

1 And then, on the other end, we're
2 hearing a bottom-up approach for a large
3 primary care network that's going at the
4 problem from a different view.
5 This is really interesting, and it
6 spins the gears in my head.
7 The -- to me, there's a common
8 theme, though, and I have not heard from any of
9 the three of you enough blocking and tackling
10 on this to make me satisfied.
11 I heard the statement from somebody
12 that said that 60 -- it works best with 60
13 percent of the primary care's income is coming
14 from care protection.
15 Well, what about your specialists?
16 How do you get the hearts and minds of those
17 specialists?
18 It's very fine to have an individual
19 doctor go and talk to another specialist. I
20 mean, that's fine.
21 But where are they taking risk? How
22 much risk are they -- how much of their income
23 is at risk? How do you get their hearts and
24 minds to participate in value-based care?
25 Unless you have mechanisms in place,
26 we're going to be having this discussion in

1 five years again.

2 MS. BROWER: So, this is Emily.

3 I don't know that I'm going to

4 satisfy you, give you a satisfactory answer

5 because, frankly, when we talk to our

6 specialists who are very involved in the

7 leadership and governance of our ACOs, they

8 said, just remove barriers for me. Get rid of

9 the paying points.

10 Don't send me a check, don't give me

11 a -- that's not what I need. What I need is

12 better coordination of care. I need to get the

13 right referrals. I need to build

14 relationships.

15 That's where the network, the

16 clinically integrated network, that's sort of

17 our operating structure, provides the most

18 value to me.

19 I mean, we are, as I mentioned, and

20 with our -- one of our nephrology groups, you

21 know, getting a little bit deeper, but that's

22 just not what I'm hearing from our specialists.

23 Right?

24 We went down the road of let's

25 choose some MIPS[37] measures and build an

37 Merit-based Incentive Payment System

1 incentive around that. No.
2 Then we said, well, let's do a PMPM
3 based on attribution. No.
4 That just -- those were not
5 meaningful, what, you know.
6 At the end of the day, what our
7 specialists told us is, we want to actually be
8 part of a medical community. We want
9 relationships. We want the right referrals.
10 We want support for our most complex patients.
11 And we want -- if we get people
12 attributed to us who really need primary care,
13 please find us help on primary care. We don't
14 want to be doing all this, you know, the
15 management of primary care-focused disease and
16 prevention.
17 So, that's what we do. So, I
18 understand why you're asking. I get that. I'm
19 just saying, we've got a lot of specialists all
20 across the country, and that's not what they're
21 asking us for.
22 DR. KOSINSKI: They're afraid you're
23 going to demand it.
24 DR. MAXSON: I think we need to
25 demand it. And I love that question, Larry.
26 And I think that the problem that we

1 have is that specialists truly thrive in a fee-
2 for-service system in a way that primary care
3 doctors and clinicians don't.
4 And so, when we're trying to really
5 meaningfully shift from a fee-for-service
6 paradigm to one of value, they don't stand to
7 win.
8 And I think one really interesting
9 example of this is in retinal injections for
10 macular degeneration. Right?
11 There's more than one medicine out
12 there. They're bio similar. It's the same
13 thing drawn from a different bottle. One costs
14 $2,500, one costs $60.
15 And yet, we do not see universality
16 at the $60 drug. It may be because of the 2
17 percent administration fee, it may not. There
18 may be true and legitimate beliefs that one
19 drug is better than the other. And I want to
20 honor that because I'm not a retinologist, and
21 that's not my bailiwick.
22 But I think that until we have a
23 payment system that demands specialists pay
24 attention to value, we're going to be the tail
25 that wags the dog.
26 DR. KOSINSKI: That's somewhat

1 speaking from the bottom up.
2 CO-CHAIR SINOPOLI: Thank you.
3 Cheryl, any comments to add to
4 those?
5 MS. LULIAS: Well, going to the fee-
6 for-service, fee-for-service, you know, doesn't
7 count on care management or assume
8 coordination.
9 Specialists don't get paid to do
10 that. You know, so much what Emily said.
11 And, you know, where it makes sense
12 to attribute patients, you know, to the
13 specialist, you know, and then you can wrap
14 VBC[38] around them which is, you know, just, you
15 know, just select cases. That's one potential
16 solution.
17 Also, Larry, you talked about ground
18 up. We do have in our total cost of care
19 savings a pool for hospital and specialist.
20 But it's not the full answer. It's just
21 beginning to reward specialist care and have
22 them focus on total cost of care.
23 But like Emily said, the fee-for-
24 service system now isn't set up to accelerate
25 the change we need to see.

38 Value-based care

1 CO-CHAIR SINOPOLI: Thank you, thank
2 you.
3 Jennifer, I think you were next with
4 a question.
5 DR. WILER: Thank you so much for
6 great presentations and your insights.
7 I actually have two questions. My
8 first question is, we heard you describe how
9 important flexibility is as leaders of
10 Accountable Care Organizations in developing
11 incentives and relationships.
12 But I'm curious, are there any, in
13 your experience or in your opinion, are there
14 any specialists or conditions that you think
15 should not be included within a VBC model
16 that's tethered to an ACO?
17 And then, my second question is
18 around multi-payer alignment. How important is
19 that or has that been to the programs that
20 you've described today?
21 DR. MAXSON: So, on the first
22 question, this is Emily Maxson, and I would say
23 that all conditions should be game because all
24 conditions are important to the patient.
25 And we have opportunity to make
26 improvement no matter what.

1 If we think about something like
2 oncology, it's most often a rude surprise for
3 the patient. It entails exorbitant costs and,
4 you know, to tell you the truth, I don't think
5 that we should be trying to give the patient
6 the state-of-the-art drugs no matter what the
7 cost.
8 But where can we help? We can help
9 on better coordination of symptoms, on
10 palliative care, on complete advanced care
11 planning.
12 There are so many patients who
13 aren't given the appropriate antiemetic to
14 stave off nausea or vomiting after they start
15 on a very toxic therapy.
16 And so, it's no surprise that
17 they're in the emergency room with nausea and
18 vomiting.
19 So, what would happen if we embraced
20 those patients in an oncology model? Not to
21 decrease the drug total cost of care, which is,
22 I think, unpalatable to many patients and
23 families, but to embrace patients in the way
24 that we can and alleviate suffering as much as
25 possible and enable them to be at the helm of
26 their care planning.

1 CO-CHAIR SINOPOLI: Great.
2 Emily Brower?
3 MS. BROWER: Yes, sure.
4 I would say include them all.
5 Right? So, getting back to why we do this work
6 at Trinity Health, we want the whole community
7 in. So, we are a “carve-in” kind of place.
8 And so, with that, as I said, always
9 comes lots of complexities. But we want just
10 for the reasons Emily Maxson so eloquently
11 pointed out, we want it all in.
12 On multi-payer, I would say, it's
13 very important. Right? We are providers and
14 so, as all the -- everyone knows, providers
15 don't really practice differently.
16 Yes, we can bring them extra tools
17 and supports and insights for some populations,
18 but at the end of the day, they have a
19 practice, and patients are going through their
20 day. The more patients we can get into these
21 models, the more that that transformation
22 actually helps in their daily work. Right?
23 And so, that's what we want. Our
24 goal is to get all patients who see Trinity
25 Health as their medical home into a value-based
26 payment model. And we work hard every day to

1 do that.
2 So, yes, multi-payer alignment, yes,
3 absolutely. But we also, you know, we work as
4 hard as we can with what we have when we can
5 get it.
6 That's why I said we tend to like
7 raise our hands and get in as much as we can.
8 It's just to keep the momentum, carve it all
9 in, all of the payers, all of the providers,
10 because we're -- that's sort of in service of
11 improving the health of the community,
12 everybody in the community.
13 CO-CHAIR SINOPOLI: Great.
14 Cheryl, you want to add to that?
15 MS. LULIAS: One model multi-payer,
16 you know, they're like grips, because full
17 flexibility of the care team.
18 And then, on the former, you know,
19 we really believe one practitioner needs to be
20 responsible for the full continuum of care.
21 So, like the both Emilys said, you
22 know, it's all in. And then, we work with our
23 team-based care approach to coordinate and
24 collaborate with specialists.
25 And again, the only thematic thing I
26 would add is, in some cases, that leader could

1 potentially be the attributed specialist.
2 CO-CHAIR SINOPOLI: I think next on
3 the list was Chinni.
4 DR. PULLURU: Sorry, trying to
5 unmute.
6 Hi, everyone, thanks for doing this.
7 This is -- and the work you do every day.
8 Cheryl, great to see you again. I
9 know we've interacted a few times over the
10 years.
11 So, this question is for Emily
12 Maxson and Cheryl, and then, you know, Emily in
13 that order.
14 You know, one of the things that I
15 haven't heard sort of in this conversation,
16 and, you know, as if this isn't complex enough,
17 I'd like to add another layer on, is the
18 concepts of health equity as they're integrated
19 within this specialty world. Right?
20 And so, you know, as you think about
21 health equity in primary care, or inequity in
22 primary care, it gets exacerbated when you
23 start, you know, as anybody who's tried to get
24 a Medicaid patient to see a specialist
25 understands that, you know, the difficulty
26 there.

1 So, when you guys were looking at
2 how you deliver care to different populations,
3 and particularly populations of that sort of
4 cohort, how did you think building your ACO?
5 How did you implement it? And how did you get
6 your specialists to play ball?
7 DR. MAXSON: So, I will answer with
8 the caveat that we have specialists in very few
9 of our practices.
10 Health equity, I think, is core to
11 the work of value-based care because we are not
12 embracing value-based care if we leave patients
13 behind.
14 So, one thing that we are trying to
15 do is, first, model this by integrating
16 disparity measurement across all of our
17 organizations, key performance indicators and
18 metrics, and really starting the work where we
19 have the most glaring disparity, which was, for
20 us, our blood pressure control rates and
21 severely, poorly controlled blood pressure for
22 our Black patients. So, we did a lot of work
23 on that.
24 From our partners, whether it is a
25 specialty-oriented partner or not, we talk
26 about health equity and ask what they are doing

1 from the very first conversation.
2 We ask them to show us data about
3 engagement rates across socioeconomic levels,
4 across rural versus urban distinction, and
5 across race and ethnicity.
6 And we really try to make sure that
7 when we're using machine learning algorithms,
8 we do not allow the bias to creep in, that is
9 the hallmark of machine learning.
10 So, if machine learning is acting on
11 existing data sets which require health care
12 utilization, then our patients who don't access
13 the health care system won't have the inputs
14 for machine learning.
15 And so, they will be regularly de-
16 prioritized from machine learning-based
17 algorithms.
18 So, we retrained the algorithms, and
19 we do deliberate things so that we make sure
20 when we are targeting patients for kidney care
21 management, for example, that we do not
22 inadvertently worsen those disparities because
23 we're intentional about it.
24 So, I think the intentionality is
25 really my main point with where we're starting.
26 To be intentional ourselves and to ask for

1 intentionality from all partners and
2 specialists with whom we work.
3 MS. LULIAS: Really well said.
4 The core of our whole care
5 management process, we start our whole process
6 by screening addressable social determinants of
7 health.
8 So, we are working to capture
9 medical, behavior, and social from the get-go,
10 and we form our care management process based
11 on mitigating the addressable social
12 determinants of health, as well as medical.
13 And so, we actually risk-stratified
14 based on social determinants of health. And
15 we've proved that approach is predictive of
16 perspective cost and utilization.
17 But it is front and center in our
18 holistic approach to, you know, team-based care
19 and care coordination.
20 So, our care teams who work with
21 primary care are always focused on social
22 determinants of risk and mitigating those with
23 the goal of improving health and focusing on
24 disparities.
25 We communicate that in what we're
26 doing, you know, in coordination with specialty

1 care. But we also have some tools, like the
2 baseball card that we share that shows the
3 common care plan goals or things we're working
4 to address, as well as a longitudinal snapshot
5 of care, including meds and utilization. And
6 we share that via the EMR.
7 And so, that's something that's
8 available to both primary care and specialists
9 who are managing the patients.
10 But the care team that is end-to-end
11 managing continuity of care is very focused on
12 social drivers and then communicating and
13 integrating with all the clinical practitioners
14 serving the patient to ensure that everybody
15 knows what's going on with the patient,
16 especially post-discharge.
17 You know, we participate in a
18 flexible housing pool. And all members of the
19 care team know when we're supporting a patient
20 and moving them into the flexible housing pool
21 to assure we have a stable post-discharge plan
22 and supportive services post-discharge.
23 So, Chinni, I don't know if that
24 answers the question, but it's central to the
25 whole care model, starting the process focusing
26 on social drivers of health and risk

1 stratification, including AI, all incorporates
2 this.
3 We have a common care plan. This is
4 always front and center for all people to
5 understand what's the medical risk and
6 behavioral risk and the social, and what are we
7 doing to mitigate each of these factors.
8 CO-CHAIR SINOPOLI: Emily Brower,
9 anything to add?
10 MS. BROWER: I would say this is
11 where we, in our sort of ACO world and Trinity
12 Health really benefit from the commitment of
13 the delivery network to eliminating
14 disparities, bias, and racism.
15 We sort of have that power, part of
16 that, and so it is just how we do our work for
17 which I'm very grateful.
18 Specific to and how it shows up in
19 some of our work in the ACO, I'll just use one
20 example, because it's one I think is a really
21 nice connection point is, I can assume, I
22 think, that every ACO out there is trying to
23 reduce preventable hospitalizations, the sort
24 of using that very common. It's good to have a
25 common measure of ambulatory care sensitive

1 condition admissions, the AHRQ[39] measure.

2 So, it's a measure in the ACO
3 measure set. It's a measure that many people
4 embrace and work on.

5 When we were digging into that where
6 we saw, not surprising, really, to anybody, I'm
7 sure, is where we had the greatest number of
8 preventable admissions.

9 So, admissions for things that we
10 should be doing a good job in the ambulatory
11 space is in -- for those who are dually
12 enrolled and within that population, for
13 patients who are Black and dually enrolled, the
14 greatest number of preventable
15 hospitalizations. So, work we should be doing
16 a better job with a standard measure.

17 So, we're able to take that measure
18 and put it into our Trinity Health System
19 scorecard of which we have a very few number of
20 the most important measures. How are we doing
21 as an integrated delivery network improving the
22 care for the communities we serve?

