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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Tuesday, June 13, 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
TERRY L. MILLS, JR., MD, MMM
SOUJANYA R. PULLURU, MD
JAMES WALTON, DO, MBA
JENNIFER L. WILER, MD, MBA

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

A-G-E-N-D-A

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

9:03 a.m.

* CO-CHAIR SINOPOLI: Good morning and welcome to day two of this public meeting of the Physician-Focused Payment Model Technical Advisory Committee known as the PTAC.

My name is Angelo Sinopoli, and I'm one of the co-chairs of PTAC along with Lauran Hardin sitting here beside me.

* **Welcome and Co-Chair Update - Discussion on Improving Management of Care Transitions in Population-Based Models Day 2**

Yesterday, we began our day with opening remarks from CMS[1] Deputy Administrator and CMMI[2] Director Dr. Liz Fowler.

She offered some context on how our work fits into the Innovation Center's vision.

We also had several guest presenters share their ideas on financial incentives for improving care transition management.

Today, we have a great lineup of experts for two more listening sessions today.

1 Centers for Medicare & Medicaid Services
2 Center for Medicare and Medicaid Innovation

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

Later this afternoon, we'll have a public comment period. As a reminder, public comments will be limited to three minutes each.

If you have not registered to give an oral public comment, but would like to do so, please email PTACregistration@NORC.org. Again, that's PTACregistration@NORC.org.

Then, the Committee will discuss our comments for the report to the Secretary of HHS[3] that will be -- that we'll issue on improving the management of care transitions in population-based models.

*** PTAC Member Introductions**

Because we might have some new folks who weren't able to join yesterday, I'd like the Committee members to introduce themselves and share your name and your organization.

If you'd like, you can tell us a little bit about your experience with the topic

3 Health and Human Services

at hand, and we'll cue each of you as we go around the table.

I'll start. My name is Angelo Sinopoli. I'm a pulmonary critical care physician by training. I've been on PTAC now for almost five years.

I am the -- presently the Chief Network Officer for UpStream, which is a value-based company that supports primary care physicians. And prior to that, was the Chief Clinical Officer for a large integrated delivery system with a large integrated network.

Lauran?

CO-CHAIR HARDIN: Good morning, I'm Lauran Hardin. I'm a nurse by training and Chief Integration Officer for HC2 Strategies.

I spent the better part of the last 20 years focused on underserved populations, originally leading care management and ACOs[4] like MSSP[5] and BPCI[6].

Then, was one of the founding members of the National Center for Complex

4 Accountable Care Organizations
5 Medicare Shared Savings Program
6 Bundled Payments for Care Improvement

Health and Social Needs, worked with communities around the country, payers, health systems, states on designing models for complex populations.

And now, working deeply on building integrated systems of care, networks of care in communities.

DR. BOTSFORD: Good morning, I'm Lindsay Botsford. I'm a family physician in Houston, Texas.

I am Market Medical Director with One Medical where we care for older adults on Medicare both in the Medicare Advantage space and in the ACO REACH[7] model.

DR. WALTON: Good morning, my name is Jim Walton. I'm a general internist by training and currently the president of my own consulting firm for health care value-based work.

I had a long career as a CEO of a large independent physician association in Dallas, Texas. And developed an Accountable Care Organization with multiple payer value-based contracts.

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7 Realizing Access, Equity, and Community Health

Prior to that, I was the Chief Health Equity Officer for the Baylor Healthcare System.

DR. LIAO: Good morning, I'm Josh Liao. I'm an internal medicine physician at the University of Washington in Seattle.

There, I also serve as the Medical Director for Payment Strategy. And in that capacity, work with population health, value-based care, and a range of teams to implement changes under value-based payment models like the ones we're talking about at this meeting.

I'm also fortunate to lead an evaluation and research group that studies and evaluates national and regional models.

DR. PULLURU: Good morning, Chinni Pulluru. I'm a family physician by trade.

I'm Vice President of Clinical Operations and Chief Clinical Executive for the Walmart Health Omnichannel business that manages the professional entities, as well as the clinical care in clinics, telehealth, and social determinants of health.

Prior to that, I led a large medical group named DuPage, or Duly Health and Care,

where I'm -- as part of my portfolio, I managed our value-based care service line and its subsidiary MSO[8] which helped clients on the path to risk.

Thank you.

DR. WILER: Good morning, I'm Jennifer Wiler. I'm the Chief Quality Officer for UC Health in Colorado Metro, a tenured professor at the University of Colorado School of Medicine, and I'm a co-founder of UC Health's Care Innovation Center where we partner with digital health companies to improve outcomes of care for patients.

And I was a co-author of an Alternative Payment Model that was reviewed and endorsed by this Committee.

DR. MILLS: Good morning, I'm Terry Lee Mills. I am Senior Vice President and Chief Medical Officer of CommunityCare of Oklahoma, a provider-owned regional health plan operating in the commercial ACA[9] Marketplace and Medicare Advantage space.

I'm a family physician by training.

8 Management Services Organization
9 Affordable Care Act

And prior to my current role, I worked in large multi-specialty groups and health systems and operated and led multiple innovation pathways including ACOs, MSSPs, BPCI, Primary Care First, and CPC[10] Plus.

DR. LIN: Good morning, I'm Walter Lin, internist by training, founder of Generation Clinical Partners. We are a medical group that focuses exclusively on the care of the frail and multi-morbid elderly population living in senior living.

CO-CHAIR SINOPOLI: And we have one member that will be joining us a little later today.

And then, we have one member online. Jay, you want to introduce yourself?

DR. FELDSTEIN: Sure. Good morning, everyone. My name is Jay Feldstein. I'm the President of Philadelphia College of Osteopathic Medicine. I'm an emergency medicine physician by training.

And prior to my current position, I've spent 15 years in the health insurance world, both in commercial and government

10 Comprehensive Primary Care

programs, the last seven in Medicaid running five plans with five different states, and am very familiar with risk, full risk, and fully capitated and shared risk models.

*** Listening Session 2: Financial Incentives For Improving Care Transition Management**

CO-CHAIR SINOPOLI: Great, thank you for that, Jay.

All right, so, at this time, I am excited to welcome the experts on our first listening session of the day which is around financial incentives for improving care transitions.

We've invited three experts to present their thoughts on some financial incentives with potential to improve the management of care transitions.

You can find their full biographies posted on the ASPE PTAC website along with their slides.

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

Presenting first, we have Dr.

Richard Gilfillan who is now retired, but previously led both Trinity Health and Geisinger Health Plan.

He also served as the first Director for the Center for Medicare and Medicaid Innovation.

Rick, welcome.

DR. GILFILLAN: Well, thank you, Angelo, and thank you, Lauran, and to the rest of the PTAC. My thanks for the opportunity to be with you this morning. And thanks, Amy, for all the support from you and your team.

Just a brief introduction, as I looked at my slides, I thought, gee, they're a little negative. They might be coming across as being a little negative. And I thought, that's not the right spirit.

So, I just want to start by saying, you know, the reality is, we have had, over the last, I think, 13 maybe more years, an incredible learning across the health care system about what it means to actually deliver better care for patients, and more patient-centered care, and care that is focused on delivering better outcomes and lowering costs

for the payers.

I think that's real. We've had an incredible engagement by, you know, probably millions of people at this point who are health care providers, trying new things, testing different models.

We've had new payment models from lots of players. And we've just learned a ton.

So, the reality is, I think it's important to look back and say, we know a lot more now than we knew in 2010 about what it takes to deliver better care, hopefully, it delivers better outcomes at lower costs.

What we have not been successful at is scaling the will to invest and transform institutions to deliver on that knowledge, I think. And I think that's what I'm going to try and provide a little context around today. And that's what my comments really get at.

So, I look forward to going through these quickly and then, the conversation.

So, as I said, you know, the storyline I think, to date, is one of impressive engagement, limited results.

We've seen extensive engagement, but

the reality is that most of the models that we put out there have provided limited business opportunity for the providers who are doing them.

And the result has been very limited investment and limited commitment.

And so, we have to be careful about evaluating things, evaluating models when they're implemented in a context where people are half-heartedly implementing them, which I think is often the case.

I think it's also been the case, we've seen from most private payers have not followed CMS' lead in implementing Alternative Payment Models that facilitate or that require good transitions management.

And then, of course, COVID, the incredible work on by health providers naturally stalled some progress on this. And post-COVID now, we see people emerging from very difficult financial circumstances for many health care organizations.

Next slide?

The results, obviously, ACO growth has been dramatic. It's over 12 million now I

believe. I believe we've seen proof of concept of the ACO model. We've seen it from the pioneer earliest days which were documented.

And we've seen it on an ongoing basis in that the best performers save a significant amount, many over 10 percent.

And the problem has been, you know, we've had this ratcheting of the baseline in the benchmarks that makes it impossible for that to continue. But of course, overall, savings are limited, as has been demonstrated, modest quality improvement.

You know, when you average the results of people making a lot of investment, people making not much investment, you get small results on average.

And to me, I think we miss the point if we try and evaluate a model based on the overall impact. We should be looking at the proof of concept. Have people consistently demonstrated that operating under a model will actually change and improve outcomes? And I think we clearly have that.

I think we have also learned, and this was actually one of the purposes of the

early CPC model. Can primary care models alone deliver lower costs and better quality? And the answer is, I believe, is no.

We've learned that. We've learned it through three iterations of these models. And I think that that is a lesson that I think primary care models should be embedded in broader population health models in order to test their ability to make a difference.

I think we saw BPCI decrease costs. You're going to hear more about that later today, but the nature of the payment relationship with CMS was such that a voluntary arrangement was such that it didn't result in overall savings.

Again, wrong conclusion to say the model doesn't work. Right conclusion to say, it was -- it demonstrated proof of concept. We need to change the context, that is, I believe, we need to make it mandatory not voluntary.

We've -- interesting, not a lot of results from a couple of specific readmission reductions programs.

And we've seen -- we have learned, I think, also that we need to pay explicit

attention to addressing inequities. Because the way we went at it did not, if anything, it may have made inequities worse.

Next slide.

Learnings, as I said, you know, lots of learnings already. Clinicians like doing the work, which I think is really important. But voluntary doesn't work by and large.

People -- change is hard. People don't want to change, generally speaking. And if you don't give them a strong reason to do it, they just don't make the investment.

So, they've taken advantage of many of the programs, but haven't really gotten down and dirty and done the work necessary to transform their organizations.

So, we understand what it takes, I think. And you're going to hear -- we're going to talk some more about some specific models. We've learned what it takes. We need to get to a point of actually creating the institutional will to transform.

And that includes on plans because they are not, I think, have not been addressing , have not been supportive of this

transformation by and large.

The accession, primarily at this point today is around MA[11], because MA provides easy money, to be honest, as we've written about in other places.

Next slide.

Current stance, I think participants, kind of where are they coming from? This is, you know, this is my take on it.

For payers, value-based care, it's all -- it's a catch all where they throw it all around lots of places. It fundamentally translates into risk coding for money, the money machine deals.

The Medicare Advantage that we've talked about, we've written about, Don Berwick and I and others.

And I think that's, quite honestly, the overwhelming force in the marketplace right now driving all the investment. And it's easy money, so people go after it naturally.

On the integrated health systems side, clearly, still recovering, limited

11 Medicare Advantage

commitment, although continuing and addressing -- trying to get into the MA game, I would say.

ACOs have been remarkably staying in the game, and the physician ACOs have been very successful, I think, well, many have been successful. It's getting harder and harder, I think, but nevertheless, people have remained committed, and I think that's a great sign.

For PCPs[12], you know, the reality is if 75 percent are employed by other institutions, the thought process around what it takes to provide incentives for primary care physicians to actually engage in a big way needs to be targeted and thought through very clearly.

A lot of -- right now, we have these small disrupter organizations of mainly MA-focused primary care entities that are, again, I think primarily focused on coding and, to a lesser extent, on the care model.

And we have these large disrupters now, the Amazons, the Googles, et cetera, looking to grab pieces of the delivery system, a little bit of an unclear strategy, but I

12 Primary care providers

think driven primarily by the belief that there's just too much money out there to ignore and not be a part of.

Next slide.

So, I think the fundamental reality in the APM[13] world is we've created this unlevel playing field between MA and ACOs. I'm not going to go through each one of these, but suffice it to say, that on virtually every dimension, we have made it easy to make money in Medicare Advantage and hard to make money in ACOs.

Notwithstanding that, people have persisted in the ACO business. I think to some extent now, people in REACH are thinking about ways to move people into MA as the primary business opportunity. And I would be an advocate for trying to find ways to level the playing field, make it more reasonable as CMS could, to some extent, recently would be new regulations around risk coding.

Next slide.

So, my conclusion, voluntary models, you know, lots of potential -- promising

13 Alternative Payment Model

potential payments, you know, or penalties or losses, 18 months later, they don't work. They don't drive aggressive investment.

The implementation and transformation is, you know, weak.

And in a world where you've got easy money to make -- be made on the MA side, it's hard to get people to make the investments necessary.

So, I think, you know, I -- if you think about, Angelo, a guy like you who's, you know, Chief Population Health Officer sitting on a management team, you know, where everybody's talking about revenue today, and the expenses today, to sit there and say, I might be able to deliver a couple of million dollars or $5 million 18 months from now if you give me this money to invest today.

I just think, generally speaking, it is not an investment that people take seriously. And I think you probably need to move to capitated models where the money's all in the bank. And now, people can have a serious conversation about how to redesign here.

What are the elements? What are the care models? Et cetera.

So, I think that's kind of my thinking about the situation at this point.

Next slide.

So, in thinking about -- when looking at models, you need to look at this issue of, you know, why don't -- why haven't we seen large-scale programs and more impact on them?

Limited intervention, limited investment, change is hard. People won't do it without a good reason.

There's lack of a clear evidence-based clinical delivery model in some ways. But actually, it's -- I would say, there's much more evidence of aspects of the care model that we know about that will work at this point.

This evaluation focused on average result versus demonstrating proof of concept, I think, has limited CMS' willingness to actually engage. The lack of payer engagement is a real thing. And real care delivery, change takes time. It doesn't happen quick. I mean, it took us, you know, 15 years to get maximum

impact from DRGs[14], and those are mandatory.

And then, again, the MA focus dilutes attention, I think.

And the final slide.

So, some questions to think about, you know, be clear about what we're testing. Are we testing a care delivery model? Are we testing a payment model? Are we testing both?

I think we need -- I think we're not as clear about that as we could have been in the early days.

What's the objective? How does it impact health inequities? Who are the target providers? We need to be really clear about that because we have to ask the next question is, why will those target providers make a serious and effective investment and effort?

And if we can't answer that, the answer is, they won't. That's another absolute learning that we've had.

Then, how do we structure the test to make it fast and adaptable? I think it is important to try and give this information as quick as we can and to be adaptable in its

14 Diagnosis-related groups

pursuit.

And then, we have to ask, what is -- what's considered positive? Is it average, overall savings? Or is it proof of concept? I think is an important question.

And if the positive -- if the test is positive, what is the next step? And for CMS, this is, you know, are we going to be able to scale this?

And I think the question, and one thing I think we missed early on, was asking this question and saying, is the test structured to justify the next step?

And voluntary testing, as we did early on and still are doing to some extent, raises the question of, will the outcomes be the same in a mandatory world? Right?

And I think we've, kind of, have lost track of that a little bit, and I think we need to revisit that. Because there's no sense in doing the test if, in fact, it's just going to raise questions about whether or not we can go ahead and scale it.

So, I'll stop there. Thanks.

CO-CHAIR SINOPOLI: Thank you, Rick,

that was great.

Next, we'll hear a presentation from Dr. Mary Naylor who joins us from the University of Pennsylvania.

She is the Marian S. Ware Professor of Gerontology at their School of Nursing, as well as the Director of the New Courtland Center for Transitions and Healthcare at Penn Nursing.

Mary, please go ahead.

DR. NAYLOR: Thank you. I want to thank the Committee, Lauran, Angelo, and all the members. And I'm delighted to be here today with Rick and Grace to engage in this conversation.

So, I titled my few remarks, Evidence-Based Transitional Care is not Just a "Good Idea." And this is a play on a book led by Mark Pauly who's been a lead health care economist on our work for the past 30 years. He wrote a book last year, Seemed like a Good Idea: Alchemy Versus Evidence-based Approaches in Healthcare.

We received very significant attention in this book in our discussion of the

evolution of the transitional care model. And I'm using transitional care model versus TCM[15] so we don't get concerned about -- this isn't about the codes, this is about a model of care.

It is a 30-year model, but it's not 30 years -- over those 30 years, a lot has taken place. We've had an evolution of this work that's been informed by multiple randomized clinical trials, NIH[16]-funded randomized clinical trials, comparative effectiveness studies.

And in the recent times, real active work, partnerships with health systems, with communities in multiple diverse contexts to really understand what it takes to move evidence in a meaningful way to redesign transitional care for older adults and for their caregivers.

I had the great fortune of listening in yesterday and wanted to highlight that the kind of work we do is really somewhat agnostic to where someone begins to experience an acute episode of care.

15 Transitional Care Management
16 National Institutes of Health

So, we've worked with primary care to extend the walls of primary care through care transitions, through the transitional care model.

We've worked in the context of thinking about transitional care as part of a longitudinal care approach to older adults living increasingly with complex health, social, and behavioral needs.

But today, I'm going to focus on what I consider as at least one significant opportunity on the path -- the path you're on to take us from where we are today to, in the next 10 years, moving the needle in terms of transitional care for older adults more to a value-based approach.

So, I have two recommendations. I'll start with them, work through it, and then, bring you back to them.

Within the Medicare fee-for-service system, my recommendation is that we implement an episodic, 60-day case rate per member for evidence-based transitional care services provided to hospitalized, at-risk older adults and their caregivers.

I have also a recommendation related to the MA program. And that is that, the criteria for the transitions of care star rating measure be strengthened to align with evidence.

Next slide.

So, let's start with a sense of who it is in MA or fee-for-service at risk for poor outcomes. And you heard a great deal about this yesterday, so I won't belabor. But, you know, in this case, Mrs. Jones, 84-year-old widow, she has what many people at the age of 84 have. And that is, the accumulation of multiple health problems, living with medical complexity.

But she is at risk for other reasons as well. And many of these listed here mean that her care, her health concerns are complicated either by cognitive deficits, behavioral health challenges, functional deficits, and evidence of which is often in this increasing rising risk in hospitalization or in the use of acute care services.

Next slide.

So, I'm going to talk, again, about

the transitional care model as we apply it in the hospital to home segment of our care system. And in our work, it is hospital to home, from hospital admission through 60 days. The care in this model is delivered by an advanced practice registered nurse, master's or doctorally prepared, in collaboration with the existing teams in that sector where they're working.

So, with the team in the hospital, and when they move into the community with the primary care physicians, the specialists, the community-based organizations. So, it's this advanced practice nurse who is the quarterback, the hub, throughout the patient's journey, following them from hospital through those 60 days, seven day per week availability.

What is very unique about our work and distinguished it even from the beginning is that we've always thought about this opportunity, with Mrs. Jones being hospitalized as a chance to interrupt the illness trajectory. These individuals are on a path that, if we don't interrupt it, it is likely to get worse over time.

So, our focus is not just on trying to figure out how to address breakdowns in communication or gaps in care, but really to position Mrs. Jones and her care system, her support system to be able to prevent future use of acute care, unnecessary acute care services.

And most importantly, our protocols are based on rigorous evidence, rigorous evidence in testing within the clinical trial framework, but most recently, within the real world of health care delivery.

The core components then are, it's an APRN[17]-led, she's the hub, the quarterback, but it's a team-based approach. And you heard a great deal about that yesterday. It's getting the right people screened who will benefit the most. It is foundational that these -- this work is based on trusting relationships.

We work with large segments of the population who've lived many years of their lives coping with and dealing with systemic and structural barriers to allow them to have access to equitable care. So, maintaining

17 Advanced practice registered nurse

relationships, building trust, rebuilding trust is critical.

We've placed a lot of emphasis on engaging older adults and caregivers. In fact, the entire framework of care delivery here is guided by what Mrs. Jones defines as her goals, what her daughter defines as her goals. And sometimes, those goals do not align.

There's a lot of attention early on in education, but ultimately, to position these individuals to be able to early identify they’re running into trouble and to know what to do about it, to have the systems in place to support it.

It's focused on, as Diane Meier said, the reasons people come into the emergency room and hospital, on the symptoms, on the pain, on the shortness of breath, those factors that bring them in. It places a premium on collaboration. Outreach is done immediately when a patient is identified to the primary care clinician to learn what's going on.

Collaboration with the specialist, with the care teams in both the hospital and in

the community, including teams in community-based agencies, places a premium on something people care about.

Older adults care a lot about the fact that they have one person to whom they can turn throughout an extraordinarily vulnerable time in their lives. And we place an emphasis on coordination, not just making sure referrals are out there, or that referrals are made, but making sure we're using increasingly finite resources in the best way imaginable.

Next slide.

So, let me just briefly walk you through what it's like for someone like Mrs. Jones.