23 So, all of our leaders across the
24 great nation of Trinity Health are working on
25 that, are working to reduce preventable

39 Agency for Healthcare Research and Quality

1 hospitalizations.
2 So, it's a utilization measure.
3 It's common to our ACOs. We get that data from
4 CMS. It has a flag for the duals. Right?
5 So, we sort of started with, well,
6 what's an easy way to measure? Are we making
7 an impact?
8 And we are seeing some good work
9 coming out of that focus, really just
10 amplifying that disparity and putting together
11 explicit care models.
12 So, we have a community health
13 worker workforce that we then said, okay, we're
14 going to dedicate the time and energy and focus
15 of those folks to those people who are dually
16 enrolled in Medicare and Medicaid within our
17 ACOs because we can find it. We can measure
18 it. We have a baseline. There are benchmarks
19 out there.
20 So, that's just one example of how
21 it -- an ACO and it's just like everyday work,
22 I would say, can take that and focus on
23 reducing something like disparities in care.
24 CO-CHAIR SINOPOLI: Perfect, thank
25 you.
26 So, I think we have questions up

1 next from Jim Walton and then Walter Lin after
2 that.
3 Jim?
4 DR. WALTON: Thank you.
5 I appreciate y'all spending some
6 time with us and sharing your thoughts.
7 As the conversation's gone on, one
8 of the things that kind of popped in my mind
9 has something to do with some market dynamics
10 that come out of Dallas, Texas, that I'll just
11 kind of briefly comment on.
12 Which is -- and it kind of is
13 supported by the literature that shows that
14 health system owned and operated ACOs maybe
15 don't save as much money or don't perform as
16 well financially as independent.
17 And there's been some thoughts that
18 maybe consolidation pressures and just has
19 created some anti-competitive behaviors in
20 large markets.
21 And so, one of the questions that
22 comes up for me when we think about advising
23 CMMI and CMS around integrating specialists is
24 how -- what would y'all think -- or what do
25 y'all think as SMEs[40] around what could CMS,

40 Subject matter experts

1 CMMI do to maintain a competitive marketplace
2 while simultaneously creating incentives that
3 move specialists along the continuum of taking
4 accountability, being accountable with our
5 primary care physicians?
6 Recognizing, though, that the
7 marketplace is continuing to consolidate and
8 that consolidation pressure has an almost
9 reverse anti-competitive behavior and which
10 drives prices up or holds prices up?
11 And so, I thought I'd just ask that
12 question about the design that you might
13 recommend?
14 I heard Emily say something around -
15 - from the -- Emily from Trinity saying
16 something about, well, just let us do it. Just
17 the -- just let Trinity decide how to do that.
18 But with enough market power, you
19 might could say, I'm going to do it this way
20 and it could actually be an anti-competitive
21 decision. Not that you have a governance
22 decision like that.
23 So, how do we sustain -- how do we
24 create a sustainable system that's patient-
25 centered that has the proper incentives but CMS
26 and CMMI understand what you want to make sure

1 that the system that they design for your ACOs
2 is pro-competition?
3 MS. BROWER: So, this is Emily, I'll
4 jump in.
5 So, I -- what I was trying to maybe
6 perhaps ineloquently describe before, I think
7 of as very pro-competitive because what we are
8 saying is, give us the -- we have lots of data
9 in our ACO, for those -- so, for those patients
10 who are attributed to our ACOs, we have good
11 data on the specialists in our network and on
12 the -- and some data on specialists outside of
13 our network.
14 But what we would really love and
15 sort of we put this in our -- as CMMI was going
16 out and asking for input from ACOs around what
17 data they need, we want to know, we as an ACO,
18 and I think I can speak for others, we want to
19 know who the high-value, right, high-quality,
20 low-cost specialists, people who are good
21 stewards of the dollar, the health care dollar,
22 who those are so we can bring them into our
23 network and work closely with them.
24 And then, for those in our network,
25 we want to be able to do that same -- have that
26 same insight so that, really, it's not so much

1 about consolidation as it is on having the care
2 go to the highest value, highest quality, best
3 steward of the dollar provider.
4 And we don't -- most of our
5 providers are not employed by us. We are not
6 necessarily looking to have to own that.
7 So, when I say -- I was thinking
8 more of ACOs than Trinity Health specifically.
9 But I do feel like it creates a
10 marketplace. So, there's -- with transparency.
11 I mean, we just -- in the utilization or cost
12 data, you're only getting a little piece of the
13 picture. Right?
14 And so, we're working with folks who
15 have these broader data sets to say, how do we
16 get a quality -- let's look at sequalae, what
17 are the downstream measures of an effective
18 episode of care that goes past those days so
19 that we can really have better insight into how
20 care is being delivered so we can make rational
21 decisions based on our commitment to quality
22 outcomes, cost, affordability, equitable care.
23 CO-CHAIR SINOPOLI: Thank you,
24 Emily.
25 And I want to remind the group, we
26 only have 10 minutes left. So, I don't know if

1 we'll get to Walter's question or not.
2 But any other participants want to
3 make any comments about that before we move on
4 to Walter's question?
5 DR. MAXSON: I can chime in briefly.
6 In one of our practices in Delaware,
7 they have 90 percent of their patient
8 population on value-based care contracts. And
9 so, 40 percent of their revenue comes from
10 value-based care, and 60 percent comes from
11 fee-for-service.
12 The reason that I mention this here
13 is that my first thought was, hmm, well, could
14 we go toward some sort of payment model through
15 CMS where we gradually promise to convert a
16 piece of specialist revenue towards value-based
17 care and total cost of care versus all fee-for-
18 service?
19 And then, I thought, well, the
20 backlash against that would be that many
21 specialists would just stop serving our elderly
22 patients and that would be catastrophic.
23 So, then, I was trying to think
24 about just price transparency and value
25 transparency and quality transparency. It's
26 really hard to compare and contrast relative

1 value amongst specialists today.
2 We're paying through the nose to do
3 it right now through an external party that
4 does nothing but this.
5 After we tried to do it in-house,
6 and it's just there's so much complexity, it's
7 really hard, for example, to tell the cost of a
8 procedure in one location or another by
9 provider because some providers practice in
10 facility fee area locations in part of their
11 week, and some of them practice in an
12 independent freestanding in part of their week.
13 And so, my point is that price
14 transparency is really hard, and value
15 transparency is harder. Because they would
16 also be incorrect to provide a unilateral
17 claims-based view on specialists because we
18 know that bedside manner isn't captured there.
19 We know that communication with
20 primary care isn't captured there.
21 So, I think that probably the most
22 practical way to start what wouldn't risk our
23 Medicare patients being out of specialty access
24 might be to start with global access to
25 transparent information for patients.
26 Because, remember, our Medicare

1 patients don't need a primary care referral to
2 see a specialist for the most part. Medicare
3 Advantage, many of them do.
4 But for our Medicare patients, writ
5 large, if they were armed with better
6 information and if that information included
7 quality, as well as price infrastructure, I
8 think that can be a helpful place to start.
9 CO-CHAIR SINOPOLI: Great.
10 Cheryl?
11 MS. LULIAS: Great question, Jim.
12 What I would add to those really
13 beautiful answers is, risk-adjusted and
14 reporting data, I think, is really important.
15 And then, timely insight, you know,
16 as we start to understand value, what's
17 important for ACOs who are at risk and while
18 we're in this transitional model, is really
19 timely insight, not, you know, even, you know,
20 daily. Right? Just understanding what's going
21 on, I think, is really important as you work to
22 build all the things that we just talked about.
23 But as an ACO and we're managing and
24 trying to engage with specialists, timely
25 insight would be a good thing to be able to
26 understand.

1 And then, any kind of reporting, I
2 think, you have to consider risk adjustment
3 because it's so complicated when you're doing
4 value equations.
5 CO-CHAIR SINOPOLI: Great.
6 Walter, you want to see if we can
7 get your question in real quickly? We've got
8 just a few minutes, a couple of minutes.
9 DR. LIN: I'll try and make it
10 quick.
11 I wanted to add my thanks for the
12 panelists for being here today. It's really
13 great hearing all these perspectives.
14 Also, hats off to the PCDT team for
15 convening this panel and the wide variety of
16 ACOs represented here from one that focuses
17 just on -- mainly on primary care and other --
18 both primary and specialists are welcome, and a
19 third on Medicaid.
20 This is a question actually, it's a
21 two-part question, hopefully, they're not long
22 answers necessarily though.
23 For Emily Brower, I wanted to
24 revisit this concept you mentioned of
25 attribution-eligible specialists.
26 I believe you said nephrology,

1 cardiology, and oncology were the ones that you
2 kind of focused on.
3 So, for the Trinity ACO, the first
4 part of the question is, are these attribution-
5 eligible specialists attributed to patients
6 solely or jointly with their primary care
7 provider?
8 MS. BROWER: So, yes, and
9 pulmonology is in there, too.
10 DR. LIN: Oh, pulmonology.
11 MS. BROWER: So, those are ones that
12 CMS and the ACO attribution methodology
13 includes. And where we see the most -- where
14 we see that sort of claims-based attribution
15 falling the most in those four.
16 So, the attribution is to the ACO,
17 and I don't know, you know, I'll try not to
18 take us down a rabbit hole there.
19 So, yes, I would say it is the
20 combination of the entity of the 10 they're
21 billing under and all of the providers that are
22 included in that 10.
23 So, really, the attribution is to
24 the ACO, it's not from CMS.
25 What we then do is say, when we see
26 that attribution that includes both primary

1 care and one of those sub-specialists, right,
2 we sort of internally assign or attribute those
3 patients to primary care.
4 When, as their primary care
5 provider, when there is no primary care, then
6 those sub-specialists or those IM[41] sub-
7 specialists become the primary attributed
8 provider.
9 So, a little bit of sort of just
10 technical, we get the data, CMS doesn't really
11 attribute to an individual provider, we do.
12 And we sort of take that data and parse it out
13 and assign it.
14 And for patients who do not have a
15 primary care provider, one of the first things
16 we do when we get that list of new patients is
17 find out from that specialist, does that
18 patient need a primary care provider? Like
19 maybe they're happy, and they're just not in
20 our network. That's okay.
21 But if they need that coordination,
22 let's get them connected and start effectively
23 co-managing or coordinating that care together.
24 Does that help?
25 DR. LIN: Yes, that helps.

41 Internal medicine

1 And I guess the follow-up question
2 to that is, it sounds like then from what you
3 just said that these attribution-eligible
4 specialists probably participate in shared
5 savings in the same way that a primary care
6 provider might, if they had kind of sole
7 attribution for that patient.
8 What if they had joint attribution
9 with a primary care provider? How are they
10 paid?
11 MS. BROWER: So, they are just
12 receiving fee-for-service.
13 And then the benefits that I spoke
14 to earlier of being in the network, I will say
15 we went down the road of, do we attribute the
16 shared savings to them? Do we give them a
17 PMPM? Is there a share?
18 And when we talked to the
19 specialists, because they are us, they said,
20 no, that's not really meaningful. It's not
21 going to change anything that I do. Let's just
22 work on how we work together, remove barriers,
23 address pain points. Let's just actually try
24 and be a network of providers and really a
25 medical home for that patient. And don't send
26 me checks.

1 So, I know that there are people out
2 there who probably hear differently, but I will
3 tell you that was like a lot of where we
4 started and then sort of backed from because
5 that's not what we heard was meaningful to the
6 specialists.
7 CO-CHAIR SINOPOLI: Thank you for
8 that answer.
9 And I want to thank the panelists
10 tremendously for their time today. Clearly
11 lots of experience and expertise on this panel,
12 and you've given us a lot to think about and
13 take back to chew on.
14 So, you're welcome to stay and
15 listen to as much of the rest of the meeting
16 today as you would like. We'd love to have you
17 continue to listen.
18 We're going to take a short 10-
19 minute break now, and then we'll come back for
20 the next session.
21 Thank you all.
22 (Whereupon, the above-entitled
23 matter went off the record at 2:29 p.m. and
24 resumed at 2:41 p.m.)
25 *** Listening Session 1: Implementing**
26 **Nesting in Population-Based Total**

1 **Cost of Care (PB-TCOC) Models**

2 CO-CHAIR HARDIN: Welcome back. I'm
3 excited to start our afternoon listening
4 session. At this time I ask our
5 presenters to go ahead and turn on your video,
6 if you haven't already.

7 We have four invited outside experts
8 to speak with us about nesting within
9 population-based models. You can find their
10 bios posted on the ASPE PTAC website along with
11 their slides.

12 After all four have presented, our
13 Committee members will have plenty of time to
14 ask questions.

15 Presenting first we're honored to
16 have Dr. Mark McClellan, who is the Robert J.
17 Margolis Professor of Business, Medicine, and
18 Policy and Founding Director of the Duke-
19 Margolis Center for Health Policy at Duke
20 University.

21 Welcome and please begin, Mark.

22 DR. McCLELLAN: Great. Thank you
23 all very much. It's great to be back with PTAC
24 and ASPE and see some familiar faces virtually
25 and in the room, and great to be on with such a
26 distinguished set of panelists.

1 If you go to the next slide, this is
2 a topic that we at Margolis, like the rest of
3 you, regard as both very important and also
4 very timely given some recent policy
5 developments at CMS and a high priority of
6 addressing specialized care in the context of
7 whole-person care throughout our health care
8 system. It's a topic that we've been working
9 on for a while at Duke-Margolis, including in
10 collaboration with other panelists here like
11 Francois and Kevin Bozic who are participating
12 in this meeting. I would encourage people to
13 take a look at some of these documents if they
14 want to hear more detail about what I'm
15 covering today.
16 But with that, let me go to the next
17 slide, which is the way we're thinking about
18 the role of specialty care. And we are pleased
19 that CMS adopted kind of a similar patient
20 journey framework for their announcements this
21 past fall going forward on their specialty care
22 strategy in Medicare.
23 Throughout the whole patient
24 journey, especially as you get to the more
25 right side of this slide, but increasingly to
26 the left where specialized diagnostic

1 techniques and early disease interception and
2 interventions are available, and cooperation,
3 especially perspectives and specialty
4 expertise, is increasingly important in
5 creating a whole-person care journey that is
6 effective.

7 To date we've seen some payment
8 reform to support efficient high-quality
9 patient journey mainly focusing on acute
10 episodes, where it says most payments or most
11 Alternative Payment Models that have been
12 implemented to date, bundled payments triggered
13 on things like a DRG[42] admission for a limited
14 time period after a major procedure or
15 hospitalization or a major event occurs.