She's hospitalized, and the TCM is initiated. She's screened at day one as at risk for poor outcomes. During her four-day hospital stay, there is this communication, in-person visits wherever possible by the advanced practice nurses. But we work in rural communities, in underserved communities, and often, that is impossible.

So, facilitated video visits can take place to build and establish the

relationship, to assess goals, preferences, and priority needs of both Mrs. Jones and her daughter who's living in another state.

This is a really important factor, and this has been shown over and over again. These advanced practice nurses have advanced knowledge and skills in the care of at-risk populations, this geriatric population. And a lot of the challenges that happen in terms of transitions start in the hospital, delirium often starts there. It can be prevented if assessed.

A lot of the functional decline that Harlan Krumholz and others have talked about has long-term impact if we do not address that on day two, three, and four of that hospitalization.

Sepsis is a challenge that people could be coming in with it or developing there. And it has long-term implications. So, the goal is for this expert to work with the staff to prevent those hospitalizations or hospital outcomes.

And then, obviously, to coordinate the actual transitional care plan with Mrs.

Jones, her daughter, the clinical team, and community-based organizations.

Also know, again, outreach is being made during this time to other people in the communities such as primary care who may know a great deal about this patient.

Next slide.

So, in the -- another core element of this is, and we've known this from study after study of the critical need for immediate follow-up by these nurses into the patient's home.

The same nurse, then, is visiting the patient in the home, making the patient much more willing to receive that individual because he or she has built the trusting relationship.

There, these nurses get to assess home risk, new risk, new challenges, address immediate concerns, complete medication reconciliation, establish a plan. What are you going to do? Here's how you get in touch with me if you have any issues. And making sure that all of the services they had planned for in the hospital are now available.

Next slide.

And in the next couple -- in the next week, that same advanced practice nurse is continuing to work on management of symptoms, not just now medication reconciliation, but helping people to make sure that they know how to take those medication management, making sure that all those medications that should never have been there in the first place are removed.

They join Mrs. Jones on her follow-up visit to the PCP or specialist. This has been essential. We heard yesterday about many systems where when the PCP or specialist are part of the system, there's great exquisite communication through the electronic health record. But many of these people are going to PCPs or specialists outside the system.

This communication enables the clinician who's following in the community to begin to trust the advanced practice nurse. So, a few days later when someone -- something is going wrong in the home, communication can be facilitated between the specialist and the advanced practice nurse to collaborate on what

they can do. And the knee-jerk is not to send the patient back to the emergency room.

Then, this is also during the time when advanced care planning has begun.

Next slide.

Over the next couple of weeks, all of this is happening via virtual or in-person visits, although we have patients who are, at the end of 30 days, really are saying, just call me, just call me, I don't need to be seeing you. I'm in a good position. And so, based on their preferences and their progress in meeting their goals, we make adjustments, obviously, as needed.

A lot of work is going on here on getting these individuals positioned with the health and social services that they need for long-term impact. And again, if aligned with goals, coordinating, and now, I'm going to adapt Diane's comments of coordinating the addition of palliative care. But in some cases, in many cases in our work, is coordinating the transition to hospice for many of these people.

Next slide.

And then, the last visit is all about doing what we cannot afford not to do, and that is the transitional plan being clearly communicated to all the members of the care team who will be continuing to work with these patients, what progress has been made, what goals have been achieved, what are the recommended next steps.

It's essential, as essential that we have a plan in the beginning as transitioning from the transitional care services to the care team who will follow up.

Next slide.

So, the question then is, what is it going to take? This is, again, we have learned so much in the -- especially in the last three years as we've replicated this model in major health systems, VA[18], UCSF[19], Trinity, for example. In the context of COVID, what's it going to take to make sure that Mrs. Jones and all at-risk Medicare beneficiaries benefit from these services?

Well, Rick, I'm going to suggest

18 Veterans Administration
19 University of California San Francisco

that it is a CMMI demo, voluntary. I will say, when this -- when our first paper was published in 1999, Philadelphia Enquirer did a front page story, and they asked me, what's it going to take, Dr. Naylor, for this to happen? And I said, it's going to take a Medicare benefit, mandatory, that's what I said years ago.

But here, I'm suggesting that there should be a path from voluntary to mandatory. It should take the availability, I mean, we have spent years developing tools that support widespread implementation of the evidence-based transitional care.

You cannot -- we failed miserably when we sent all of our protocols wrapped up in bows from Pennsylvania to Kaiser many years ago as one of our first efforts to implement the evidence-based solution. This really takes the tools, training programs which we have developed, tools about how to engage patients, tools about how to promote and facilitate the kind of collaboration.

I'm recommending an advanced payment to an accountable entity. It could be an ACO,

CBO[20], post-acute hospital provider. But an entity to build the cross site partnerships and infrastructure that are needed to make this happen. This is how we start every relationship with our systems. We first build the partnerships. We build the plans for communication.

It will take calculating an episodic case rate, 60 days, and shared savings methodology, and changes in the risk adjustment methodology to account for both medical and social complexity.

Within the Medicare Advantage, it will require a review of the criteria used to measure transitions of care, and revisions based on available evidence. It is not adequate to have a criteria that says, you need to see a patient within 30 days as a review criteria for transitions in care.

So, we know what it takes, and our evaluation and measurement should take this into account.

Next slide.

And what are the key design

20 Community-based organization

features? I think that the participating entities must agree to the following.

Evidence of cross site partnerships, a plan to implement an evidence-based solution.

Let me say this here, this is important to us, we've learned, you don't transplant a model onto an organization. Organizations have major strengths, communities have major assets. This is an asset-driven model designed to fill in gaps. So, we worked with partners, Boston Medical Center, for example, who's implemented the transitional care model with a very high-risk population and seen fabulous results.

And what they've done is they've used an advanced practice nurse and a community health worker as a team to deliver. So, you have opportunities here to innovate and constantly learn. All of our efforts within all of the organizations with whom we've had the great fortune to work, we've learned from that about how to augment and build solutions.

It would require commitment to assess key process, documentation of fidelities to the proposed solution. And the proposed

solution should be aligned with evidence, with what we know are core components, as well as to assess outcomes, including patients' experience with care, goal attainment, days at home.

And a commitment, obviously, to absorb care costs from the index hospital discharge, we propose, to three months post-index hospital discharge.

Next slide.

So, back to where we started, my key recommendations are 30 days are not enough. It took Mrs. Jones 84 years to accumulate all the health issues and challenges in a context that has not always been responsive or honored what it is that she wanted and needed. And it will take more time than 30 days to be able to reposition her.

And for Medicare Advantage to strengthen the criteria. We should have really stringent criteria or, at least, evidence-based criteria in star rating measures.

Thank you.

CO-CHAIR SINOPOLI: Great presentation, Mary. That was very informative. So, next, I'm excited to introduce Dr. Grace

Terrell, who is one of the founding members of PTAC and a former Vice Chair of the Committee. Grace is a Chief Product Officer now for IKS Health.

Welcome back, Grace. Go ahead.

DR. TERRELL: Good morning, and I just want to first of all say that I am really honored to be asked to speak today on the topic of transitional care as it pertains to the physician-focused payment models.

As that former Vice Chair of PTAC, it has given me great pleasure to see the evolution of the ongoing work that we started way back in 2015. So, I'm really pleased to be here today.

For those of you that do not know me, I'm a practicing general internist who has held many roles in the health care industry, including leading the multi-specialty medical group that was early in the value, a genomics start-up focused on developing an ecosystem for diagnosing and treating rare diseases, and an integrative primary care mental health medical practice delivering care to medically vulnerable adults residing in skilled nursing

facilities, assisted living, or homebound.

And most recently, as you just heard, I'm Chief Product Officer of IKS Health, which is a provider-enablement platform that's focused on eliminating the unnecessary chores that affect the lives of our clinicians so they can focus on their core mission: delivering high-quality, affordable care to patients with excellent outcomes.

So, I have a personal mission statement that explains my rather eclectic career path. I will use all of my talents, scars, and experiences and work with other people to radically improve the U.S. health care delivery system.

It is from that perspective that the work I participated in with PTAC was so meaningful for me. That work and the diverse work of my medical career has taught me that real change in health care requires a fundamental redesign of three aspects of the health care delivery system: the patient care model, the payment model, and the operational model of the delivery system.

These three aspects must be

redesigned in tandem and integrated into a comprehensive transformed delivery system, but this is easier said than done. Next slide, please.

I learned many things from my colleagues on PTAC and from the many physicians and other stakeholders who brought forth proposals for PTAC to assess. Harold Miller's point of view was that if you pay doctors right, they will do the right thing. And he had thought long and hard about what paying them right looked like.

But there is a widespread skepticism that doctors will do the right thing from the payers and regulators, such that much of the current waste of the health care delivery system can be attributed to excessive documentation requirements, prior authorizations, and other throttles to physician behavior.

Bob Berenson's point of view was a bit different. He was not focused so much on paying physicians right as he was paying for the right things.

Thus, he would often make the point

that many of the excellent care models proposed by physicians to PTAC could be accommodated in a fee-for-service model by paying for the proposed services and not paying for unnecessary services often embedded in the amber of the fossilized RVU CPT[21] payment methodology.

This leads me to my point of view on today's topic of transitional care management. Third slide, please.

From my point of view, the problem we are seeking to address within the wide context wrapped up in the term transitional care is partially the result of what the current fee-for-service payment system has done to silo various components of care for patients.

Specifically, in my specialty, internal medicine, which was once a comprehensive discipline focused upon care of adult patients with non-surgical medical problems, it has disintegrated into a number of different types of jobs based upon how adequately and efficiently providing care in a

21 Relative Value Unit Current Procedure Terminology

single setting with a single form of payment can be done.

In the 1990s, the early managed care movement created copayment differentials between specialists and primary care physicians in the ambulatory setting, and suddenly, family physicians, internists, and pediatricians, three specialties with different training and skill sets, were suddenly lumped together under the new rubric as PCPs.

The hospital DRG payment reform created the need for more efficient care in the hospital setting, and a group of internists just focused upon delivering care in the inpatient setting became hospitalists. Later we got SNF[22]ists, laborists, proceduralists, and with the advent of Medicare Advantage plans focused on containing the cost of patients likely to be admitted to the hospital, we got extensivists.

The telling aspect of these divisions is it was not necessarily built upon a deeper need to specialize based upon an organ system or disease, such as a pulmonology or

22 Skilled nursing facility

infectious diseases point of view, but around the efficient use of generalist physicians in seeing a group of patients in a single setting with a single payment model.

The positive aspect of this change is the more efficient and possibly higher quality of care that could be provided by clinicians dedicated to a single type of care, whether it's with acutely ill patients in the inpatient setting, ambulated care, skilled nursing facility, or what have you may exist.