16 What we're focusing on here is
17 expanding that framework. And on the next
18 slide, we think of this being very important
19 because there are a variety of really critical
20 types of specialized care. Much specialized
21 care is delivered by experts in intensive
22 procedures, in particular episode-contained
23 environments. Hospitalists, general and
24 specialized surgeons, there, further steps to
25 help them implement comprehensive data and

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42 Diagnosis Related Group

1 safety systems like have been proposed by
2 American Cancer Society and others are really
3 important.
4 There are other specialists,
5 including in such areas as nephrology where the
6 specialist really is the basis of a
7 comprehensive medical home for a patient,
8 whole-person care. And there are payment
9 models to address that in development and being
10 expanded as well.
11 What I want to focus on is this
12 third category, going onto the next slide, of
13 longitudinal coordinated care. Important as
14 those other categories are, most of specialty
15 care by dollars and by impact on populations
16 involves interactions between specialty care
17 and other providers, particularly primary care
18 groups and advanced primary care groups, in
19 delivering care for chronic conditions such as
20 cardiovascular disease, musculoskeletal
21 conditions, diabetes, metabolic conditions,
22 dementia, lung diseases, inflammatory bowel
23 disease, serious mental illnesses. The list
24 goes on.
25 Here we don't yet have the
26 implementation of policies and payments that

1 support integrated longitudinal condition
2 management, including engagement with primary
3 care providers that are participating in an
4 increasingly advanced accountable care and
5 other arrangements.
6 And so onto the next slide, in terms
7 of starting these efforts we would advocate
8 starting with where you can get the most bang
9 for the buck. So all conditions are important
10 in terms of magnitude. There's the most
11 experience, the most data in areas like
12 cardiovascular and musculoskeletal care,
13 respiratory care. Already some models engaging
14 specialists in longitudinal cancer care
15 management, though I'd emphasize there the
16 episode models typically start with initial
17 major treatment for a diagnosed condition.
18 They don't really address the
19 diagnostic process, which involves primary-
20 specialty interactions or the care for the
21 increasingly large number, fortunately, of
22 cancer survivors who need ongoing effective
23 management, hopefully as conveniently and
24 efficiently as possible for monitoring for
25 occurrence and potential long-term
26 complications of treatment.

1 So we would advocate, as the next
2 slide shows, finding ways to support taking the
3 limited resources that are in the blue category
4 of these payments by specialty and finding ways
5 to help them expand out. The blue category
6 here is payments for base condition management
7 as opposed to payments -- as you can see the
8 biggest part of these pies are going to major
9 procedures, minor procedures, acute events.
10 The episode payments we have now that are about
11 acute events and procedures do drive more
12 efficiency and hopefully more coordination
13 within and right around those episodes.
14 What we're talking about here is
15 enabling specialists to participate and sustain
16 models that shift more resources into avoiding
17 the hospitalizations and the need for perhaps
18 major procedures in the first place, a focus on
19 the best longitudinal outcomes for the patient.
20 And those best outcomes often involve or could
21 involve avoiding hospital stays and major
22 procedures.
23 So next slide? The idea we have for
24 this is a notion called specialty condition
25 models. We're not the only people to have
26 thought of something like this, but we see this

1 fitting into very well the CMS specialty
2 strategy that's been articulated so far. CMS
3 has laid out potentially a path to
4 transitioning to mandatory acute episode
5 bundles based on BPCIA, but mainly being
6 hospitalization plus 30 days, which again
7 supports optimization of care within the
8 episode and complements the goal of getting all
9 Medicare beneficiaries, and for that matter
10 just about all Medicaid and other Americans,
11 into longitudinal coordinated care models.
12 CMS recognizes the need to engage
13 and support specialists in longitudinal chronic
14 care models as well and has put that on their
15 long-term set of goals for specialty care
16 reforms. And we see the specialty condition
17 models and approach to jump-start that and
18 maybe move up and clarify the implementation of
19 that long-term goal.
20 This would be a complement, really a
21 nesting around the acute bundles for conditions
22 that really are about chronic management, not
23 just about management of the acute conditions
24 effectively, and would be intended to provide
25 support and sustainability for coordination of
26 care and alternative care models that really

1 are focused on maximizing longitudinal patient
2 outcomes.
3 The next slide illustrates how this
4 might work. We have acute condition bundles
5 now. We have whole-person accountability
6 bundles as well. You think ACO models, ACO
7 REACH, et cetera, that have total cost of care
8 benchmarks.
9 Some of the challenges with doing
10 condition-based benchmarks in the past have
11 been that they weren't done in conjunction with
12 accountability for total cost of care. That's
13 why we view these models as appropriate for
14 nesting, nesting in a way that might become --
15 might be voluntary for physician-led ACOs where
16 they -- we could provide potentially templates
17 and data to help guide their decisions and
18 support for working with specialists on
19 enabling longitudinal care coordination within
20 their overall models, but potentially mandatory
21 for hospital-based ACOs where the revenues are
22 all flowing to them for patients anyway, both
23 for the primary care and the specialty care,
24 for their hospital-based ACO patients.
25 But they right now don't have the
26 flexibility to enable specialists to, if they

1 can, engage more longitudinally. The only
2 revenues they get, unless they transition fully
3 over to a capitated risk-adjusted model, are
4 primarily tied to more procedures, these DRG-
5 based acute episodes, which doesn't enable so
6 much financial support for the longitudinal
7 models.
8 Another way of looking at this in
9 the next slide is showing also how the
10 specialty payments can be -- specialty
11 condition payments can nest the acute event
12 models and can in turn fit within on a
13 voluntary basis or a mandatory basis the total
14 cost of care models for physician-led ACOs, and
15 hospital-led ACOs particularly.
16 And onto the next slide. Some
17 promising areas where a lot of work has already
18 been done on this topic include musculoskeletal
19 conditions. I think you're going to hear or
20 have heard from Kevin Bozic and colleagues
21 about degenerative joint disease models in this
22 space. Longitudinal cardiology care. I had
23 the privilege of working with the American
24 Heart Association, American College of
25 Cardiology on some of these concepts. CMS is
26 working on a dementia model now which also is

1 promising from this standpoint. And PTAC has
2 looked at a number of these models in the past,
3 just not yet in the context of the CMS Medicare
4 strategic goal of getting all Medicare
5 beneficiaries into accountable total cost of
6 care models and finding ways to implement these
7 specialized care reforms within that overall
8 context.
9 So I have a couple of slides that
10 I'm not going to spend much time on now in the
11 interest of time that go through in more detail
12 how these models would work.
13 So an implementation pathway for
14 condition payments that I would encourage CMS -
15 - we would encourage CMS to start using and
16 developing shadow bundles for these leading
17 conditions as part of their effort to implement
18 shadow bundles related to BPCI-A measures this
19 year. That would be making data available to
20 ACOs maybe more publicly for not just BPCI-A
21 participants, but all specialized care
22 providers to get a handle on what's going on
23 with care, utilization, outcome-type measures
24 at the level of BPCI-A for all providers to
25 help jump-start progress in adopting those
26 models more widely. We really would like to

1 see that include specialized conditions as
2 well.
3 I've talked about nested -- nesting
4 measures. The development of these condition
5 measures really facilitates the longitudinal
6 patient-reported outcome measures that matter,
7 like functional status for the conditions that
8 I've been describing, or independence.
9 Next slide. I've talked about
10 transitions for several different types of
11 beneficiaries, ways in which these models could
12 work with physician-led ACOs on a voluntary
13 basis and hospital-based ACOs for beneficiaries
14 and advanced ACOs. They've already moved away
15 from fee-for-service, so this is less critical.
16 And then finally, in terms of the
17 next slide, short-term steps. Implementing
18 shadow bundles with reporting and data sharing
19 to help facilitate the movement into specialist
20 engagement in these longitudinal management of
21 chronic condition opportunities, data sharing
22 to support that, and align fee-for-service
23 changes.
24 Thank you all very much for the
25 opportunity to join you.
26 CO-CHAIR HARDIN: Thank you so much,

1 Mark. That was really interesting.
2 We're saving all questions from the
3 Committee until the end, so please capture your
4 thoughts and be ready after the end of these
5 presentations to bring them forward.
6 Next, we'll hear a presentation from
7 Mr. Francois de Brantes, who is a senior
8 partner at High Value Care Incentives Advisory
9 Group.
10 Please go ahead, Francois.
11 MR. DE BRANTES: Great. Thank you.
12 And it's a pleasure to be here and reacquaint
13 with old colleagues.
14 It's appropriate that I follow Mark
15 because I always think of myself a little bit
16 as Mark's understudy. And so I'm going to try
17 to unpack a few of the points that he made.
18 But if you just pull back and reflect on his
19 comments, ultimately what we're all talking
20 about is what ACOs, whether they're PCP- or
21 hospital-led, should actually be doing in
22 engaging the entirety of a delivery system to
23 become far more effective than simply focusing
24 on what they do at a micro level and then
25 referring out and hoping for the best.
26 So if we flip to the next slide,

1 ultimately in a payment model what matters to
2 anyone involved in that payment model are these
3 two issues of relevance and actionabilities.
4 So it has to be relevant to me. Obviously,
5 Larry doesn't do cardiology because he's a
6 gastroenterologist, but he does everything
7 associated to gastroenterology. So if you give
8 him a basket of conditions, procedures, et
9 cetera, that need to be managed in
10 gastroenterology, he's going to know how to do
11 that, and his colleague cardiologists are going
12 to know how to do that. And that's obviously
13 the principle that we're espousing, which is
14 leverage the expertise of the specialty care
15 providers in optimizing care of beneficiaries.
16 But of course it also means what you
17 do. And when you get engaged in an Alternative
18 Payment Model, it's got to be meaningful. And
19 by meaningful I mean it needs to cover enough
20 of the costs of care of the patients that I'm
21 seeing, that I truly am going to invest in the
22 critical clinical reengineering.
23 So if you flip to the next slide,
24 I've taken a piece of what Mark showed and
25 focused here on unpacking a little bit what
26 Mark presented as being the entirety or what we

1 could calculate as being the vast, vast
2 majority of cardiology care that Medicare
3 beneficiaries receive. And this analysis was
4 done using a very highly representative sample
5 of Medicare fee-for-service beneficiaries.
6 And when you look at that
7 combination of procedural episodes, acute
8 events, normal routine medical management, et
9 cetera, base condition management -- so think
10 of base condition management of heart failure,
11 coronary artery disease, hypertension, et
12 cetera -- it only represents a third of the
13 total cardiac costs of Medicare beneficiaries.
14 The other two thirds are going into minor
15 procedures, major procedures, and acute events.
16 And the whole notion of specialty
17 care management, just like the whole notion of
18 primary care management, is to reduce the
19 amount of unnecessary minor procedures,
20 unnecessary major procedures, and of course
21 reduce the incidence of acute events. But if
22 you focus the specialty care only on minor
23 procedures or only on major procedures or only
24 on acute events, it essentially misses the
25 boat.
26 And longitudinal patient management,

1 these specialty condition models that Mark
2 talked about, is taking that base condition
3 management, but the -- and the entirety of the
4 medical spend and telling the specialty care
5 providers, this is the nut that you have to
6 manage, and the goal is to reduce the things
7 that could be reduced because maybe it's low-
8 value care, or it's indicative of failures of
9 care coordination.
10 And so that's why we talk about nesting
11 procedures, acute events underneath population-
12 based management. And if you flip to the next
13 slide, this chart is just designed to
14 illustrate how this works in a sample of 5,000
15 beneficiaries within which there are 2,000 who
16 happen to have a variety of cardiac conditions.
17 And then of those, 375 end up by having
18 procedural episodes during the course of a
19 year. And the numbers inside each one of these
20 little rectangles represents what could be for
21 each one of these areas a specific benchmark
22 and an actual.
23 And so what I'm teeing up is the
24 next slide, which talks about reconciliations
25 and how these pieces fit together, but
26 intuitively you kind of understand that if you

1 have a primary care physician who's managing
2 5,000 beneficiaries, some of them are going to
3 have specialty conditions -- conditions that
4 can and should be managed by the specialty care
5 providers. Why not have a risk contract for
6 those specialty care providers? Why not fully
7 engage them in the management of those
8 patients?
9 And within that specialty bundle,
10 this specialty care model, we know that there
11 are going to be procedural episodes, and so why
12 not create benchmarks for those procedural
13 episodes so that everyone along the chain --
14 the proceduralists, the specialty care
15 providers managing the conditions, and whatever
16 the ACO is that's managing total cost of care -
17 - are all accountable for optimizing outcomes
18 of beneficiaries. And essentially everyone is
19 in the same boat rowing in the same direction,
20 which is different than being in the same boat
21 but rowing in different directions.
22 So the way in which -- and this is -
23 - I keep reminding people when they -- when I
24 talk about nesting condition episodes,
25 especially when people go oh, my God, it's so
26 complicated -- no, it's relatively simple math.

1 It's pluses and minuses. It's arithmetic.
2 So if you go to the next slide I'll
3 just give you a representative example of this
4 arithmetic. You start typically at the base
5 with the lowest unit of accountability, which
6 in this case ends up being procedures. And
7 much like you would in a procedural bundle, you
8 got a benchmark, you got an actual, you
9 reconcile, and that reconciliation yields
10 either a plus or a minus. And in this case
11 there are savings, and so the savings accrue to
12 the proceduralists.
13 Those who are managing the condition
14 category, the specialty care models, that's the
15 middle bucket. And in this instance, they also
16 have a benchmark. By the way, their benchmark
17 includes an expected incidence of procedure
18 episodes, so it's in their best interest to
19 reduce the amount of procedures to the extent
20 that it's medically appropriate because that's
21 how they're going to generate savings in
22 addition to reducing the amount of acute
23 events.
24 So once you reconcile the
25 procedures, you reconcile at the condition
26 level. Once you reconcile at the condition

1 level, you reconcile at the total cost of care
2 level. And I hear and I continue to hear the
3 refrain from those who manage ACOs and
4 hospital-based ACOs or even PCP-based ACOs that
5 there's just not enough money to share, and all
6 we need to do is kind of refer patients out.
7 And I think what this chart shows is
8 that there's plenty of money to go around. I
9 think we all know this. But if we really want
10 everyone in the same boat rowing in the same
11 direction, you need to create these sub-
12 contracts, these sub-risk contracts that really
13 create this alignment of incentives across the
14 delivery system.
15 So the net effect of all of this, in
16 the next slide, is that proceduralists are
17 encouraged to optimize procedures.
18 If we flip to the next slide, those
19 managing the conditions are encouraged to do a
20 good job, reduce acute events, minimize the
21 number of inappropriate low-value procedures.
22 And then those who manage total cost of care
23 have a huge incentive to find the most
24 effective, efficient specialty care providers.
25 And this goes back to what Mark said, which is
26 of course there's a concern I think from all of

1 us that if you have a hospital-based ACO that
2 has its own specialist, they may actually not
3 be the best. They may think they're the best,
4 but they may not actually think they're the
5 best.
6 And so as CMS and you all continue
7 to deliberate on the importance of specialty
8 care models, if this works well, then everyone
9 is encouraged to optimize. And sometimes the
10 best are not necessarily within the system;
11 they're outside the system. And that shouldn't
12 matter, right? And so that's how when you set
13 the benchmarks, when you set the incentives,
14 you also encourage robust competition for value
15 among specialty care providers.
16 And I'll end on this telling you
17 that I have witnessed this personally. I've
18 been involved in deploying this model for the
19 State Employee Plan of Connecticut, and it
20 works incredibly well. And the primary care
21 physicians work with the specialty care
22 physicians. Those who manage the conditions
23 work with the proceduralists. It absolutely
24 works, and it's just a shame that it hasn't
25 come to Medicare yet.
26 That's it.

1 CO-CHAIR HARDIN: I was taking it
2 all in, Francois. That was really interesting.
3 Thank you so much.
4 Next, we have Dr. Rozalina McCoy,
5 who is Associate Professor of Medicine at the
6 Mayo Clinic in Rochester, Minnesota.
7 Welcome and please go ahead,
8 Rozalina.
9 DR. McCOY: Thank you so much and
10 thank you for the opportunity to talk about
11 patient attribution, which I think is really at
12 the core of all the models that we're talking
13 about, but also one that is least defined and
14 where I think we have the most uncertainty at
15 this point. So it's truly an honor to be here
16 today.
17 So while seemingly simple on the
18 surface, I think attribution, particularly for
19 patients with multiple or serious chronic
20 health conditions, the management of which
21 really requires multiple touch points with
22 health care providers and the health care
23 system, is really not.
24 So as we think about who is or are
25 the accountable unit for a given patient, we
26 can think just who's likely to be involved in

1 the care of one of my patients with diabetes?
2 And I think diabetes is a great case because it
3 really illustrates the complexity of
4 attribution. It's truly a whole-person disease
5 with complex multifaceted treatment regimens
6 and complications that affect every single
7 organ system requiring the engagement of
8 multiple specialists.
9 So for a person with diabetes, they
10 may be seeing a primary care clinician, maybe a
11 physician who may then be supported by an
12 advanced practice provider like a nurse
13 practitioner or a physician assistant. They
14 may see an endocrinologist. They'll then need
15 to get assistance from a pharmacist, both
16 acutely to start a medication and then
17 longitudinally to help with dose adjustment and
18 fix their other medications as their kidney
19 disease status changes.
20 They may need assistance at home
21 working with community care medics or community
22 health workers who may or may not be part of
23 the same organization. They'll be seeing
24 dieticians, nurse educators, a psychologist.
25 They'll be touching base with their care team
26 nurse, trying to coordinate it all. So you

1 really have this army of people working to
2 support the patient, but how do you know who is
3 doing what and who is ultimately responsible
4 for the multitude of outcomes that happen with
5 diabetes?
6 So if we go to the next slide, I
7 think that really highlights, I think, the
8 challenges to patient attribution.
9 Historically we thought about major challenges
10 being the fact that many patients don't have a
11 designated primary care clinician, even if we
12 ask them. But patients are also obtaining care
13 from multiple physicians and multiple advanced
14 practice providers across multiple networks who
15 use multiple different electronic health
16 records.
17 There is variation in the quality
18 and access to data sources that define
19 patients' interactions with all these aspects
20 of the health care system. So if we try to
21 measure health outcomes rather than process or
22 structure measures which are much more easily
23 linked to a specific clinician or group or
24 organization, that becomes more challenging.
25 So as a result, there really is no
26 gold standard for attribution. There have been

1 multiple attribution models developed, and they
2 all produce very different measurement results,
3 which is why it's kind of helpful to think
4 through the process of how attribution models
5 are built and what they mean.
6 So currently there are over 170
7 different attribution models either in use or
8 proposed. And if you look at the next slide, it
9 kind of demonstrates the wide heterogeneity of
10 these attribution models. And this is from
11 2016, so there's been even more models
12 developed since then. But first are the type
13 of clinician that is attributed for the
14 different models. Most go to any kind of
15 attributable physician, which again isn't many,
16 but it's either primary care or a certain
17 number of specialties, which varies. Others
18 attribute to a facility, primary care
19 physician, or they prefer primary care
20 physician, but they do somebody else. They can
21 attribute to a group, to a specialist, or it's
22 actually just not clear.
23 And then the other aspect is how
24 many people -- patients can be attributed to.
25 And the vast majority, 80 percent, of
26 attribution models really attribute to a single

1 entity or provider.

2 So if we go to the next slide, I
3 think that really highlights the challenges to
4 identifying attribution in total cost of care
5 models because we really need to move beyond
6 the dyadic patient primary care physician
7 attribution.

8 So first, even though it's obviously
9 easier to attribute a patient to one entity,
10 Medicare patients see a median of two primary
11 care physicians and five specialists associated
12 with four different provider organizations in a
13 given year. So there's a lot of fragmentation
14 and a lot of people being involved. So you
15 have to recognize not only primary care, but
16 different specialists.

17 Then we know that especially for
18 chronic diseases, team-based care is associated
19 with significantly improved health outcomes.
20 So how do we account for advanced practice
21 providers who are delivering care both in
22 primary care and in specialty care,
23 collaborative practice agreements with
24 pharmacists who manage an increasing share of
25 the patient -- of the chronic diseases as part
26 of a multidisciplinary care team? The same

1 thing for other clinical support staff. And
2 then clinician extenders who are almost never
3 visible in claims data that are used for
4 attribution like community paramedics and
5 nurses, social workers, mental health
6 specialists, community health workers, and
7 coaches.
8 And then finally there's non-visit
9 care. So a lot happens in primary care, as
10 well as in specialty care that never sees the
11 light of a bill, even though that is going to
12 be -- likely going to be changing. But e-
13 visits, portal messages, care coordination, and
14 case management -- all of those are resource-
15 intensive touch points that improve patient
16 health outcomes, and yet the responsibility for
17 those is very hard to assign because even if a
18 primary care physician is overseeing all of it,
19 that will not be visible in any of the data
20 sources that we are using to attribute
21 patients.
22 So next slide? Now so attribution
23 models ideally would identify accountable
24 entities that are able to meaningfully affect
25 the measured outcomes either directly or
26 indirectly through collaboration with partners

1 whom they can reliably influence.
2 So when we think about specialist
3 integration into primary care specifically,
4 there's many ways that they can be integrated
5 with different degrees of visibility in claims.
6 You can have a stand-alone specialist separate
7 from primary care. They could be within the
8 same integrated health care system, which could
9 be either closed -- like a truly integrated
10 health care delivery system which manages all
11 of the patient like an ACO.
12 It can be an open system where
13 patients can come and go and can see people
14 across multiple systems. It can be a regional
15 referral practice where people can coalesce to
16 see those specialists or a destination referral
17 practice where people come from all over the
18 country or the world. Again, they're still
19 responsible, but with very different
20 utilization patterns.
21 Now when a specialist is co-located
22 in -- together with primary care -- that's
23 actually my role as an endocrinologist inside
24 of a primary care practice, there's different
25 ways that we can be co-located as well. We can
26 do consultative practice where we see patients

1 occasionally like a regular specialist would;
2 we're just located together, but we can also be
3 overseeing and consulting on the patient's care
4 electronically without ever seeing the patient.
5 We can be co-managing with primary care
6 providers, with seeing patients or not.
7 So again, in this case specialists
8 are involved and responsible for patient health
9 outcomes, but the way that it's presented in
10 the data is very different. And not only does
11 this change depending on the health care system
12 that we're dealing with, it also changes across
13 a patient's disease journey. As their disease
14 becomes more or less complex or they experience
15 exacerbations of their illness, different
16 models of specialist utilization can be
17 apparent.
18 So next slide? And as an added
19 layer of complexity, we have to consider the
20 role of physicians and advanced practice
21 providers. APPs can have -- can practice
22 completely independently having their own
23 panels, both in primary care and specialty
24 care. Or they can be supporting the physician
25 where the physician conducts the first visit
26 and then supervises the APP. The physician and

1 the APP are jointly responsible for the
2 patient, but we only see evidence of one in
3 claims. Or the physician conducts all visits
4 and that's what we see in claims, but the APP
5 supports all non-visit care, education, and
6 coordination efforts. So they're still there
7 and that entity may provide a lot of care. We
8 just don't see it all.
9 So next slide? Like I mentioned
10 before, the level of specialist engagement and
11 how it's evidenced in claims and EHR data is
12 not static. So if you think about any chronic
13 health condition, it goes through phases.
14 Early on management of a chronic disease may
15 fall into -- entirely into primary care. As it
16 becomes more complex, a specialist may engage
17 in a consultative model, seeing the patient
18 occasionally. Then it becomes advanced and
19 dominant, and a specialist manages most of
20 their disease, but other specialists are likely
21 going to be involved too.
22 Even a disease like end-stage kidney
23 disease where we think about nephrologists
24 owning and being the primary care clinician for
25 that patient, patients still have other health
26 needs that a nephrologist may not be equipped

1 to handle, such as complex diabetes. And
2 within this there are variable levels of
3 communication, coordination, and integration
4 with primary care and other specialties. And
5 then the other end of the journey as the
6 patient enters palliative care and potentially
7 hospice, we kind of go back again to a sole
8 overseeing clinician. So it changes through
9 the patient's journey.
10 So next slide? Now because of this
11 complexity, we may need to have different
12 attribution models for different needs. One
13 may be to determine which patient is included
14 in a program such as an ACO, another for a
15 quality measure such as diabetes, heart
16 failure, COPD, or surgical outcomes. So
17 ultimately the accountable unit needs to be
18 responsible for the care that it has actionable
19 control over, but at the same time, we need to
20 be mindful of administrative burden in ways
21 that can be incurred by implementing these
22 different attribution models. So it becomes a
23 bit of a catch-22 and a double-edged sword
24 where we have to balance practicality with
25 accuracy and fairness.
26 So next slide? So hopefully I kind

1 of didn't instill too much fear and anxiety
2 about attribution, but as we think through all
3 of these complexities, we all start thinking
4 well, how do we even identify these patients,
5 these accountable units? So we could ask the
6 patient. I think ultimately that's a great way
7 to do it, but often it's not possible, and our
8 patients often don't know who are all the
9 people who are responsible for their care.
10 So the most common way is to use
11 claims data. And we can either do
12 retrospective or prospective attribution,
13 right? So with retrospective attribution,
14 patients are identified at the end of the
15 measurement year based on who was seen during
16 that measurement year. So it allows assignment
17 based on how care was actually delivered. But
18 at the same time, health systems and clinicians
19 don't know who they are responsible for until
20 they have actually cared for them.
21 With prospective attribution,
22 patients are attributed at the beginning of the
23 measurement year based on who was seen the year
24 before. So that removes the uncertainty but
25 creates concerns about gaming the system,
26 providing differential levels of care based on

1 attribution status. Patients may seek care
2 from units who are different from the ones that
3 they're attributed to. So that could lead to
4 inadequate representation of the care provided.
5 So most attribution models use now
6 retrospective attribution models, but there is
7 increasing interest and update for prospective
8 attribution. And I guess important because
9 about two-thirds of patients who are attributed
10 to one unit in one year stay for the next. So
11 these methods aren’t perfect.
12 We then think about well, we're
13 going to be measuring utilization, use, or
14 contact somehow, but over that time period? So
15 usually we do either one or two years, again
16 depending on your disease and how frequent you
17 expect the touch point to be. Then what are
18 going to be your unit of comparisons? Are you
19 going to be looking at touch points or claims
20 or visits, or is it going to be cost and
21 spending? And those can create very different
22 results.
23 What kinds of eligible claims? In
24 primary care, we often use well visit or
25 routine visits, but that doesn't work for
26 specialty care. What about non-evaluation and

1 management codes? How will they be considered?
2 And like we talked about, who are the eligible
3 clinicians? How many can be considered for
4 exclusivity? Is there a minimum threshold for
5 someone to even be considered to be counted?
6 And how do we assign? Do we use plurality of
7 visits or costs, or do we use a majority? And
8 all the existing attribution methods basically
9 take a different permutation of a way of
10 identifying different accountable units.
11 So next slide? So can I go to the
12 next slide? Almost done. Okay.
13 So once we identify those groups, we
14 assign either single or shared
15 responsibilities. So for our purposes here,
16 we'll look under the shared responsibility to
17 multiple clinicians or systems. And we can use
18 -- so using attribution rules for either one
19 touch or requiring multiple visits, we assign
20 responsibility to a primary care clinician and
21 disease concordant specialists for all of the
22 patient's diseases based on eligible claims.
23 And then you'll also, using the same
24 attribution methods, assign patients to a
25 system or to a team depending on which measure
26 you're talking about.

1 So next slide? One idea that has
2 been proposed and used really in other
3 industries but not in health care that I think
4 could be an interesting solution is these
5 weighted multi-attribution models where
6 patients are attributed to all clinicians
7 involved in their care based on predetermined
8 weights, as long as we have a single kind of
9 gold standard and a fair model that everybody
10 agrees on to figure out those weights. But
11 those are currently used a lot for MBA[43] or
12 internet marketing and ads to figure out who's
13 responsible. And we can use something like
14 that in health care, but again recognizing the
15 need for standardization.
16 So next slide? So to kind of
17 conclude with some final thoughts on
18 attribution that you see here. And I think
19 there's a lot -- even though -- so attribution
20 I think is very important for all of these
21 models, but there's a lot of uncertainty about
22 how to do it with advantages and disadvantages
23 with every decision point along the way. And
24 it's important for whatever attribution models
25 are developed for them to first be tested,

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1 verified, and reviewed across very different
2 types of delivery systems and care models to
3 make sure that they yield the outcomes that we
4 want them to yield, that are fair and equitable
5 and don't disadvantage any type of organization
6 or patient population.
7 And ultimately I think it -- as we
8 think of total cost of care models prioritizing
9 measures that are ascertained at the care team
10 or health system level rather than individual
11 clinician level -- because that really will
12 recognize and acknowledge team-based care, as
13 well as the complexity of managing patients
14 with multiple chronic conditions.
15 So thank you.
16 CO-CHAIR HARDIN: Thank you so much,
17 Rozalina. It was very thought-provoking.
18 Next we're going to go Ms. Lili
19 Brillstein, who is the Executive Officer at
20 BCollaborative.
21 Go ahead, Lili.
22 MS. BRILLSTEIN: Thank you so much.
23 I thank you for having me today. I'm delighted
24 to be here and participate in this discussion.
25 I've spent the last 10 years really hanging
26 around with specialists, building episodes of

1 care and other models, so I will share with you
2 today some of my experiences around how to
3 engage specialists in these models.
4 And just sort of to start out, the
5 goals really I think about from ACA[44] was to
6 create accountability related to quality,
7 patient experience, and cost of care. And I
8 think what we have today across the country are
9 very well-established mostly primary care-
10 attributed ACOs. There are a very small
11 percentage of specialists that are engaged in
12 specialty care models alone and certainly with
13 the ACOs as well.
14 As we kind of built these models,
15 they were built kind of independently, right?
16 So we built PCMH[45] models for primary care. We
17 built ACOs ostensibly for integrated delivery
18 of care, although I think they really focus
19 still today on primary care. And we built
20 episodes of care or bundled payments for
21 specialty care.
22 So we kind of moved from the fee-
23 for-service unit silos to kind of more
24 collaborative models, but still silos, right?