But this has a tremendous downside as well. Handoffs from providers from one setting to another lead to issues with access, loss of information, inadequate understanding of both the chronicity of medical problems, as well as understanding the significance of changes in conditions.

Much more emphasis has to be placed on longitudinal care planning, handoffs, documentation, follow-up, medication reconciliation, and health information exchange. At every handoff, there is a risk of losing access to care, deterioration in information, and patient safety concerns.

When patients transition between providers or care environments, they are at increased risk for harm. Factors that contribute to suboptimal transitions include poor communication between health care team members, incomplete transfer of information, and inadequate patient education.

In the hospital setting, two-thirds of sentinel events occur in the setting of inadequate handoffs. The transition from hospital to home or SNF to home is far less studied, but likely these same factors are at play.

I thought it was a step forward, for example, that one of the questions on my internal medicine recertification exam two months ago emphasized that a phone call to a patient within 48 hours of hospital discharge for acute decompensated congestive heart failure and a prompt physician appointment within seven days to review the medication list and assess volume status and adherence to diets and medications reduces the risk of heart failure admissions. That was new.

Based upon evidence that a physician

visit within seven days of discharge and early phone contact improved patient outcomes and reduced -- and reduces readmissions, CMS developed the transitional care code several years ago. This fee-for-service approach to the problem is built upon the concept that pay for the right things, and physicians will do the right things.

These codes pay a higher reimbursement rate than the usual evaluation and management codes, and rewards ambulatory physicians for providing access to patients early after a hospitalization or SNF stay, but create more documentation burden to demonstrate the medication reconciliation review of hospital records, et cetera, et cetera, has occurred. That's a fee-for-service payment model approach.

There's a patient care model approach I'm aware of that looks quite different from this. In 2019, just prior to the pandemic, I worked part-time in the Wake Forest Health Network’s transitional care clinic.

This program had been developed due

to the belief that a certain number of patients with multiple co-morbidities who were discharged from the hospital were not receiving adequate care from their primary care physicians, even with the use of TCC[23] codes, due to access issues and operational efficiency issues. So, for patients in Medicare Advantage risk contracts or the ACO next generation risk contracts who were identified as being of a high risk for readmission, they were seen by a dedicated team at the transitional care clinic. This team consisted of a group of general internists, advanced practice providers, clinical pharmacists, social workers, certified medical assistants, phone triage, and front desk staff who saw these patients within 72 hours of discharge and did comprehensive care needs assessments, including clinical pharmacist-led comprehensive medication management, social risk assessment, pre-visit summaries and gaps in care assessments, and daily huddles. The clinicians would see the patients quite frequently until they were deemed stable enough to be transitioned back to

23 Transitional care codes

their primary care medical home.

Now, there's several points I'd like to make about this clinic. In many ways, it's yet another cut along the continuum of longitudinal care, a place in space now between the hospitalists and the primary care physician, which has its own issues with respect to discontinuity.

In some organizations, hospitalists had an extension of their own practice in the second setting rather than a whole separate, dedicated team which potentially could take care of that issue, provided it was adequately integrated operationally with the hospital's service model.

But part of why it worked at our community is that the additional resources of clinical pharmacists, social workers, et cetera, cannot be staffed in all primary care clinic settings efficiently, as the individuals who would need this comprehensive multi-disciplinary care would make up a small component of the average primary physician's ambulatory practice.

Additionally, a care team with

social workers, clinical pharmacists, physicians, and advanced practice providers is an expensive resource, and the increase in transitional care code fees does not in any way cover the cost of these professionals. So, the benefit of this service was only available with patients in risk contracts.

And there was constant skepticism on the part of the health system finance team, or so I was told, that this expense might not be necessary. It was hard to prove the value in real time because reduction in readmissions compared to usual care is difficult to normalize in the real-time clinic world. Next slide, please.

My recommendation to you today is to always think through the payment models and care models together. And we need to think hard about how to study and measure what works.

For example, about 10 years ago, the independent medical group I led at the time, Cornerstone Healthcare, was working on a lot of care models for different high-risk patient populations. Like a model for our congestive heart failure patients that embedded a

behavioral therapist in the heart failure clinic because there was evidence that depression and anxiety were high drivers of hospital readmissions in heart failure patients.

We embedded a general internist in our oncology clinic because data indicated that non-cancer medical problems inadequately addressed in patients with active cancer led to unnecessary admissions and higher falls.

We had a co-managed strategy with an internist and a psychiatrist in our Medicaid/Medicare dual eligible clinic, an embedded pharmacist in our complex care clinic. All of these clinics reduced admissions, improved quality, and lowered the cost of care within 13 months of initiation.

But it took us a long time to get our results published, and ultimately, only as a case report because these were not controlled trials. We were simply redesigning models of care to "do the right thing." It seemed to work.

The closest we came to a transitional care model back then with any

semblance of scientific evidence was a care model we designed for patients with COPD[24] who had been discharged from the hospital. Our intervention was to send a respiratory therapist tied to our pulmonary critical care practice to their home post-discharge.

We studied our COPD readmission rates post-intervention, which was significantly improved, and had a natural case control with a hospital-on-hospital service in the same facility that did not participate and whose patients continued to have a high readmission rate.

It was my observation while serving on PTAC that most of the proposals we received for evaluation were thoughtful, probable, better care models similar to the ones that we did 10 years ago, and that the clinicians proposing them were asking to be paid for "doing the right thing."

For many of them, the difficulty was that marrying that to Alternative Payment Models that they were often -- they often focused on how to make the care model fit with

24 Chronic obstructive pulmonary disease

the Advanced Alternative Payment Model criteria as defined by CMS to get their five percent bump in fees and opt out of MIPS[25].

In reality, I don't think that there are any new ways to pay for medical services. The fee-for-service, the pay-for-performance bonus, to shared service, to shared risk, to partial capitation, to full capitation risk is really all there is along the continuum.

So, the real issues for transitional care management or any other proposals that come before PTAC is to start with the basic questions of: Is this the right thing to pay for? And if so, what is the right way to pay for this?

Over the course of the next few years, these type of questions will become easier to answer because information integration will be exponentially more nuanced with the maturity of machine learning tools in the payment world. CMS will be able to parse high-value care and outcomes in ways that have been previously been unavailable. We need to be moving to precision medicine in the broadest

25 Merit-based Incentive Program System

sense of the word, including precision payments for the real cost of services and outcomes.

A perfect place to start would be the transitional care delivery space, where there remains ample room for innovation while data continues to accumulate with respect to those who are providing what type of care at these crucial junctures.

So, my recommendations are very basic. Start with these basic questions of is this the right thing to pay for, and what's the right way to pay for it? And then, let's really start incorporating information integration to look at how we can start really understanding what works.

And then let's pay attention to how payment models lead to delivery system operational changes. We've seen this, as I illustrated, in the past with distinction between specialists and PCPs, hospitalists, SNFists, extensivists. If we pay for transitional care in a new way, we'll get some new -ist, -ologist or something out there too, because that's what the payment system has done to the way we provide care.

And let's consider the transitional care delivery space as an ongoing innovation space. That can be an effective area to understand how best practice care models properly paid for can markedly improve patient outcomes.

Thank you.

CO-CHAIR SINOPOLI: Thank you for that, Grace. Now I'd like to open up the discussions to our Committee members for questions. And to indicate that you have a comment or question, please flip your name tent over.

I'd also like to -- since we have such a great panel today, to offer the opportunity that if they want to ask each other questions that might be beneficial for our PTAC colleagues, to feel free to do that.

I'll start out with one question just to kind of get the juices flowing, so to speak. So, Rick made a good comment that, you know, in today's world, sometimes it's very difficult to get the owners, the entity, to fund certain things like transitions in care, mainly because they're not sure that there's

going to be a return on investment at the end of the year or at some point in the future. And I really like the model you described, Mary.

So, my question is, as we did a proposal to a health system or an ACO to invest in the transition care management team as you've described, which I love, what would we propose to them would be the quality and financial outcomes that we would be measuring over the course of the following year to show that these were effective models?

DR. NAYLOR: So, first, I think the most important from our perspective is that patient's experience. And that they're incorporated in that. We've been tracking very carefully what are the factors that people consider essential during this time.

And we have very -- three or four messages that we hear all the time. That there was somebody to whom I could turn when I had questions or concerns that I trusted. That you cared about what mattered to me. And that I always felt you had my back. So, we have actually, literally questions.

Of course, we measure quality outcomes in terms of symptom status, functional status, and perceived quality of life. Very simple measures.

In cost, we are very deliberate in understanding what does it cost to deliver. So, we carefully measure over the course of the time what is the additional cost of the intervention in both direct care and indirect care, and then what is the return.

And so, in the clinical trials, we were able to demonstrate reductions in one trial with heart failure, older adults with heart failure, reductions in all-cause readmissions through 12 months, post-index hospitalization at a mean savings of $5,000 per Medicare beneficiary after accounting for the additional cost of the intervention. And this has been replicated in multiple studies.

So, I think what we're looking for is to communicate to decision-makers that this is an opportunity to both improve patients' alliance with you as a health system, to help them achieve what is important to them, to reduce all-cause readmissions, all-cause use of

emergency department services, all of those things, and to do so in a way that is making much better use of increasingly finite Medicare resources.

CO-CHAIR SINOPOLI: Right, great answer. Rick, would you like to comment on that also?

DR. GILFILLAN: Yes. Thanks, Angelo. A couple of thoughts.

I think on the issue of, like, paying, you know, paying for the right service, like, I think it's true that if you pay a doctor to take out an appendix, she will take out an appendix. Okay. And she can do that with a knife and a couple of nurses in the OR, whatever. Right?

Saying I want to get the results of an effective care management program is not amenable to giving a payment to a doctor, right? It's not about that. It's about creating a context, as Mary has described, and as Grace described also. And payment for that just doesn't get it done.

It creates the context in which a doctor says, what's the least I can do to get

the -- to submit the documentation or to have the documentation so I can get paid, right? It's totally -- they're two different worlds. So, I think it's important to keep that in mind as we think about these.

Secondly, I think as CMMI thinks about models, you know, I think we didn't -- we didn't -- here's what I would suggest, I would go to CMMI with. I would say to them, you know, let's take the issue of the cost of Mary's model off the table. We will give you the money it costs to implement Mary's model.

And I'm not trying to say only Mary's model, but let's put -- let's take the dollar investment by -- and I would only put it in the context of an ACO that has the broader incentive systems, incentives operating to deliver lower cost and reduce readmissions.