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1 So we have primary care, and we have specialty
2 care living really side by side.
3 So from my view, I see that we're on
4 a glide path to getting to those goals of
5 creating really comprehensive, collaborative,
6 fully-accountable care, and we now really need
7 to talk about -- and very grateful to be here
8 to do that -- about how do we do that
9 integration, and how do we actually engage
10 specialists in these models?
11 Next slide, please? So the number
12 one thing that I really think about a lot is
13 the perception of the docs, is the reality that
14 we absolutely have to address. And the reality
15 is specialists are afraid, and they're
16 concerned. They don't trust payers, whether
17 it's CMS or commercial payers. They're afraid
18 they're going to lose their ability to make
19 clinical decisions for their patients, and
20 they're afraid to take on risk because they've
21 never yet seen the longitudinal view of the
22 patient.
23 They don't necessarily know what's
24 happening to the patient or what somebody else
25 may be doing for that patient that may have an
26 impact on what they do. They're afraid they're

1 going to lose money. Unlike primary care docs,
2 there's typically not anything up front for
3 specialists, and they almost immediately begin
4 to lose money when they come into these models.
5 They're afraid they're going to lose control of
6 their practices. They're going to be told to
7 practice cookbook medicine, and they're afraid
8 that there are going to be increased
9 administrative burdens and time required if
10 they come into these models.
11 Next slide, please? So if
12 perception is the reality we have to address,
13 we have to actually be thoughtful about the
14 language we use as well because the language we
15 use drives many of those perceptions. And I
16 just put a few things down here like presenting
17 to a specialist that we've built a model for
18 you is not really something doctors ever --
19 anybody really wants to hear, right? They want
20 to -- it reduces their trust. It implies some
21 level of control and sort of creates more
22 discord.
23 Anything that is deemed mandatory
24 implies a power imbalance which I think is
25 really counterintuitive to what these models
26 and the work that we're all doing is about.

1 Bundled payments. I do work in
2 specialty care and in episodes of care, and
3 this happens to be a phrase I don't like. I
4 don't use it. I think when docs hear bundled
5 payments, the only thing they hear is money.
6 And it kind of reinforces their perception that
7 payers are only concerned about the money and
8 not really about the quality of the care.
9 And here I went out on a limb too to
10 say even value-based care -- I think we need to
11 be thoughtful about using that term and how we
12 use it. I think it has some connotations that
13 you're shopping in the bargain basement. And
14 nobody really wants to be engaged in that,
15 right?
16 Next slide, please? So really this
17 is so simple I think in terms of how to think
18 about engaging them, but in my experience it
19 really works very well. So instead of inviting
20 physicians in to share with them what you have
21 built as a payer or any other group, invite
22 them in to build it with you, right? They have
23 expertise that can be leveraged and should be
24 leveraged. Payers' expertise, no disrespect at
25 all intended, is not in the clinical to-dos, if
26 you will, or the clinical care pathways.

1 And so invite them in to build it
2 with you, and keep them with you through every
3 stage of the build. So collaborate with them
4 as partners in designing the model, what will
5 actually work, in reviewing the data. They
6 haven't seen the data before. They don't know
7 where the variations in care and costs of care
8 are until they actually see it. Allow them to
9 help define the metrics. They know from a
10 clinical perspective what are the outcomes that
11 are the best. And get the patient's
12 perspective as well. And then keep them in as
13 you continue to review it and refine the
14 models.
15 I think it is really important, and
16 I think Francois spoke to this as well,
17 recognizing and respecting the -- all of the
18 stakeholders and leveraging the expertise of
19 them. Partnerships really -- nothing -- don't
20 have anything built without the engagement of
21 the other.
22 And a lot of what I spend my time
23 talking to groups about these days is that
24 these models need to be clinically meaningful,
25 and they also need to be able to be
26 administered by a payer. So we need everybody

1 thinking about this. We don't need payers who
2 are only thinking about creating predictable
3 costs, of critical importance, but we need them
4 also thinking about clinically meaningful
5 models, and we need physicians thinking about
6 clinically meaningful models that really make
7 the most effective and efficient use of very
8 limited resources.
9 And then of course there's the keep
10 it simple. If it can't be easily explained or
11 described to a doc or by a doc, it's not going
12 to be able to -- they're not going to be
13 successful within it.
14 Next slide, please? So I have a few
15 sort of considerations for how to kind of
16 incentivize and engage specialists in some of
17 these models. The first thing is respect that
18 each specialty is unique. There's primary
19 care, and then there's specialty care, but
20 specialty care isn't a thing. Specialty care
21 is a whole lot of things. It's cardiology,
22 it's orthopedics, it's oncology and so many
23 others. And so each of them is unique. Each
24 of them have unique requirements. So if you
25 have one specialist, you don't have specialty
26 care covered, meaning if you have one

1 specialist engaged. The disease treatment
2 pathways, whether it's acute, chronic, or
3 procedural, really have an impact and need to
4 be considered individually.
5 I think the docs and the providers
6 who are caring for people with chronic
7 conditions -- and Mark and Francois both talked
8 about this as well, and actually Rozalina.
9 Often doctors who care for individuals with
10 chronic conditions are the principal point of
11 contact for that individual. They may not even
12 be seeing a primary care doc. And so I think
13 we need to figure out how to address that,
14 right? That care is not typically episodic in
15 nature. And if it is -- like in oncology, it's
16 long, right? It's not a short 120-day-
17 procedural kind of episode.
18 When docs caring for patients who
19 have long care needs in the specialty space,
20 they don't -- there's not money up front that
21 helps support their ability to implement tools
22 and make changes in their -- in the way they
23 care for their patients. And they often have
24 to wait a very, very, very long time to see the
25 outcomes and then get paid. It's a big
26 disincentivizer, if that is actually a word.

1 I would also say inviting
2 specialists to be represented in the leadership
3 on the ACO governance teams, the boards, and
4 committees, is really important. I heard some
5 of the comments earlier today that sounded a
6 bit to me like the primary care docs are at the
7 helm and are going to be telling the
8 specialists what to do and whether they can or
9 can't do something for the patient. I think
10 that is not a way to engage specialists, and
11 it's really not a way to get to the most
12 consistently good optimized -- optimal
13 outcomes. I think we need them engaged in
14 leadership. We need then engaged in some of
15 the decision-making. And they don't want to be
16 led by primary care docs. Partnering with them
17 as partners, yes, but not directed by them.
18 Next slide, please? Thank you.
19 So again, creating financial models
20 that don't immediately put specialists at a
21 loss. So in primary care again, there's money
22 up front. There's an understanding in primary
23 care I think that you need to spend money in
24 the short term to get to better long-term
25 outcomes, right? Bring people in for their flu
26 shots and their mammos and all the preventative

1 care. Typically that's not considered in
2 specialty care, and the minute a doc steps in,
3 they often again start to lose revenue. So I
4 think building models that have some financial
5 -- not even incentive, but support for the docs
6 to be able to make these changes is really
7 important.
8 I think keeping -- staying focused
9 on the long-term improvements in care rather
10 than only on the immediate ROI[46] is really
11 important also as I think we think about it in
12 primary care.
13 I would talk to them about what they
14 perceive they need. I also heard a lot of
15 discussion today about how specialists can
16 provide information to primaries, but I would
17 argue that the specialists need a lot of
18 information from the primaries who often have
19 the most information about the patient that can
20 actually have an impact on the work that the
21 specialist does.
22 This last one, I should have put it
23 bigger and bolder because I find it so
24 important and have had lots of discussions
25 around this over the years, but specialists

46 Return on investment

1 don't have enough experience here, and they are
2 really afraid. And I understand the need to
3 get to predictable costs. That is a number one
4 priority for payers, but I think bringing
5 providers in in no- or low-risk, minimal-risk
6 models to begin to allow them sort of to be in
7 a -- like a live learning lab, if you will, to
8 study the data, see that longitudinal view, see
9 where the variations in care and cost of care
10 are, they will then get to a place where they
11 begin to understand perhaps their school chum
12 or the person they met at church where they're
13 referring might really not be the best place
14 for them to make their referrals. And without
15 that data they can't -- they don't know that,
16 right?
17 And we heard talk earlier too about
18 how difficult it is to change those patterns,
19 but I think if primaries and specialists are
20 engaged together, see the same data and are
21 focused on the same goals, you'll begin to see
22 those patterns change. I've never presented
23 data to a provider and not had them say oh, I
24 didn't realize that's what was happening. We
25 can address that. So again, sharing the
26 longitudinal data to assess the opportunities

1 is really, really important.

2 And then I would say sort of
3 cultivating and nurturing the relationships are
4 so important in a way that we don't see in fee-
5 for-service in any respect, right? We
6 typically have units of care, and they're paid
7 in units of cost, or unit fees. In these value
8 models we really -- they rely on ongoing
9 communication and collaboration to review,
10 refine the models, make tweaks, see what's
11 working, what's not working. And so a regular
12 cadence of collaborative review of the
13 challenges and the successes is really
14 important.

15 And I know this sounds kind of
16 shocking, but I think it is really important
17 that CMS and all the other payers -- by the
18 way, I spent 20-plus years on the payer side,
19 and so I saw this live for myself. You can
20 become the trusted advisors of providers, which
21 is just amazing, right, to be really working
22 hand-in-hand as long as you are open to it, and
23 you are willing to share data and talk on a
24 regular and ongoing basis.

25 Next slide, please? Oh, do I have
26 another one? Yes.

1 So this is just really in summary.
2 I think I do think it's the spirit of
3 collaboration that will get us closer to
4 creating comprehensive accountability for care
5 quality, for patient experience, and cost of
6 care.
7 And again I think if I could
8 reiterate the most important points I think of
9 -- that I think in this space, I think inviting
10 the doctors in to build with you, leveraging
11 the expertise that they have, have appropriate
12 representation in the leadership of these
13 integrated models. We need to build -- I think
14 we all want to and we need to build meaningful
15 medical neighborhoods. And that isn't just
16 primary care. That's really an integration
17 with the specialists. And I think by doing
18 that, you begin to see not just engagement by
19 the specialists, but you see enthusiastic
20 engagement, which also leads to ongoing
21 innovation and engagement that leads to
22 improved outcomes.
23 So I thank you so much for the time
24 and the opportunity to speak today.
25 CO-CHAIR HARDIN: Thank you so much,
26 Lili. That's such an interesting way to tie

1 together all four of these presentations.
2 Now we're going to move into the
3 section with questions from our Committee
4 members. If you could put -- tip up your name
5 tag like this if you have a question? And what
6 I'd like to suggest -- we have from now until
7 4:10, and there's a lot of rich content here --
8 if you can think about a succinct way to ask
9 your question and then choose two of the
10 panelists that you would like to respond so we
11 can get to as many questions as possible with
12 this esteemed panel.
13 So who has a question for our panel
14 members? Angelo?
15 CO-CHAIR SINOPOLI: Thank you.
16 So, yes, great, great presentations.
17 And I guess my question for more clarity on my
18 part is to Mark and Francois. So as I think
19 about the sub-cap models as you described, help
20 clarify for me how you identify the population
21 for the particular specialists. And so it all
22 patients within that category of disease, or is
23 it risk-stratified in some way to hit a
24 threshold that gets I guess attributed to that
25 physician? And if that patient has multiple
26 comorbid conditions, then how you decide which

1 specialist that sub-cap might go to? Thank
2 you.
3 DR. McCLELLAN: Francois, I might
4 defer for you to go first. Despite your
5 comments earlier, I think you've got more
6 certainly technical experience here. Maybe I
7 can add a few just high-level comments.
8 MR. DE BRANTES: I'm trying to get
9 myself off mute.
10 DR. McCLELLAN: There you go.
11 MR. DE BRANTES: Okay. I was trying
12 to get myself off mute. Sorry about that.
13 Yes, so a few points: First, it's
14 not necessarily a pure sub-cap, but I guess
15 it's not a bad idea to think about it in a
16 simple way, number one, sort of from that
17 perspective.
18 I do think building on Lili's
19 comments, this isn't just about carving out
20 patients and putting them into the hands of
21 specialty care providers more than having a
22 population of patients, some of which are going
23 to require specialty care, some of which are
24 going to require primary care, and a
25 collaboration between both. And the patients
26 in fact can be shared and should be shared

1 between the primary and the specialty care
2 providers based on their severity at any point
3 in time.

4 If you use the CKD[47] model as kind of
5 a base for thinking about this, as you know,
6 there is a clear delineation. It's when you
7 reach a certain stage of CKD that you become
8 attributable to the nephrology practices that
9 are participating in that program.

10 And Rozalina spent a fair amount of
11 time talking about the challenges associated
12 with attribution. And there are challenges,
13 but I think there are also ways of working
14 underneath a population health umbrella to have
15 the delineation between when the patients start
16 falling under the responsibility of the
17 specialty care providers and when it's better
18 for them to continue to be cared for by primary
19 care physicians.

20 And yes, you're right that many
21 Medicare beneficiaries have multiple conditions
22 at the same time, and the costs associated to
23 those can be attributed again to different
24 specialty care providers. So it is math. And
25 there are ways and mechanisms to parse out

47 Chronic kidney disease

1 those dollars to the extent that it should be
2 done and it makes sense. Because if the
3 patient again has severe IBD[48], in addition to
4 having an advanced cardiac condition like heart
5 failure, then they're going to be co-managed by
6 both specialty care providers and by the
7 primary care physician.
8 So some of this is we try to over-
9 complexify it sometimes, but if you pull back
10 and you think well, in an integrated system, it
11 kind of works, and so how do we replicate the
12 mechanisms from a financial standpoint and
13 attribution standpoint so that it works just as
14 well when everyone doesn't belong to the same
15 legal organization?
16 DR. McCLELLAN: Yes, I would just
17 add -- I agree with everything Francois said
18 and just maybe a little bit higher level here.
19 Rozalina did a great job of outlining just how
20 hard this is given the complexities of care.
21 And I would say that's especially true if
22 there's not an overall accountable provider or
23 entity that can help put these pieces together
24 and make sure they make sense for that
25 particular patient.

48 Irritable bowel disease

1 And CMS has worked out a way to do
2 this for the acute episodes. I think that's
3 one reason we have acute episodes. And I'll
4 say it, Lili. Bundles. That's what they're
5 called because it's a relatively short period
6 of time after a major procedure, and you can
7 kind of be confident in attributing that to a
8 particular specialist or group for that
9 episode.
10 It's harder for the longitudinal
11 conditions, and that's why we've focused on
12 sort of two main points. One is if you are in
13 a hospital-based ACO, that includes
14 increasingly attributed primary care providers
15 or associated primary care providers and
16 specialists. And there will be acute episode
17 payments within that. There's just no easy way
18 for that hospital-based ACO to shift resources
19 and support for those specialists out of just
20 doing those procedures and into more of a
21 longitudinal model.
22 So having attribution to a specialty
23 provider for the condition based on, as
24 Francois said, some minimum threshold set of
25 conditions; for example, for -- he gave one
26 example for degenerative joint disease, which

1 everybody has. It could be referral to an
2 orthopedist or orthopedic condition management
3 group with a certain minimum level of findings
4 or workup or something like that. Well, that's
5 hard to make work as a stand-alone because
6 everybody's got some -- at that age has some
7 level of degenerative joint disease. But if
8 it's within a hospital-led ACO, well, they've
9 got some reasons to pay attention to how many
10 patients are getting referred to specialty --
11 hopefully longitudinal care, not just
12 orthopedists who only have a reimbursement path
13 for the procedures.
14 Conversely, for the primary care
15 ACOs, we view that as being a template that
16 they can use to facilitate their interactions.
17 Much as Lili said, let's start with providing
18 data at the condition level and how different
19 specialty groups are doing. And again you can
20 start with -- you have to start somewhere --
21 with a reasonable measure of when an episode, a
22 chronic episode should start and what services
23 should be included. We're only going to make
24 those better if we start trying out these
25 models and get more experience over time.
26 There are a number out there that

1 can be used, and they need to keep getting
2 refined. We think we ought to start with some
3 of the most common conditions where there are
4 these big opportunities potentially for
5 supporting better longitudinal care model
6 collaboration.
7 And from the primary care group
8 standpoint, if they're only implementing these
9 models with specialty groups or longitudinal
10 specialty care providers that fit with their
11 priorities, they can have some control over
12 when that attribution occurs. They can keep
13 trying to do all the care themselves if they
14 really think they can -- there's not enough
15 savings to go around, and they can do all of
16 this. I don't think, as Francois said earlier,
17 that's very feasible, but at least they'll have
18 a clear path and start with some initial data
19 on where they ought to go. And there would be
20 a clear path for the specialists who want to
21 work.
22 Maybe it's capitated; maybe it's
23 just a more limited amount of risk sharing and
24 scope of responsibility sharing, but at least
25 you've got a framework with a range of options,
26 clear options to start with and some data to

1 help encourage that kind of constructive
2 longitudinal collaboration.
3 CO-CHAIR SINOPOLI: Got it. Thank
4 you. That was very helpful.
5 CO-CHAIR HARDIN: Larry, please go
6 next.
7 DR. KOSINSKI: And this time I
8 remembered to hit both buttons.
9 Fantastic session. I love the
10 application of science to the chaos we've been
11 living in for the last 30, 40 years.
12 And, you know, I don't know who is
13 best to comment on what I'm going to say. But
14 what I've come away with from this session is
15 to no longer want to talk about primary care
16 this, specialty care that, but rather to look
17 upon this, what we should be doing, as crafting
18 a complex attribution model or a set of
19 attribution rules to create sub-buckets of risk
20 that are disease-specific and then apply the
21 right providers to take care of that, because,
22 you know, in the GI space, some of my
23 colleagues, all they do is colonoscopies for
24 screening. So they are prevention doctors.
25 Then there's others that love to be
26 at the hospital in the acute phase and love to

1 take care of the acutely ill patient. And then
2 you have those that love to be in the office
3 and take care of the chronic care. They're all
4 gastroenterologists. They're all specialists
5 that provide different segments of the care
6 that a patient with a disease takes.
7 So maybe we need to turn this upside
8 down a little bit in our terminology and say
9 we're creating disease-specific attribution
10 models so that we can provide the right care to
11 the right patient at the right time. Great
12 session.
13 CO-CHAIR HARDIN: Did you want to
14 ask any panelists to make any comment on --
15 DR. KOSINSKI: Should we start
16 reversing how we're talking about this?
17 Instead of talking about specialty models and
18 primary care models, should we be talking about
19 disease-based models?
20 MS. BRILLSTEIN: So I'm happy to
21 make a comment, if I can just jump in.
22 I think, Larry, to my view, it is
23 really about sort of creating collaborative
24 models, not primary versus specialty, but
25 leveraging the expertise of each and every one
26 of them to be able to build models that address

1 the care of the community, right, so sort of
2 that medical neighborhood concept I think.
3 In terms of turning it upside down
4 on its head, I, you know, at the risk of, you
5 know, really being out there, I think in some
6 ways that is what we have to do. We have to
7 sort of rethink the language that we use. And
8 we have to rethink, you know, what the builds
9 look like. You know, we don't build for, we
10 build with is sort of I think the model that
11 we'll get the most engagement and create the
12 most success.
13 CO-CHAIR HARDIN: Any of the other
14 panelists like to comment? I see Mark shaking
15 his head.
16 DR. McCLELLAN: Yeah, I agree.
17 CO-CHAIR HARDIN: All right. Thank
18 you. We'll move on to Jen. Please go ahead.
19 DR. WILER: Thank you, again, to
20 each of you. What a wonderful series of
21 presentations.
22 I want to go back to focus on one
23 very small point. And, Lili, you made the
24 comment about anything mandatory implies a
25 power imbalance and why that might not be
26 palatable.

1 But at our last session, we actually
2 had a lot of conversation around should
3 participation in value-based programs be
4 mandatory? So I'm curious your thoughts on
5 that idea with regards to specialty care, or I
6 guess if we're going to reframe, disease-based
7 care models for which specialists provide care.
8 I think for Mark and Francois, this
9 is for you. But I'd open it up to anyone who
10 has an opinion.
11 DR. McCLELLAN: Well, I agree.
12 Sorry. Go ahead, Francois.
13 MR. DE BRANTES: No, please.
14 DR. McCLELLAN: No, I agree with
15 Lili's point. But, Francois, let me defer to
16 you. And I'll pick up from there.
17 MR. DE BRANTES: Yeah, look, I think
18 what we have learned in the process of the past
19 decade or so is that there are some models,
20 when they are fully baked in and where there is
21 evidence around the effectiveness, they should
22 be mandatory.
23 I mean, in the document that Mark
24 mentioned and prior ones that we've worked on,
25 we, I think we're really clear about that we
26 all think, you know, there should be kind of

1 mandatory 30-day, if you want to call them
2 bundles, you call them bundles, if you want to
3 call -- to payments for acute and post-acute
4 covering 30 days, and it should cover all DRGs,
5 and, you know, just get on with life, because
6 it helps optimize post-acute care, and we kind
7 of know it works.
8 I think for the rest, it's really
9 difficult to do mandatory unless you really
10 know that something is effective. And the
11 concern of jumping into, say, mandatory today
12 in the scope of what the agency has really
13 focused on, which are things like total joint
14 replacement or, you know, if they want to do
15 the equivalent in cardiology, let's say CABG[49]
16 or stents, is that, again, you take in a piece
17 of a slice.
18 And it's, and taking just a slice is
19 not the way to engage the specialty care
20 providers. And you're treating at that point
21 the procedure. But what about all the upstream
22 work that, you know, should be the focus of
23 these longitudinal care, these condition-based
24 programs?
25 And so, to Larry's point, I think if

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49 Coronary artery bypass graft

1 we do flip this and think of it, individuals
2 have to dish in. These conditions need to be
3 managed. And they need to be managed
4 collaboratively between primary and specialty
5 care providers. And the specialty care
6 providers come in different forms and
7 varieties, as Larry has mentioned.
8 And before we start mandating a
9 whole bunch of programs that will likely mostly
10 be centered either around acute episodes or
11 procedural episodes, let's start by testing out
12 and working through. What really matters is
13 the longitudinal management of conditions.
14 DR. McCLELLAN: And to get to the
15 longitudinal management, just to build on
16 Francois' comment, you know, mandatory has come
17 up in a couple ways in this session.
18 One is, you know, I referenced the
19 CMS statement that they are considering, and
20 they're not doing it, and they're not doing it
21 right now, but considering moving to mandatory
22 versions of these acute episode models. And I
23 think that's a reflection of a real challenge
24 that I hope PTAC can engage on with voluntary
25 models.
26 So it's not that they can't improve

1 care, and they can't reduce the total cost of
2 care delivery. It's that they can't do those
3 things and save money for Medicare or even
4 break even for Medicare very easily, especially
5 as you get into more fine definitions of
6 episodes of care.
7 So BPCIA, according to the Medicare
8 actuaries, and their numbers may not be exactly
9 right, it's hard to know, but lost a lot of
10 money in its early years because it was hard to
11 set those benchmarks right.
12 And then once you set the
13 benchmarks, it was an opportunity for groups to
14 understandably look at how they're doing now
15 under current financial performance on the
16 current payments versus how they'd do under the
17 alternative model. And if it didn't look good,
18 a good reason not to participate. If it did
19 look good, it's a great reason to participate.
20 But again, and it will help drive
21 the changes in care that you want. But it
22 leads to more, not less, spending for Medicare.
23 And that's happened in a lot of the voluntary
24 specialty models.
25 When we adopted other major payment
26 reforms that I think have generally been

1 regarded as successful, at least incremental
2 steps forward, they've, A, generally moved away
3 from fee-for-service and, B, generally haven't
4 been voluntary, so think about DRG-based
5 payments for hospitals and all the episode
6 payments under the traditional Medicare system
7 that are now in place for essentially all types
8 of facility-based care and even home-based
9 care.
10 So I think it's going to be hard to
11 get to a truly person-centered, longitudinal
12 care-focused system if we are only forever
13 planning on doing voluntary approaches, at
14 least doing it in a way that's at all fiscally
15 sustainable for the country. So, if we are
16 moving to mandatory, we need to do it carefully
17 and thoughtfully.
18 What CMS laid out, for example, for
19 the future of the BPCI is we're going to,
20 they're going to, aiming to provide data on all
21 specialty providers and do it for maybe a
22 couple of years to help people get a sense of
23 where they are, help set the benchmarks and
24 other features of the program right before
25 moving to something mandatory.
26 We talked about mandatory in one

1 other context in our presentation, which was
2 within the hospital-based ACO models.
3 Remember, there it's a little bit different.
4 Those hospitals are already accountable for the
5 total cost of care for the patients that are
6 attributed to them.
7 They're just a bit hamstrung in
8 implementing these specialized care,
9 longitudinal models in that they're being paid,
10 their specialists are being paid on a DRG plus,
11 you know, episode basis, which means if you
12 look at the financial arrangements in these
13 hospitals, they've got primary care providers
14 that are trying to keep at least some, you
15 know, chronic patients out of the hospital.
16 But for the specialists to sustain their
17 practices, they've got to do the procedures.
18 That's where most of the money is.
19 So a mandatory shift away from that,
20 it's still all, you know, money that the
21 hospital gets or is accountable for. But it
22 provides a stronger push in the direction of
23 moving towards these longitudinal care models.
24 And we do think that, you know,
25 moving beyond that at some point may be worth
26 going to. Just like we have a mandatory, you

1 know, fee-for-service payment system now,
2 someday we may get to one for specialized care.
3 But there's a lot to learn on the
4 way. I just think it's probably not realistic
5 to think we can only be voluntary and really
6 move away from, you know, very fragmented fee-
7 for-service, procedure-oriented care.
8 MS. BRILLSTEIN: May I make a quick
9 comment on this?
10 CO-CHAIR HARDIN: Please do.
11 MS. BRILLSTEIN: Thank you. So I
12 just want to clarify. I work very hard every
13 day to help progress the move from fee-for-
14 service to value. I think it is the right
15 thing to do. I think the language we use to
16 engage or talk about it is so important.
17 So, to Mark's point that he just
18 made, you know, we don't refer to fee-for-
19 service as mandatory. It is just the standard
20 model of payment. And so, you know, talking
21 about voluntary and mandatory, it's the
22 language I think, right.
23 Like maybe the folks who start out
24 in what's called mandatory now, maybe they're
25 the beta testers, right, or some other
26 language. And then ultimately, the value-based

1 models, whether they're called that or
2 something else, becomes the standard model of
3 payment.
4 But the language we use, from my
5 experience and in my view, makes a huge
6 difference in how and if you're able to get
7 doctors and others actually to engage in the
8 models.
9 Nobody wants to be told you're going
10 to be mandated to do this, rather we're
11 evolving perhaps to another model of payment.
12 And we have, you know, initial beta testers or
13 whatever we call them.
14 So I just want to make sure that's
15 clear. It's not that I don't think the move to
16 value is critically important. I do. I think
17 if we want to get there, though, we have to be
18 really considerate about the language that we
19 use.
20 CO-CHAIR HARDIN: Committee members,
21 any additional comments, questions? I'm going
22 to throw one out then. So this may sound like
23 a tangent.
24 But I think a lot about longitudinal
25 management and how important that is, the
26 relationship, the trust, and how strongly that

1 type of approach builds the possibility for
2 anticipatory management, preventing crisis, and
3 really holistically addressing clients' needs.
4 So I'm curious, in light of that,
5 how are you thinking in these payment models
6 about the integration of community partners,
7 health-related social needs, and some of the
8 people who naturally have longitudinal
9 relationships with patients and may actually
10 have the most contact with the client? Just
11 open that up to any of the panel members to
12 comment on.
13 DR. McCLELLAN: Maybe I can start
14 with a few comments.
15 So I, you know, completely agree
16 with you and I think just everybody on the
17 panel, who has really put out some good ideas
18 and encourage the path forward to more
19 longitudinal, and to support, more longitudinal
20 engagement of specialists and whole-person
21 care. I think you've seen a consistent theme
22 around that.
23 I just would emphasize that if we
24 really want, I think there's now a lot of
25 experience, if we really want to address these
26 social factors and reaching patients where they

1 are, establishing trust, et cetera, it's very
2 hard to do that under fee-for-service.
3 I mean, we're making, you know, very
4 incremental changes in Medicare in that
5 direction. And there are some care management
6 fees, mainly only for primary care providers, a
7 little for behavioral health now, and those are
8 hard to get added to fee-for-service because
9 they look like, you know, if they're not
10 coordinated, they're concerned they're going to
11 tend to add the cost.
12 There's a little bit of payment in
13 fee-for-service for maybe for a pathway for
14 food or some preventative community services,
15 like the diabetes prevention program. But even
16 there, those are quite limited and not very
17 comprehensive.
18 In contrast, in organizations, in
19 Medicare, Medicaid, especially where we're
20 going to pay people with a lot of underlying
21 needs and complications, lower incomes, that
22 are getting in the way of and causing health
23 problems that are preventable, we've seen a lot
24 of examples now of ACOs and other programs,
25 including programs involving specialists, move
26 to addressing nutrition needs, addressing

1 transportation needs, building care teams that
2 rely on traditionally unreimbursed in Medicare
3 providers, at least not directly reimbursed.
4 So the more we can adopt these
5 models, and especially if we can reinforce the
6 importance of engaging specialized care
7 providers and giving patients the best
8 longitudinal experience, you know, they can be
9 very helpful. It's not their only job, but
10 they can be very helpful for patients that have
11 that strong specialty care relationship and
12 identifying early interventions.
13 Kevin Bozic has a great program at
14 Dell in Austin that has sort of essentially
15 eliminated the waiting list for uninsured
16 Austinites. And there are, you know,
17 unfortunately too many of them for getting
18 access to joint procedures, not by doing a ton
19 more joint procedures, but by setting up these
20 care models that get to an early triage, early
21 intervention, addressing behavioral health
22 needs, supporting, you know, community-based
23 nutrition interventions, exercise
24 interventions, things like that that are just
25 so much more effective for people with
26 specialized conditions.