I would say okay, ACOs. We will actually give you the what, $600 per member, whatever it is to implement Mary's model. Show us that you have implemented Mary's model, because what we're testing here is Mary's model. And pardon me for personalizing it, Mary, but no one has been more persistent on

this topic that I know of – then Mary. And say okay, let's find out whether the model works.

And then we'll see what the savings are, right? We can talk about shared savings. We can track it. But take the investment issue off the table and say we want to test the actual implementation of this model, or maybe that model versus others.

Unfortunately, in the -- as Mary reminded me, in the TCM model, we add, you know -- nobody did Mary's model. I think the reason, quite honestly, was because it was too expensive, and people made a decision not to invest. They did the chronic care model, which is what they were doing anyway, so they figured they could just kind of get the benefit of the program that way.

So, I think it's important to think about what it would take to actually get an institution to make the investment to do the model that we want to test, and then see the results.

That way, hopefully, we get a full-blown implementation and see the results of it, as opposed to a, you know, piecemeal, minimal

investment, how can -- you know, you get the CFO, as you say, you know, saying, you know, what's the return going to be?

Let's be specific and clear about testing a model, and let's put it in a context in which the overarching system, presumably to some extent, at least, has the incentives to actually reduce utilization and improve care.

CO-CHAIR SINOPOLI: Perfect. Thank you. Grace?

DR. TERRELL: So, I agree with Rick. The point I was making is that we created the transitional care clinic, or Wake Forest did, because the TCM alone wasn't working. You have to have those resources.

One of the complexities of the problem -- and it really almost is a workflow issue, and Mary's done so much work through the years of working out those various components of what you're actually trying to do -- is to understand where those resources are and how you're going to put them together for any particular community that it would work.

So, what we did in our particular care model, in a community of 100,000 people

with hospitals and a large medical community there, could not be done in a rural area where the same needs might be there.

So, part of what needs to be thought through within the care model and the payment model discussion is to understand what the basic needs are, the basic things we're trying to do, and understand the different environments that are going to require some nuances. So often, what ends up happening is that you -- we create criteria for what we're going to pay for. They simply do not work in certain environments.

So, I think one of the problems with the current transitional care management code is that to really do transitional care management right, it takes more than just the minimal types of documentation, and seeing the patient within a few days after discharge, and saying that you've looked over the medical record. All those things that Mary was talking about are much better care in today's environment, but how you actually accumulate those things from one medical setting to another is nuanced.

And we probably need to be thinking about that as we're putting together the payment models and care model discussions so that we don't get so rigid with it that it just is not going to work across the various types of communities.

DR. NAYLOR: And I did want to highlight, if I might here -- this has been actually our work for the last 10 or 15 years, is to say how can we make an evidence-based solution add value to the work in rural contexts, with VA, with veterans, with very diverse population? The work has been trying to figure out what will it take to be able to make evidence foundational to redesigning care in multiple contexts with very diverse populations?

I mean, the clinical trials were one thing where we were able to test it increasingly with very diverse populations, cognitively impaired individuals with a range of chronic health problems, et cetera. So, that was foundational, but the last 15 years have been implementation.

That what does it -- how do you

position organizations to be able to create the network, to be able to talk to each other, collaborate with each other, and see that they have a shared opportunity here to improve the care of the population across contexts?

CO-CHAIR SINOPOLI: Perfect. Thank you for that.

We have a couple of questions from our Committee colleagues. Jim, you want to go first?

DR. WALTON: This is perfect. So, the follow-on to Mary and this conversation really was the questions that I've been writing down.

So, Mary, I led a large independent physician organization that was committed to staying independent, which represents 25 percent of the delivery system today, right? So, it's shrinking.

And they're passionate around this idea of transitioning to value, right, transitioning the way they get compensated and the way they practice medicine. They're committed to integration with their partners, from primary care to specialty. They're

committed to transitions of care.

But one of the big problems that we've identified at this Committee, and it came up just a moment ago around rural -- the whole idea of broadband access.

And what experience -- I guess the question is, is what experience or advice would you give our Committee to advise and -- you know, to advise around the technology infrastructure that maybe you tested your model with, right? An integrated delivery network. How does that need to look going forward?

And because -- we kind of intuitively know that we need to connect, right? We know people need to connect to communicate and share data so that you're not reentering a bunch of information. But that doesn't exist in a lot of communities, especially with independent physicians and such.

So, is the model -- do you think that the model's just going to work really, really well for highly consolidated, you know, integrated networks? Or would you recommend that CMMI or someone within the government

finance infrastructure build, outside of the episode rate, right? Because, you know -- so that they would enable this to actually spread, you know, because the evidence is so strong.

DR. NAYLOR: So, let me answer this in a few ways.

First, I think the conversation yesterday about investment in infrastructure to position that world, post-acute community, to be able to more efficiently, effectively communicate with other partners is, I think, a really -- I really, fully endorse that. I think that this is essential.

I mean, we're working in communities where people don't have access, internet access, et cetera, so the challenge is therefore making sure that patients and their families have the ability to capitalize on available tools. It's essential.

I think that the 25 percent that you're talking about of primary care physicians, part of -- one of the reasons that we deliberately thought through how it is that you could augment primary care with transitional care services. So, how it is that

an advanced practice nurse, maybe working with a cluster of smaller primary care practices, could really help to add value to the care of the patients they're serving.

That took us on an amazing journey of trying to figure out how do you get people to feel they're part of a team? I mean, one of the things -- one message that I had for all the time is that these advanced practice nurses cannot be seen as outside the system. They must be viewed as part of the system.

So, we work through the journey of getting these individuals credentialed in individual practices, credentialed in hospitals, so that they could follow the patients if they're hospitalized, that they're caring for, bring them back home as quickly as possible.

So, you know, I think there's opportunity for smaller practices to be able to capitalize on transitional care services, but foundational to that is your -- the recommendation that investments in digital -- in infrastructure generally, but in technology, is essential.

The last thing I'll say is that the work we're doing right now, a replication of the transitional care model in multiple health systems, took place during COVID. So, it has helped us to understand, and we deliberately now mapped out what technology will be needed to more efficiently create that kind of communication across team members.

Mrs. Jones runs into a problem. You don't just have to talk to, sometimes, the primary care. You have to talk to a specialist, et cetera. What communication technology is going to make that as efficient and effective as possible?

So, we have mapped out the tools, and sometimes they exist in big integrated health systems that align with the delivery of this model, and sometimes they need to be brought into that system to make it happen.

Did that answer your question?

DR. WALTON: Yes. Thank you very much.

CO-CHAIR SINOPOLI: Grace and Rick, anything to add to that?

DR. TERRELL: Not right now, no.

CO-CHAIR SINOPOLI: Grace?

DR. TERRELL: No, she's got it.

CO-CHAIR SINOPOLI: All right. Lindsay, you had a question?

DR. BOTSFORD: I do, thank you. Thanks to all of you. This is, I think, fascinating.

I think one of the themes we were talking about is how do you -- how do we make this transition from fee-for-service model to entirely value-based? And I think the thought of this transitional care model as being separate from the TCM codes is a -- it almost seems like a natural progression from the more checkbox-y requirements of the TCM code to more of a philosophical shift, taking some same elements of that.

I think one follow-on question that I think, Dr. Naylor, you touched on a little bit is -- want to just question a bit about the who participates in that transitional care model. You mentioned that in one of the places that a community health worker was used.

I think the question I have, you talked about the same APRN and really

emphasizing that continuity, that relationship and trust-building as an important part of the model. Is it continuity with a specific APRN? Could it be team continuity? And could that continuity be with a community health worker, a navigator that then links into maybe even different APRNs? Would you see the same results? Have we tested it?

And I guess, curious: what other health professionals have you considered that could fulfill some of these needs of that transitional care management? Certainly, there's a clinical complexity where you need clinicians involved. But that relationship-building and continuity, how do you think about other members of the team that could help provide that in a world where you're getting more of a bundled episodic payment?

DR. NAYLOR: So, an excellent question. The site that I was talking about uses an advanced practice nurse in partnership with a community health worker. So, the advanced practice nurse is still the kind of lead or hub of the care management transitional care team, but is able to call on the community

health worker to be able to support.

Yesterday, we heard many talk about the value and importance of other team members. And to the extent, you know, social workers might be really important, we're in some sites now where social determinants of health dominate as the priority needs of the patient population that are coming into the hospital.

So -- but the thing that I wanted to stress is this is what we've tested. Because of the complexity of the needs of these patients, both clinical and social and behavioral, it really has been, from our perspective, of high value to have an advanced practice nurse who can kind of oversee, assess where the bigger challenges are, address the clinical needs.

In our work, the advanced practice nurse works, as I said, with the existing team, but once the patient is home, that person is delivering and coordinating the care, substituting for traditional nurse services.

I'm not making -- yet adding another layer, but drawing, and the capacity to draw in to other team members is central. It's central.

Others talked yesterday about the

pharmacist and the ability of the clinician, an advanced practice nurse, to work directly with the pharmacist in streamlining patients, many of whom are on way too many or inappropriate medications.

So, all of that requires clinical acumen. The collaboration with the physician requires very sophisticated collaborative skills, communications skills, but the other team members are central to the outcomes.

So, I think there's a lot of opportunity to, as sites are doing, to test. One site that's finished the clinical trial with us about a month ago started their transitional care services last week and just sent us a note last night that they have seven or eight patients enrolled in one day. They are using a model of the advanced practice nurse, but an RN helping to support with some of the activities.

From a patient's perspective, it's -- what's central is that the patient knows that this APRN is the point person. You are the person whom I can call, the relationship part of it.

So, did that help?

DR. BOTSFORD: Yes, thank you.

DR. TERRELL: So, I'd like to add that as I'm listening to this, you know, one of the things that is part of this whole issue of how ought we to pay for this, and what ought it be that we're paying for, you really need to take a systems thinking approach.

Because if you're just looking at the physician themselves, the clinician, they have typically been trained about disease management. Of -- okay, somebody just got out of the hospital with heart failure, and, you know, are they on the right medicines? You know, does this or that need to be tweaked? How's their condition compared to last week? Are they weaker now, or whatever?

But the types of needs, and Mary did a really good job of articulating just a broad spectrum of them, it's much broader than that. It's social. It may be nutritional. It may be financial. It's the whole system, and any of those factors can, you know, have a massive influence on the outcome of the patient.

And so, as we're thinking about the payment model, we've come from, you know, the

Medicare system, which pays for medical services. We're trying to come up with something where we can use systems thinking to come up with what -- to figure out what we need to pay for in a very complex, environmental sort of sense.

And so much of the work that probably CMS is going to have to do around this is going to be to take a systems thinking point of view and basically say what types of things need to be assessed, and Mary did a good job of talking about how what many of those things might be, and with that assessment, what types of resources can we draw on such that the patient has the best possible chance of having an outcome.