1 MS. BRILLSTEIN: I'm going to add a
2 comment, too, and say, you know, as I think
3 about these models and the comprehensive care,
4 you know, so much of what happens these days is
5 about what the health plans have defined as
6 covered benefits.
7 And we know that what impacts a
8 patient's ability to get to the best outcome
9 and physician's ability has a lot to do with
10 things that are not traditionally covered
11 benefits. So, for example, in the commercial
12 world, it's very unlikely that if a patient
13 can't get to the doctor that a plan would pay
14 for an Uber or a Lyft, right.
15 When we move into value-based models
16 and we contemplate patients' outcomes, you
17 know, we know that getting a patient to the
18 doctor has a pretty big impact on their
19 outcome. So we begin to see the incorporation
20 of transportation, food, all sorts of ancillary
21 services, people going into the home to see
22 does the patient actually have a refrigerator
23 to keep their meds cold, things like that.
24 And I think as we move into value-
25 based care and we begin to create models that
26 pay for outcomes and allow the clinicians and

1 the care providers to assess what is it that
2 really has the biggest impact on the
3 individual, and let them spend the money the
4 way it makes sense, right, once they move into
5 risk-based models, I think really begins to get
6 at kind of, I wouldn't say all, but most of the
7 things that impact a patient's health that
8 include and are outside of traditionally
9 covered benefits.
10 CO-CHAIR HARDIN: Rozalina, I see
11 you shaking your head. Would you like to go
12 next?
13 DR. McCOY: Yeah, I definitely
14 agree, especially for, you know, chronic
15 diseases and multi-morbidity, social
16 determinants of health and factors that are
17 outside the health care system are really
18 dominant. And they can't be addressed I think
19 without up-front investment and recognizing the
20 care that those community partners or non-
21 clinical partners deliver, which is why I think
22 finding ways for them to be present and claims
23 to be captured and then for payment to be
24 shared with them and assigned to those
25 services, that's going to, I think is really
26 important.

1 But to start, there has to be an,
2 there is an up-front cost to starting those up
3 and to creating the community clinical
4 partnerships. So I think that would have to be
5 a part of the total cost of care model that
6 really recognizes the totality of the patient's
7 needs.
8 And, you know, in Minnesota,
9 Medicaid, for example, has been reimbursing for
10 community paramedicine. And we've seen a lot
11 of growth in that. But that's really unique.
12 But I think we've seen how much even small
13 financial investment in new models of care can
14 make a big impact. So learning from
15 experiences like that I think can be very
16 helpful.
17 CO-CHAIR HARDIN: Francois, would
18 you like to add anything? No. Okay. We have
19 exactly five minutes. Any last burning
20 questions? Lindsay, please go ahead.
21 DR. BOTSFORD: Thank you. I don't
22 know if it will do it justice for five minutes.
23 But I think, you know, in other industries we
24 think about how, you know, we have consumer
25 demand that drives us in certain directions.
26 And it's been great hearing, I think, the

1 conversation about, you know, how we can value
2 specialty care in some of these disease-based
3 models.
4 But I think one question I have is
5 once we build it, once we figure out
6 attribution, how do we, outside of it being
7 mandatory, what incentives can we create for
8 patients to want to go down that path. And I
9 guess, you know, I guess what incentives do we
10 think patients have or what incentives can ACOs
11 or specialists create to use those high-value
12 sites of service or specialists that have been
13 baked in?
14 I think I just -- the missing piece
15 for the consumer, in this case the patient, to
16 understand why a model like this is beneficial
17 feels a bit missing. And I worry about a
18 mismatch in patients placing other things at
19 higher value, such as it's a mile from my house
20 or I know them from my church, as opposed to
21 being able to understand that there's a value
22 to it.
23 So it feels like a bit of a
24 tangential conversation, but just curious how
25 we think about, you know, once we've designed
26 this system, what incentives could we create in

1 a payment model that also takes into a fact how
2 does the patient benefit from it, outside of
3 just getting a higher-quality care in the end?
4 CO-CHAIR HARDIN: Panelists, who
5 would like to respond?
6 DR. McCLELLAN: Well, higher-quality
7 care is an important benefit. But I would say
8 that the time to build in consumers or patients
9 isn't, you know, once the model is developed
10 but as you're aiming, you know, what should we
11 be aiming for.
12 I think the, you know, the recent
13 CMS specialty care strategy that really
14 emphasizes the whole patient journey and as,
15 you know, as Lauran was just talking about,
16 that's what people care about. I mean, the
17 best surgery is the one they don't have to
18 have. The best hospital admission is the one
19 they avoid. You know, the best complication is
20 the one that doesn't happen.
21 And right now it's very hard for
22 patients or for that matter their doctors to be
23 informed about that. I mean, we heard earlier
24 about the lack of data at key times when
25 patients are making major decisions, you know,
26 which primary care doctor do I use? Well,

1 we've made some progress on that. But, you
2 know, where do I go for my joint disease care,
3 for my, you know, my heart failure, my
4 diabetes?
5 We don't have very good data on
6 that. And it's not for lack of effort. There
7 have been all kinds of, you know, transparency
8 legislation, some that CMS is trying to
9 implement now.
10 But I do think as an initial step,
11 the CMS idea of having what they're calling
12 shadow bundles, and, you know, they should get
13 rid of the bundle term from the standpoint, as
14 Lili was describing, but, and shadow also
15 sounds a little bit spooky.
16 But what those are really about is
17 level of information, the level of an episode
18 of care and experience of care for a condition
19 or for a hospitalization or for an elective
20 procedure that rolls up the total cost, maybe
21 rolls up out of pocket costs, includes some
22 important measures that people might care about
23 like complication rates and readmissions.
24 If you go to condition-based
25 versions of that, as we proposed as a starter
26 in this direction for major conditions, you can

1 also start really getting at what matters to
2 patients, which for chronic diseases is, again,
3 avoiding the hospitalizations, more so than,
4 you know, having fewer hospitalizations in them
5 and getting a better overall experience with
6 their condition.
7 So, you know, if you've got
8 condition-level episodes where you're providing
9 transparency, it becomes easier to produce
10 measures like, you could start with net
11 promoter scores. But for all of these
12 conditions, there is generally a patient-
13 reported outcome or set of outcomes that
14 matters.
15 For Alzheimer's patients, it's am I
16 independent, you know, how much independence do
17 I have, do I have to rely on a nursing home or
18 other kinds of assistance? For people with
19 joint disease, it's not how good was my
20 surgery, but what's my functional status? For
21 people with back pain, what kind of pain do I
22 have?
23 And the last thing I'd add to that
24 is you can also add in benefit-designed changes
25 where, you know, going to the provider systems
26 that are best at the condition or person level

1 should be the ones that cost less for the
2 person.
3 CO-CHAIR HARDIN: Any other
4 panelists like to comment?
5 MR. DE BRANTES: Just the whole
6 thrust of what I think we talked about, all
7 four of us, is that collaboration between
8 primary and specialty care. And so, to your
9 point today, a lot of the decisions end up by
10 being influenced by other factors.
11 And it's in large part because you
12 still have these siloed views of care. And
13 until we change both the financial and other
14 interactions between the primary and the
15 specialty care providers, it's not likely to
16 change. And, therefore, the influencing
17 factors of those decisions aren't likely to
18 change.
19 But the information that Mark
20 mentioned is critical to help create the
21 evidence base around which of the specialty
22 care providers are effectively going to manage,
23 if I'm the primary care physician, effectively
24 going to manage my patients the best. But
25 beyond that, I'm also working collaboratively
26 with them on accountability for financial and

1 clinical outcomes.
2 So it's not just a collegial
3 relationship or someone that I, you know, go
4 play golf with. But it is literally a business
5 partner, a care collaboration partner, someone
6 with whom I share patients underneath the
7 umbrella of a broader, accountable system.
8 CO-CHAIR HARDIN: On behalf of the
9 Committee and our audience, I want to thank
10 each one of you, Lili, Francois, Mark,
11 Rozalina, for the generosity of your time and
12 your tremendous expertise. So this was
13 incredibly engaging. And we really appreciate
14 all of your insights.
15 At this time, we're going to have a
16 short 10-minute break. We'll be returning at
17 4:20 Eastern. At that time, we'll reflect on
18 the day and discuss some potential comments for
19 the report to the Secretary.
20 You're welcome to stay on for the
21 rest of the meeting today. Thank you all so
22 much.
23 (Whereupon, the above-entitled
24 matter went off the record at 4:10 p.m. and
25 resumed at 4:22 p.m.)
26 *** Committee Discussion**

1 CO-CHAIR SINOPOLI: Welcome back.
2 We've had a great day today, a lot of subject
3 matter experts who have shared their expertise
4 and insight with us. It's been a very
5 productive day today with a lot of robust
6 discussion.
7 As you know, PTAC will issue a
8 report to the Secretary of HHS that will
9 describe our key findings from this public
10 meeting on improving care delivery and
11 integrating specialty care in population-based
12 models.
13 We now have some time for the
14 Committee to reflect and discuss what we've
15 learned and heard throughout the day. We will
16 hear from more experts tomorrow. And at the
17 end of the day tomorrow, we'll have more in-
18 depth discussion about what we've heard over
19 the two days. And we'll use that time to
20 construct a report to the Secretary.
21 So, at this time, I just want the
22 Committee to look at the potential topics for
23 deliberation. You know, if there's anything
24 that we feel like we need to discuss today,
25 then we've got a few minutes to discuss those
26 while they're fresh on our mind. Otherwise, we

1 can save topics and talk about them once we've
2 heard all the experts tomorrow afternoon.
3 So I will open it up to the
4 Committee for comments.
5 DR. FELDSTEIN: So, Angelo, I'm not
6 going to be here tomorrow.
7 CO-CHAIR SINOPOLI: Okay.
8 DR. FELDSTEIN: One of the things
9 that struck me today was, I was really
10 fascinated by the e-consult conversation,
11 because if you're really trying to drive
12 integration in specialty and primary care and
13 to leverage technology and to take some of the
14 learnings we got out of COVID, I would think
15 that either, you know, delivery system,
16 hospital-based ACOs, or freestanding primary
17 care ACOs would really try and leverage those
18 two technologies.
19 And, you know, a couple of the
20 companies that she didn't name, I'm familiar
21 with that, especially in the Medicaid space,
22 they really showed considerable savings and
23 increased patient outcomes with increased
24 utilization of e-consults, especially when it
25 was, when the health system or the specialist
26 were created by the risk-bearing entity itself

1 as opposed to going out to third-party
2 specialists across the country who may sound
3 great but have no connection to the local
4 community.
5 So I just, you know, would like us
6 others, you know, to think about, you know,
7 what are the ways that, you know, and I know
8 telemedicine is back on the table, how long
9 it's going to be covered at what level for
10 going forward, as a way that we should really
11 consider leveraging that virtual visits as
12 well, as well as e-consults going forward.
13 So that's my comment for today. And
14 I apologize for not being able to be here
15 tomorrow.
16 CO-CHAIR SINOPOLI: No problem.
17 Thank you for those comments and well noted.
18 So any other Committee members have comments
19 for today? Jen.
20 DR. WILER: Thank you. I'll make
21 these comments now rather than holding them for
22 tomorrow.
23 I have -- there were many takeaways
24 from today. But I have 10 that I think are
25 worth identifying that we could consider
26 ultimately in our final report to the Secretary

1 about best practices or key things or ideas.
2 The first is that there needs to be
3 some consideration for the up-front costs and
4 spend that saves money on the back end.
5 So, when we heard our first
6 presentation, there was some note to other
7 programs, which I believe were interpreted to
8 be meaningful use infrastructure payments, and
9 how important that was ultimately to building
10 infrastructure that was ultimately a process
11 measure for the outcome measure of delivering
12 high-quality, high-value care.
13 The second I heard was around the
14 need for continuation of or expansion of
15 technology-enabled care, i.e., telehealth, and
16 how critical that is for care delivery. And
17 then ultimately there needs to be some
18 consideration to make it more attractive from a
19 payment perspective.
20 Next was that practice
21 transformation, yes, it's expensive, but again
22 saves, can save money in the end. But it takes
23 time to build and reorganize. And it requires
24 flexibility. And so really a focus should be
25 on long-term improvements without focusing on
26 the immediate ROI if naturally we want to