And then we narrow it back to where we started from, which was it's about some disease that we -- they ended up, you know, being hospitalized for.

And that's just very complex. But taking a systems design point of view around it, I think, is probably the way to start. And as the payment models are being designed in tandem.

That's why on my point of looking at

the, you know, the care model, the payment model, I added the operating model, which is the piece of it that we have tended not to think about very deeply. And it's going to be the operating model for, you know, various health systems or various entities doing this that have to be thought through if we're going to have a true systems thinking point of view that's going to have adequate efficiency.

DR. NAYLOR: I'd like to add on that because I think that's exactly what needs to happen, a systems orientation.

So, you know, in some context you have -- I mean, I heard comments yesterday about building a new team, but what we work with is who are the existing people in the system with whom we can collaborate to accomplish goals?

And sometimes, that is -- it requires some additional training of those. Sometimes, it suggests that we might be able to identify two or three people in geropsych, in pharmacy, et cetera, to whom we can call for -- the APRN can call for consultation.

But we're not talking about creating a whole new team here. We're talking about

capitalizing on what exists in each context, and positioning them to be able to contribute meaningfully to the care of Mr. Jones or Mrs. Smith. And that is really central. I think it would be very costly to think about a whole new team being created to support this work, but in many ways, we're creating systems that make it efficient.

Social workers in hospitals. We had many fewer social workers in hospitals. We add value to their work. We add value to the work of primary care clinicians, who now are seeing these patients coming out of the hospital and understand exactly what challenges they are confronting and are able to start from the get-go with what they need to do.

This is value-added work in each of these contexts, but not adding people.

DR. GILFILLAN: I just wonder -- Angelo, a quick comment and question.

I do think context is really important. I think it might be helpful for Grace to kind of explain what she -- how she differentiates the care model versus the operating model.

And what -- I'm assuming that she's thinking about the operating model being broader in a context within which this kind of an approach would be implemented. That is, is -- and I would say it's a -- either it's a capitated entity or it's operating under an ACO-type model. A little weaker incentive to do it.

But putting it in a context where the overall system that this entity is -- that this model is operating in, is interested in getting the same outcomes and going to benefit from getting those outcomes. Is that what you're referring to? Is that accurate?

DR. TERRELL: Yes. You're accurately inferring what I was saying.

The way I think about a care model is the way a lot of things were presented to us when I was on PTAC.

Which -- you would have, say, a group of urologists or gastroenterologists or whomever who basically said this is a great way that we have designed to take care of patients with a particular problem: Crohn's disease, prostate cancer. If you would just pay us differently, we can provide that care, and it'll be great.

And you know -- and we did a lot of work and saw a lot of what I would call care models, which is provide these services for these patients. Come up with a payment model for it. And I think that there's a piece of that that's missing that has to do with the larger health care ecosystem.

So, you know, how do you operationalize as part of large health care integrated system, this, within the context? How do you do it if you're an ACO? How do you do it in a rural area?

You know, there's business entities and structures that have to think about the overall payment systems delivery of the services that you say that you're going to pay for. And the point I was making about well, we've ended up with hospitalists and SNFists and all these type things is that that really has come out of an operating model.

So, when Mary makes the point that we need to use the same people, just use them differently or to do new things or different things within the context of some of the transitional care services that have been

delivered, it still changes the operating model. And sometimes, it changes the work that somebody does.

And so, understanding how the different types of entities that are out there would actually operationalize and structure the delivery of these services is a component of it that we sort of leave up to the market at this point. And sometimes that works, and sometimes that doesn't work.

But my concern is basically around the fact that there are many of these types of services that are necessary, that it would be a very different operating model to deliver those types of care models in a rural setting with no resources versus an urban, you know, academic medical center with multiple different types of resources.

So, understanding that aspect of the ecosystem, I think, is a component we've sort of left to the market, that it might be useful to at least have some understanding that irrespective of what we pay for, there will be people coming up with things that may or may not work and will have their own implications.

CO-CHAIR SINOPOLI: Perfect, thank you. Jen, you had a question?

DR. WILER: Thank you for a wonderful discussion and some really excellent presentations. My question is going to move us in a little bit different direction, and Rick, I'll start with you.

We've talked over numerous meetings around components of MA programs and how that might be juxtapositioned to ACOs, and you laid out really nicely some of those points. And you said, I believe, that it's hard to make money in an ACO and currently easy to make money in a Medicare Advantage program.

So, as we think about recommendations for the future and a potential on-ramp into ACOs in a meaningful way that helps to achieve CMMI's goals of 100 percent beneficiary participation, what does that look like?

Is it leaning into the MA program space? Or is it leaning into the ACO space with some of the opportunities that you highlighted around pivoting from voluntary to mandatory, making incentives more meaningful to make health care delivery systems participate?

I'm curious your thoughts.

DR. GILFILLAN: Thanks, Jen. Well, I guess number one is I'd say most of the models I think I would see testing within the context of ACOs rather than isolating them to outside of that, I think. Or at least, I would think about two sets of doing things, and I would be mindful of the potential for new models that are created distinct from the ACO world actually pulling people out of that commitment.

I think we're in a battle for mindset. That's what we're talking about. We're in a battle for the mindsets of institutional leaders and clinicians, I would say.

Frankly, I think first, it's institutional leaders because they have such influence. And so, we have to convey a message to those institutional leaders, I believe, that is clear and straightforward and doesn't introduce ambiguity.

So, I would say -- look. We're going down this path of wanting everyone to be an accountable entity. Having a PCP relationship, in my mind, is not an accountable relationship.

It's only when that PCP is participating in a context that makes them and requires them to be accountable that we get the benefit I think that we're looking for.

So, I would say, number one, I'd be very mindful of that strategic need, and then I would look at the specific components of the two programs and ask the question, what's doable? You know -- what can we do, you know, to look at how we set benchmarks for ACOs versus how we set benchmarks for MA?

And I would look at the two programs in a strategic, connected way and say let's create a reasonable test to find out whether or not providers, paying providers in a manner that's direct, you know, if it's really direct, actually results in better outcomes or not. Or maybe the insurance companies are better at doing it.

But I would go down each of those dimensions and ask the question, how can we bring these closer together strategically? And I think that requires CMS talking, you know, across CMMI and Center for Medicare and coming up with a strategy that's synergistic, that

seeks to find that, find out what is the best way of creating a delivery system.

I think it's really important to recognize what Grace has pointed out. We have, ironically, even as we were trying to deliver coordinated care for the past 15 years, we've created more fragmented care. And we put the onus for integration almost entirely on the patient and their family, right?

I mean, it's crazy. If you've ever followed a, you know, a hospitalist running around a health -- an inpatient setting trying to see 20 patients or whatever in a day, it's no model for, you know, consistent, coordinated care.

And so, I think we really need to be mindful about redirecting systems back to focusing on actually delivering effective coordinated care. And right now, I think we're distracted by the whole coding thing, by the business opportunities that are out there. I think we need to dampen that down. CMS took a step. We need to do more.

I would eliminate percentage of premium contracts, to be very honest and direct,

because I think they're corrupting the delivery system and the delivery of care. And I would take other steps that might require Congress. I would recommend other steps like that to actually create that level playing field, frankly, that, you know, that you suggest.

So, let me stop there. I don't know if that's on point.

CO-CHAIR SINOPOLI: Perfect, thank you. I'll remind the group that we have 10 minutes left. We have a couple of questions from PTAC members.

Jay, you have a question?

DR. FELDSTEIN: Yeah, thanks, Angelo. Great conversation. Grace, I'd like to thank you. I'll give you credit for coining the new medical specialty of the transitionalist, so kudos for that one.

And Mary, I'm really interested in your model in the sense that you really seem to emphasize the first couple of visits being in person. And as we try and get this to scale with limited resources, is that time-tested with evidence-based results that you really need to have the first couple to be in person, as

opposed to being virtual?

DR. NAYLOR: So, it is tested within our work how central that has been for especially individuals who are so mistrustful of our system. And this is a pretty -- in our work, a pretty significant segment.

So, face-to-face. And others have demonstrated face-to-face contact is really important for people to get to believe that you are there for me and that you are going to be working on my behalf.

I also suggested that if -- and we're working in rural contexts where that's not possible. And so, facilitated audio visits where -- and someone gets to see that person directly, who's going to be the person that may be visiting them, either virtually or in person. But making sure that people understand who it is that they can count on is really central, and that has been demonstrated.

Front-loading visits has also been essential. Not getting into, you know, the idea that you can wait seven days or 14 days or whatever to get a visit with follow-up visit, that has not been as effective as recognizing

how important getting into someone's home as early as possible following a transition is to early identify the challenges associated with risk in the home. Medication issues, very common. Not getting access to the services in a timely way.

So, both of those dimensions, some level of face-to-face or facilitated video, and really front-loading interventions, really important.

DR. FELDSTEIN: Thank you.

CO-CHAIR SINOPOLI: Okay. Walter?

DR. LIN: So, this has been a fantastic discussion and has really triggered a lot of thoughts in my mind. I'd like to just to make a couple comments, some reflections about what I've been thinking based upon what our panelists have said, and then also ask a question.

My comments are I think Rick has made a really good point about the importance of context when we are testing models, you know, whether we're testing them in the context of a fee-for-service environment versus an ACO. And I think that to a large extent speaks to the

time that PTAC has been spending over the last number of sessions looking at nested models within an ACO, so I just wanted to make that comment.

And then, I also wanted to reflect on Grace's comment about the clinical model versus the operating model. You know, PTAC is so focused on payment models to foster clinical models that make sense. But I think, if I'm interpreting Grace's comments correctly, the operating model, to take that clinical model that hopefully we've shown works on a small scale and scaling it across a broader population, is really important. And the idea that an operating model might look different in a rural versus an urban versus some other environments I think resonates with me.

My question is, you know, I'm thinking about the distinction Grace made about paying doctors right and they'll do the right thing versus directly paying for the right thing. And applying that to Mary's suggestion about implementing an episodic 60-day case rate per member for evidence-based transitional care services, it strikes me that, Mary, your

suggestion to do that is paying doctors right as opposed to paying for the right thing.

You know, if we're paying for the right thing, maybe the model would be to pay for a lower 60-day readmission rate or a, you know, lower utilization, ED[26] utilization through some sort of gain sharing or shared savings mechanism.

And I'm wondering -- well, first, Grace, I'm wondering where you fall on that distinction. Should we be looking at paying doctors for the right thing versus -- paying doctors right versus paying for the right thing?

And then, I'm also wondering what the panel thinks about this applied to transitional care services, whether we should be looking at models to test for paying for the right thing, lower readmission rates, lower ED utilization rates, or rather paying doctors right.

DR. TERRELL: So, my opinion is it's an and, but we often don't even bill as if it's a distinction.

So, you know, when I was asked to do this, I went back and really reflected on the

26 Emergency department

work that happened when I was at PTAC, and I realized that we never really quite thought about the distinction between those things.

And some of the suggestions and recommendations we got from the public were one, and some were the other. We had Committee members that were strong, which I pointed out in my remarks earlier, which were strongly focused on one point of view or the other over time.

And so, probably, the answer is and. We ought to just look at -- so, if the answer is we pay for a 60-day, you know, readmission rate as opposed to a 30-day, that may be paying right, you know. And the reason it's right is because 30 days is not a long enough period of time for all that happens to a patient.

So, that is a -- I would certainly categorize it in that first category. But much of what Mary talked about was paying for the right things, and this is what the right thing looks like.

So, my point was I don't know the right answer for any particular thing, but I think the job of PTAC is to really identify, when there's ideas in front of you, what is

actually being proposed as it relates to those two things, because the more clarity there is around that, then I think the easier it will be to do the work that PTAC has been, you know, charged to do to think through how we sort of improve the overall system.

And sometimes, it's going to be an and, you know. Sometimes, it may be somebody comes with a very specific thing that is about paying for the right thing. We've never been paying for this before.

So, a lot of the work when I was on PTAC around, like, the handyman. I can't remember what it was called, but it was a care model where they -- our handyman is part of a, sort of an impoverished group of elderly, frail people, and they had all these great results. Well, that was paying for something very different. It was paying for doing the right thing.

It wasn't part of the perspective, but we really did not think through very carefully at the time, I think, which of those things it was. So, I just was challenging PTAC that that might be a tool in your armamentarium

is to start thinking that way.

DR. GILFILLAN: You know, one other thought, Walter, I'd add to that is in a world where, you know, let's say -- let's go with 75 percent/25 percent.

In a world where institutional decision-makers are making decisions in 75 percent of the cases, what exactly is PTAC seeking to address? What is your strategy for change? Is it going -- are you just working with the 25 percent? Or are you working with the 75 percent?

If you're working with the 75 percent, then you have to ask the additional questions of what is the institutional driver? How is it going to be viewed, right?

So, it doesn't become a question necessarily about paying physicians for the right things. It becomes a question of how do -- if we're going at that group, how do we think about incenting those decision-makers to do what we're after, to do the right thing?

DR. NAYLOR: I'd like to reflect on that. I think the kind of solution we're talking about here is both paying for the right

thing and paying an accountable entity.

And the right thing is evidence. At least as a foundation for change, we should be using evidence and paying the right entity, but the entity that commits itself to kind of building the relationships that are central for making it happen.

I think this is a really central -- I totally agree. Rick asked the question, are we testing a payment model, are we testing a clinical delivery model, or both? And my recommendation is that, at least to jump-start us from where we are to where we quickly need to go, given the vastly growing number of older adults who are going to be counting on us for services -- and one group that was mentioned that honestly we spend our lives talking about is the caregivers, the shrinking caregiving workforce. We have to jump-start how it is that we move over the next few years to be able to address these challenges.

So, I think it's both, Rick. I think it's paying -- it is a payment innovation. But to jump-start it, we really also need to have evidence-based solutions as the way that we move

the system. So, I would say both.

CO-CHAIR SINOPOLI: I'd like to thank the panel for their time today. This has been a great discussion. We really appreciate y'all's input and obviously your time and effort you've put into preparing for this. So, we look forward to more discussions with you.

And at this time we're going to take a short 10-minute break, and we'll be back at 10:50. Thank you.

(Whereupon, the above-entitled matter went off the record at 10:43 a.m. and resumed at 10:52 a.m.)

*** Listening Session 3: Addressing Care Transitions in APM Model Design**

CO-CHAIR HARDIN: Welcome back. I'm Lauran Hardin, Co-Chair of PTAC, and I'm excited to kick off this listening session. We've invited three guest experts who have real-world experience in using payment models to support value-based transformations.

At this time, I ask our presenters to turn on your video, if you haven't already. All three have presented -- after all three have presented, our Committee members will have

plenty of time to ask questions. The full biographies of our panelists can be found on the ASPE PTAC website, along with other materials for today's meeting.

So I'll briefly introduce each of our guests. First we have Dr. John Birkmeyer, who is the president of the medical group at Sound Physicians.

Welcome back, John, please go ahead.

DR. BIRKMEYER: Good morning, everybody. I've really enjoyed listening to some of the earlier sessions, and I'm grateful for the opportunity to share in this panel. If I could get the next slide.

In the next eight or 10 minutes, I'd like to do two things. One, I'd like to describe Sound Physicians' experience in managing and ultimately improving both acute and post-acute care.

We'll talk about the most important clinical levers for managing not just quality but total cost of care around the 90-day episode in Medicare patients leveraging our experience with CMS' various bundle payment programs.

I'm going to focus on the clinical

levers in part because it informs the providers and other players that are important in driving success and in turn, you know, the types of payment models that are likely to incentivize and be successful over time.

In the second half of my talk, I'll share heavily editorial comment on what CMS and CMMI might do next with regards to bundle payment programs.

And you know, and in the context of so-called nested bundles, I'll lay out a few recommendations in short form relative to some of the more detailed information in the recommendations that we've previously shared with Dr. Fowler and her team at CMMI. If I could get the next slide, please.

So who is Sound Physicians? We're a physician-led national scale medical group that is unique in its early adoption and its focus on value-based care as part of both its clinical and its business models. So we partner with hospitals in at least 350 different sites across 47 states. We are currently the largest hospitals group in the U.S.

We jumped in with both feet into the

bundle payment program when it first launched in '15, and until we exited last year, I believe were the single largest episode initiator in both BPCI and in BPCI-A[27].

We have some familiarity with population payment models in part because we partner with a large number of our hospital partners and ACOs and MSSPs that they host, but also Sound has its own long-term care ACO. So we have some familiarity with the mechanics. If I can get the next slide, please.

Historically we've measured our success as a medical group in trying a, you know, in being able to manage quality and reduce total cost of care around the acute care episodes. And our primary benchmark has been to leverage the nationwide data that CMMI has provided in the context of the BPCI-A program, against which to benchmark our own performance.

Our primary measure has been total spending on post-acute care, i.e., all of the spend that occurs between hospital discharge and 90 days post.

And as you can see in this slide, you

27 BPCI-Advanced

know, we have a slow but gradual learning curve, but ultimately over a period of four or five years, we were able to beat national trends in post-acute spend by give or take 4x or a little more than $1,000 per episode. You see the levers running across the bottom. If I could get the next slide, please.

You know, when we first dove into the program and as we learn the hard way what works and what doesn't work, we, you know, began to pay more attention on, you know, what we learn from the epidemiology expend around the acute care episode. Thanks in part to analyses done by, you know, my former academic colleagues at Dartmouth in the Dartmouth Atlas.

We appreciated that spend that occurs during that acute care hospitalizations in the 90 days afterwards accounts for about 51 percent of total Medicare Parts A and B spent in a fee-for-service population.

And if you hone down a little bit more carefully on what occurs within that episode spend, only a little more than a third of it is the DRG payment. But almost two-thirds is basically the most actionable, most variable

part of spending, as all of you appreciate.

And that's readmissions, but more importantly, you know, post-discharge use of inpatient rehab and health tax. So that's really where we focused our efforts. If I can get the next slide.

You get very clinically granular for a second because I think it informs some of my recommendations later. I think over a period of several years, we learned the following with regards to what are the most important clinical drivers for both quality but also total cost of care around the acute care episode.

Far and away not just the low-hanging fruit but the largest single source of excess spending is, you know, pertains to next site of care decisions, i.e., where does the patient go at hospital discharge? Do they go home, do they go home with home health? Do they go to an SNF, do they go to an IRF[28]?

And the single most important thing that we did among a myriad of other changes was to insist that the physician, you know, in our case the hospitalists or in some cases the

28 Inpatient rehabilitation facility

intensivist, has primary responsibility for that decision rather than deferring to case management employed by the hospital or others.

Patients and their families listen to physicians more than any other group. And you know, frequently in our experience, case management employed by the hospital is more incentivized towards reducing acute length of stay than they are in, you know, thinking about the holistic episode.

Readmissions for us were an early opportunity, and we had, you know, significant improvements over the first couple years of our participation with bundle payments. But we like most people got to the flat of the curve thereafter, and that hasn't been, you know, sort of our ongoing focus.

With one exception, readmissions from SNFs, which account for almost a third of all readmissions that accrue through Medicare fee-for-service patients, is extremely prevalent, highly variable, and very actionable to the extent that a disproportionate share of them, you know, accrue because of lack of SNF staffing after hours or on the weekend.

We currently have hospitals telemedicine in almost 1,000 SNFs, and that's been a very effective lever for us in keeping patients where they should be.

A pretty under-recognized lever is the use of inpatient and post-discharge physician specialists. Part B spend around the acute care episode depending on the population's 10 or 20 percent of total spend. But it is exceedingly variable and very discretionary, at least with regards to certain types of specialists.

When we implemented a diagnosis by diagnosis, you know, tech, and they both set up guidelines, we were able to significantly reduce that variation. It tends to -- and it continues to be a huge part of our focus as we partner with commercial payers on similar models.

And then finally, while less relevant to surgical populations participating in payment arrangements, among those with acute medical illness, end-of-life care is a very under-recognized, you know, aspect of both quality and cost. Many people don't appreciate that if you look solely at those admitted with acute medical

illness, the 90-day mortality in a BPCI-A program was almost 25 percent.

And in our experience, training and incentivizing the physician basically to have meaningful conversations with patients and their families about values and their preferences and to guide the intensity of care afterwards, that's been hugely important, both in the experience of the patient, but also in total cost of care for certain types of things. Next slide.

And finally just under the, you know, kind of what have we learned part, you know, in order to, you know, be successful in delivering care, you know, along each one of those levers that I just described, we've, you know, found a couple things.

The first, in no particular order, is that we were way more successful when we had explicit arrangements with the hospitals with whom we were partnering rather than when we were just working on our interface, in particular between the treating physicians, and hospital employee case management is really essential.

And finally, you know, we found that

we were way more successful if we didn't just give guidelines to a physician but we purposely invested in technology, point of care tools, and checklists for making sure that the right patients got the right things and predictive analytics that helped us identify which patients were at highest risk for certain types of adverse outcomes.

None of those investments were inexpensive, but they were really essential, you know, for our success.