1 achieve ultimately our goals.
2 We also heard endorsement from our
3 experts around a recommendation of a multi-
4 payer strategy so that there is a
5 disproportionate number or majority of patients
6 in a panel who are engaged in value-based
7 programs to make it attractive for
8 participation, i.e., an incentive.
9 I also heard, we had, as a PCDT
10 team, wondered about should there be carve-
11 outs. And I think we heard from our experts
12 that there should be carving in as opposed to
13 carving outs.
14 We also heard that price and data
15 transparency would be helpful to surface
16 information about where opportunity exists and
17 where to create value and that timely insights
18 were critical or are critical.
19 Number eight, that prospective, we
20 heard in our most recent discussion a
21 recommendation around prospective attribution
22 being a best practice and why that would be
23 valuable, and then considering letting patients
24 decide the attribution with affirmation by a
25 provider about that relationship, and then also
26 considering a weighted attribution model so

1 that it's not just based on one relationship,
2 which doesn't typically reflect actual care
3 delivery.
4 Next, that voluntary participation
5 in programs, i.e., a beta test, what I heard is
6 that this can't last forever, and if that we
7 are ultimately to get to meaningful change, we
8 need to evolve to a maybe novel payment
9 program, but one, call it mandatory or call it
10 the standard, but either way that we need to
11 pivot from testing ultimately to something that
12 is sustainable.
13 And then last I heard that we really
14 need to be focusing on prospective
15 longitudinal, whole-person care when we're
16 thinking not only about our care models but
17 payment models. Thank you.
18 CO-CHAIR SINOPOLI: Those are great
19 comments and a great list. Josh.
20 DR. LIAO: Yeah, a day with lots of
21 interesting and thought-provoking, I think,
22 comments.
23 My overall kind of takeaway from
24 today was really that, you know, we can't think
25 about specialists as like a yes/no, all or
26 nothing type of thing. Heard a lot of real

1 nuance and feathering of kind of detail in
2 there, so acute episodes or procedure-based
3 clinicians versus those who might manage
4 longitudinal or acute episodes, et cetera.
5 We saw many figures. My head is
6 still spinning about how they all come
7 together, about how these all fit together.
8 But that complexity I think was really helpful.
9 And I think what that means for me,
10 though, is that in some ends, in some ways, we
11 are a Committee focused on the technical
12 aspects of payment models. And so, when I try
13 to land that in how these models work, I do
14 think the arithmetic is a little more
15 complicated than that, I think in part because
16 sub-specialists have different scopes of
17 practice, right, that we need to acknowledge.
18 It's not that all of them just do a procedure
19 or just do acute episodes or just do
20 longitudinal outpatient care.
21 I also worry about a bit of a -- I
22 know this is not the intent, but I just want to
23 say for the record that I don't think what we
24 want is a subtractive strategy where we say,
25 well, once we take this condition and that
26 condition and that condition out, you know,

1 primary care is what's left of that. And I
2 don't think that squares with clinical
3 experience or intuition.
4 And so the last thing is really
5 like, you know, Larry's comment about this idea
6 of integrating and thinking about, well, who
7 are the clinicians and the groups we need to
8 bring together for that? And I think if we
9 really want to grapple with it, it also means
10 introducing, when we think about integrating
11 sub-specialists, it means how do we think about
12 panel management, population health measures,
13 all the -- we heard a little of that today.
14 But I think many primary care
15 clinicians, that's what we do. And I think
16 bringing that kind of awareness, skill set,
17 capacity across different clinician types I
18 think is really important also. So --
19 CO-CHAIR SINOPOLI: Perfect. Thank
20 you, Josh. I think Chinni has a question.
21 DR. PULLURU: Sorry. I'm falling
22 into Larry's double-click thing.
23 So, you know, from a comment
24 perspective, I've got, similar to Jen, about
25 five things that struck me from today that I
26 thought was really insightful.

1 First, you know, I love the idea of,
2 you know, it's come up a couple times, this
3 shadow bundle and being able to provide that
4 data to ACOs so you can actually figure out
5 sort of the arbitrage behind care mechanisms
6 and episodes between specialists.
7 And then that leads into something
8 that Larry spoke to in Jen's slide presentation
9 is the variability in disease episodes. And I
10 think we don't, you know, we don't have a
11 methodology to account for that variability.
12 And I think adding, you know, landing the plane
13 on financial incentives attributed to some
14 level of that variability I think is really
15 important.
16 You know, mandatory versus optional
17 came up a couple times. And sort of leading
18 into co-attribution, you know, we think of
19 attribution as primary care attribution and
20 really getting to a more co-attribution sort of
21 thought process.
22 And the thing that I was -- I loved
23 Mark's slide on, you know, sort of that
24 longitudinal episode and the way that it is
25 initiated by a diagnosis and it takes through
26 the life cycle and how do we sort of cost that

1 out and have benchmarks with that cost.
2 But I think the thing that I'm sort
3 of still struggling with and I feel like is a
4 really big part of value-based care and a
5 really big part of integration or anything you
6 do in total cost of care is health equity. And
7 I don't think we really, that didn't make its
8 way. That's the one thing that didn't make its
9 way into a lot of the sort of thought processes
10 today. And I would have liked to have probably
11 seen more of that.
12 I know that it was brought up as
13 measuring it, setting it, but not really as a
14 part of the solution and how the solution
15 around it. And so those are some of the
16 thoughts I had.
17 CO-CHAIR SINOPOLI: Thank you,
18 Chinni. Lindsay.
19 DR. BOTSFORD: Yeah, thank you.
20 Hard to go after those lists. I think two
21 comments, and maybe it's a little bit going off
22 of what Jay was struck by with the e-consults.
23 And I think I heard themes in all
24 three of the discussions around the need for
25 care coordination, data wrangling, I think it
26 was called by one panelist, collaboration,

1 integration. And I think all of them talked
2 about the value of it for patients, even by the
3 perception of specialists finding value in that
4 sense of relationship.
5 But I'm not sure there's great
6 definitions of what that looks like, what does
7 it take, who does it, and quantifying the time
8 it takes. And I think it ties in for me a bit
9 with the e-consults and that the valuation is
10 for the specialists to do the e-consults. But
11 what does it take for the primary care team to
12 submit the consult, digest the results,
13 communicate it to the patient, and how is that
14 quantified?
15 Now, it's valued in savings
16 downstream. But in a system where time is
17 still limited, if you're layering it on to
18 existing work and not valuing it as a separate
19 thing, how do we encourage that type of
20 behavior? And I'm not sure there's great
21 models for how you quantify it outside of a CPT
22 code. And I'm not suggesting that.
23 But just how do we quantify the
24 work, and what does it look like to do good
25 care coordination, I think still lacks some
26 definition.

1 I think the other theme maybe off of
2 that that struck me was just around, this theme
3 around the intangible relationship, and outside
4 of payment, how do you put value on a good
5 relationship between specialty care and primary
6 care? It's a little bit of that, you know,
7 quadruple or quintuple aim around joy in
8 practice.
9 I mean, I think this is in its
10 purest form what many specialists and primary
11 care docs alike would love to be able to pick
12 up the phone, talk about a patient, get quick
13 resolution, reduce friction, and how do you
14 value that and how do you measure that, and
15 would that get us somewhere as well outside of
16 just payment?
17 So I think those were themes that
18 struck me that seemed to tie into many of the
19 different panels today.
20 CO-CHAIR SINOPOLI: Great comments.
21 Jim.
22 DR. WALTON: Yeah, I want to
23 piggyback on the -- I had two comments.
24 One was on the relationship
25 management, in the broadest sense of the word,
26 between all the stakeholders seemed to kind of

1 jump off the page, that in our efforts to
2 improve quality, achieve the triple aim, we may
3 have an unintended consequence of
4 disintermediating people and their
5 relationships, their longitudinal
6 relationships.
7 And it could be that what we may
8 want to set up pretty high, that one of our
9 priorities is that we do the opposite. We
10 reduce the friction and the dissatisfaction of
11 the practice of medicine. The profession
12 itself has a high level of I would bet not
13 recommending to their children to go into
14 medicine.
15 So how do we have some degree of
16 responsibility and accountability as a
17 Committee to suggest to the Secretary that one
18 of the things that we really want to try to
19 accomplish is to help make sure that there's an
20 active workforce in the future that's in the
21 health care segment, physicians, nurses, and
22 others, that aren't feeling disintermediated
23 all the time in these kind of long
24 relationships?
25 The second comment I would make
26 would be, I heard really a great comment that I

1 think bears attention, which is a focus on data
2 analytics using new technology, which is
3 obviously AI, machine learning, that's very
4 sensitive to bias, right, that's sensitive to
5 skewing data to those less representative
6 groups, those people that are marginalized and
7 find themselves kind of on the wrong end of the
8 health care quality and, you know, oftentimes
9 avoidable morbidity and mortality, and placing
10 that at the highest level we can for the
11 Secretary to say that, hey, we really know that
12 one of the real challenges with the economics,
13 the big economics of our system has to do with
14 a historical arc that has disintermediated
15 people in certain populations based on the way
16 they, on their own personal characteristics
17 that just has a huge anchoring effect on
18 performance, on cost and quality of
19 performance. But that's generations in the
20 making that can't be unpacked in this
21 generation by a few schematic things that we do
22 here.
23 And so that we see ourselves on a
24 kind of a long-term journey and see if we can
25 shift this discussion away from this kind of
26 fear base that we're going to go bankrupt, this

1 system is going to go bankrupt, and we don't
2 find the silver bullet now, when in reality,
3 the thing that's creating the threat of
4 bankruptcy is kind of generational misbehavior
5 as a society at large toward people of color
6 and immigrants.
7 And that's just, we can't really fix
8 that with new payment schemes. We have to
9 actually do a holistic transformation.
10 Well, we can be, we, the medical
11 profession, can be an agent of that. We can be
12 the voice of that. But we can't do that
13 without proper policy support in order to
14 accomplish that.
15 So that's kind of the comment I
16 would make around the two things I felt were,
17 that weren't already stated. Let's put it that
18 way. Trying to color in between the lines.
19 CO-CHAIR SINOPOLI: Great comments
20 from everybody. And it was a good session
21 today. I heard a lot of recurring things that
22 we've heard from a lot of other sessions that
23 we've had.
24 And, you know, some of the things
25 that stood out for me in terms of really trying
26 to drive longitudinal care, which was a great

1 discussion today, is one of the big things
2 we're missing is still the ability to get
3 adequate data, because it falls into the
4 quality, the cost, the risk adjustment,
5 everything that we are trying to accomplish.
6 And then the other thing that really
7 stood out for me today, just to add to the list
8 that you all have already stated, is the
9 administrative burden of the inbox of the
10 primary care doc and the fact that they really
11 need a team around them. And right now we're,
12 you know, relying on the doc to do most of the
13 work.
14 And somehow in our models we've got
15 to figure out what that team looks like and how
16 we support that team around the longitudinal
17 care continuous, not just around the primary
18 care doc, but does that primary care doc have
19 linear integrity across the entire longitudinal
20 care and that team also does that also. So I
21 heard that loud and clear today. And so I'll
22 add those comments.
23 And any other comments from the
24 team? Larry, are you back on? Is he on mute
25 again? Larry, are you on mute?
26 DR. KOSINSKI: Can you hear me now?

1 CO-CHAIR SINOPOLI: Yes.
2 DR. KOSINSKI: I didn't realize I
3 had to hit star 6 on my phone to unmute myself.
4 Anyway, great discussion. I loved
5 the afternoon session more than any of the
6 others. You know, through the course of the
7 morning and early afternoon I felt, you know, I
8 was listening to people describe the elephant.
9 And it just depended on what kind of a
10 situation in which they were working in as to
11 what their views were.
12 But the afternoon session was a very
13 scientific (audio interference). And I came
14 away with my major takeaway being, you know,
15 said at the end was that I wanted to, I think
16 we should be looking at this as not specialty
17 but disease-specific solutions and disease, and
18 integration based upon disease.
19 And I think that's what I was struck
20 with in that last session between Mark and
21 Francois and Rozalina. I mean, she just, I
22 mean, people have to be attributed and then
23 sub-attributed, and buckets of risk have to be
24 created based upon disease-specific nuances.
25 And then you bring in the, you pay the
26 specialists and the primaries based upon what

1 services you want.
2 I thought that was a fantastic
3 session. It's going to make me, it had my
4 gears spinning, and it's going to make me think
5 and think on it.
6 I only -- you know, I listened to
7 what (audio interference) saying. And, you
8 know, this albatross called CMS, I mean,
9 they’ve got to start moving on things or else
10 they're basically going to be, you know,
11 watching Rome burn, because everybody around is
12 going to be (audio interference) in the absence
13 of leadership from CMS.
14 So I certainly hope that what we
15 come up with does impact change and that we can
16 see some forward movement. But the science is
17 certainly there. And with the right data, and
18 data is critical here, with the right data, we
19 can come up with models and solutions for
20 deployment. Great meeting.
21 * **Closing Remarks**
22 CO-CHAIR SINOPOLI: Yep, thank you,
23 Larry. Walter.
24 DR. LIN: Yeah, I also thought it
25 was a great meeting. And I'm still processing
26 a lot that was said.

1 But I'd like to just offer something
2 that's probably very controversial and play
3 devil's advocate here, right, because we heard
4 about all the complexities of trying to
5 integrate specialty care into total based cost
6 of care and find the ideal payment model to do
7 that.
8 I've come away from today thinking
9 it's not out there. I haven't heard anything
10 yet in terms of a good way to engage
11 specialists in total cost of care and kind of
12 help them share in the savings.
13 And so I'm left wondering, maybe the
14 status quo is okay. Maybe we still have
15 specialists kind of work off of a fee-for-
16 service RVU system and have the risk-bearing
17 entity be at the, you know, at the
18 organizational level through the primary care
19 provider, and let the primary care provider
20 decide through his or her referrals how to
21 manage specialty costs.
22 You know, I think, you know,
23 Rozalina did a great job of going through all
24 the complexities of attribution. And then I
25 think Lili Brillstein mentioned you need to
26 keep it simple, right, keep it simple.

1 And I think if we just have one
2 accountable entity, and I think that's
3 naturally the primary care provider for a
4 variety of reasons, maybe that's enough.
5 And I think perhaps Ann Greiner
6 might have been kind of hinting at that through
7 her comments in the very first session this
8 morning, especially as she talked about some of
9 the ways other countries are approaching this.
10 And maybe I'm reading too much into that.
11 But in any case, just to offer a
12 kind of counterpoint to everything we're doing
13 today.
14 * **Adjourn**
15 CO-CHAIR SINOPOLI: Thank you for
16 those. Any other comments? Well, if not, I
17 think that's the end of the meeting. And we'll
18 adjourn. And for the first time today, we'll
19 do the gavel.
20 (Whereupon, the above-entitled
21 matter went off the record at 4:47 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Public Meeting

Before: PTAC

Date: 03-02-23

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Court Reporter