So as a segue, let me move forward to the next slide. With that as a backdrop, let me, you know, share, you know, how we would think about the future of bundle payments going forward. If I could get the next slide, please. And then the next slide.

So just to -- being provocative, you know, let me start at a very high altitude with what CMS and CMMI might do with regards to the future of bundle payment arrangements.

You know, Option A is they could do nothing, just let the current voluntary BPCI-A program sunset as planned. Hospitals and most specialists would likely be very grateful for

that, as they could focus on other things.

But you know, I think most of us would appreciate that. To the extent that primary care physicians are largely on the other side of the moon with regards to what happens to patients in the hospital and then immediately afterwards, that would leave on the table a serious opportunity for improving quality and cost.

Option number 2 would be, well, we already have a physician-centered MIPS program. Let's just reconfigure it in a way that puts more emphasis on sort of the core framework of the bundle payment programs. So basically a more rigorous, more heavily weighted MSSP measure.

You know, the problem, as I think about that, is even though there's a framework already in place, there's so much heterogeneity at the level of individual specialists, docs, that, you know, administering it would be a nightmare, even if it actually mattered.

And you know, the way that it's configured, which is a, you know, 5 percent, as high as a 9 percent up or down adjustment on

fee-for-service payments is way too small to capture the attention of physicians in the uncompensated time that goes into managing to value. Most physicians would choose to reallocate that time just to seeing additional patients.

And as you can judge from my tone, you know, kind of what we hope, you know, occurs is, you know, what's been described as nested bundles. You know, find a way to keep hospitals and specialists in the game by embedding aspects of the former bundle payment program into ACOs, into MSSPs.

Let me move on the next slide. If, you know, I'm assuming that was the pathway, let me leave you with four discrete recommendations, some of which may seem out of left field, some of which are maybe obvious to the folks that are on the call.

The first, and you know, perhaps this will seem self-serving coming from me is start where the money is, which is hospitalists. Why do I say that? Well, hospitalists are essentially inpatient primary care physicians. They basically come from a trained background.

Like PCPs, they treat patients with -- they treat all comers with all diseases.

And importantly in this context, they serve as the gatekeepers for post-acute care for specialists, et cetera, et cetera. In the current era, you know, the vast majority of hospitalist groups are explicitly contracted or employed by hospitals, which makes it a lot more feasible to implement contractual models by which, you know, inpatient and outpatient provider groups and hospitalists share in risk and in savings.

And then finally, across the U.S., at least in the Medicare fee-for-service population, hospitalists discharge over 70 percent of all Medicare inpatient discharges. Specialists, you know, to whom I'm partial as a former general surgeon, you know, they are an extremely heterogeneous group.

Inpatient admissions are increasingly a very small part of what they do, even more so as major orthopedic surgery moves largely to the outpatient setting. And you know, as I've appreciated from my work with the Dartmouth Atlas, the largest impact on what specialists do

is not the efficiency of the acute care episode, it's really the number of things that they do.

And while, you know, there is complexity in kind of what, you know, in what this might look like, you know, the optimal alternate payment model for procedurally, or if you look at specialties, is ultimately going to be the special key specific spend in their utilization at the population level. It's not going to be the efficiency of their episodes. Next slide, please.

Recommendation number two, which is heavily informed by our own experience working with commercial payers, as well as with CMS with a bundle program, is to move away from diagnosis by diagnosis bundles to an all or near all admission framework. As you know, BPCI started with, you know, 29 to 32 discrete bundles. It then moved to eight.

So some called super bundles, and while conceptually attractive, the largest bugaboo of that entire program has been inability to get that pricing right.

You know, when sample sizes get small or when coding changes, et cetera, et cetera, a

much simpler and more empirically rigorous approach might be to focus on all acute medical discharges as a single bundle, albeit carving out some of the weird stuff that can sometimes skew mean effects, like ESRD[29] and maternity and oncology.

It gets you a much larger sample size, much more stability with risk adjustment in this ability to price. It also gets you at least 2x the total sample size, which allows hospitals and physician groups to justify the investments in the program. Next slide.

Recommendation number three, which I think is, you know, also obvious to some of the scientists and the economists that have studied the program is that the future of the bundle payment program needs to take a different model with regard to pricing and with regards to how it sets a discount.

A model of a two or three percent discount with prices that ratchet year over year was only sustainable when, you know, when there was enough noise in the pricing down participants could choose relatively favorably

29 End-stage renal disease

priced bundles. When that went away, you know, there was really no financial case that you could justify, you know, staying in the program.

So we favor one that, you know, has largely been implemented in or nationwide contracts with United and Humana, et al., which is basically an all-in model with 50-50 sharing.

And then, finally, and my last slide is -- yes, is a very detailed slide that I will not walk through. But it basically is a copy and paste from a very detailed slide that we've talked through with Dr. Fowler et al. a year ago. And it's essentially how to migrate from a standalone bundle payment program into one where those bundles are nested into ACOs and MSSPs. And I just leave you with the three take-home points that are at the bottom.

One is we strongly favor mandatory -- bundles that are mandatory for hospitals that are in -- that have largely been sitting on the sidelines of population payment models, those in episodic track A. I think it's really going to be the only way to really incentivize them to begin migrating towards managing the value.

We believe, you know, from our

empirical experience that models that hold accountable and jointly incentivize both hospitals and physicians, inpatient and outpatient, are going to be critical.

And then, finally, we believe that the specific details of attribution of risk-sharing needs to migrate along the columns that you see on this slide. You know, with models that, you know, concentrate more risk and management within the host ACO, you know, the further that you evolve towards direct contracting in these more recently enhanced track or next gen MSSPs.

So, with that, I'll stop, but I'll look forward to your comments or your questions later.

CO-CHAIR HARDIN: Thank you so much, Dr. Birkmeyer. That was a very informative presentation. Next we'll turn it to Dr. Marc Rothman, who is the Chief Medical Officer of Signify Health.

Welcome, Marc.

DR. ROTHMAN: Thanks, Lauran. Just checking on my audio, you can hear me okay?

CO-CHAIR HARDIN: Yes.

DR. ROTHMAN: Excellent. Great to be with you all today. I really appreciate the opportunity. It's incredibly humbling to be considered among the experts considering who you've talked to over the last two days, many of whom I consider the giants in my field and in my personal training over the last 20 years. And it's a great honor also to be here with John and Lewis as well.

Signify Healthcare, as of last month now a member of the CVS Health family, is a nationwide organization that fundamentally has two sides of its business, one of which I won't be addressing today, is the in-home comprehensive risk assessment that we do on behalf of Medicare Advantage members by largely a contracted 1099 workforce of over five to six thousand strong nurse practitioners, physician assistants, and physicians.

On the other side of our business, we also were one of the largest conveners of the BPCI-A program, with nearly half a million lives, Medicare lives, under management. At one point a very close partner I believe of the Sound Medical Group. I think that was before my

tenure. So it's nice to be on here with John.

And now after that work has largely concluded, we are now one of the larger conveners of Accountable Care Organizations, with a half a million to 700,000 lives under management under the ACO model, largely rural. So I appreciate some of the conversation that was already had today.

What I'm going to do today is really take you through what I consider a bit of a real-world application of the incredibly strong evidence base for transitional care medicine.

From the early days that Mary describes of some of the original papers, which I remember during my medical school and residency years up through today, give you a little bit of the operational approach, the technology and product approach that we at Signify Healthcare really lead with, not being part of a large academic institution or a part of a primary care practice in the field. So we really leverage our technology and our product approach organizationally.

And then show you some of the financials, talk a little bit about what I think

Richard and Mary and Grace were talking about today around the skepticism, the ROI[30], the lack of long-term investment, and how we have dealt with that. So it will be great to share this with you today.

I would only argue that while Richard talked a little bit about how there was not a perfect evidence basis for a lot of value-based care today, I would argue that there is no shortage of high-quality evidence-based evidence around transitional care.

From all of these logos that I've put up here, I should have put Mary's program. My apologies, Mary, if you're still on.

There are countless examples of how applying evidence-based approaches to transitional care, including some of the components that you see there at the bottom from the National Transitions of Care Coalition, into effect reduces re-hospitalizations again and again and again.

It's not the lack of evidence that prohibits the widespread dissemination of transitional care practices in my opinion. It's

30 Return on investment

really what is on the next slide that impedes the implementation and scaling of transitional care.

And that is that local hospitals and health systems, and private practices also, really struggle to implement, scale, and then maintain or sustain these transitional care programs.

The majority of the evidence base is around face-to-face interactions. I think Mary described the transitions program very well that she's the most familiar with and has spearheaded, where you have nurse practitioners either in home or in a hospital interacting face-to-face with people around transitional care, including other para-professionals.

You know, panel size is very hard to grow quickly, so you're essentially a loss leader for an unforeseen amount of time. There's usually an absence of very clear funding, especially under the fee-for-service model. We talked a little bit earlier about the transitional care codes.

The program that I'm describing for

you today, TTH[31], did not utilize any transitional care code fee-for-service reimbursement because we were under the BPCI-A program.

We essentially operationalized it, had a bit of an administration fee from our clients in health systems nationwide. And then attempted to prove the ROI on the savings on the back end, which is always in arrears, as you know.

A lot of the models that have been discussed today, and you had a very good discussion I think in the Q&A around who needs to do this model, does it need to be a doctor. John talked about hospitalists. Grace talked about extensivists, SNFists. I'm a self-proclaimed SNFist, I suppose.

And the truth is these are expensive resources that because the panel size is hard to grow and they can't fit as many visits in a day as you need, you just got a lot of high-cost providers making few visits.

And the value of the readmission prevention doesn't accrue directly to the

31 Transition to Home

practitioners in real time. That makes managing network force and giving them the credit for the work very, very difficult.

And then when you think about outcomes, my experience, because the outcome itself is not always accrued to a single cost center, you essentially have the benefits of the program, whether that's patient experience, reductions in ER[32] visits sort of spread out among multiple sources.

And that's very difficult. It's also very hard to deliver face-to-face services to broad geographies, including rural communities.

So what you're going to hear today from me is how we kind of, for better or for worse, went a little bit around the advanced practice practitioners, the doctors and the nurse practitioners, and went straight to the patients with an integrated care team, interdisciplinary care team, but led with RNs, social care coordinators, pharmacists, et cetera. The next slide, please.

32 Emergency room

So a lot of design principles that allowed our program to be successful, I'll show you the successful results in the appendix. We also were published in the New England Care Innovations Journal. You'll see a lot of design principles here. I don't really want to read all of these.

What I'll share with you that's key is we also had to a look out over a 90-day period, just like Sound Physicians has to do in the BPCI-A program. About 80 percent of our members in this program were BPCI-A, and about 20 percent were ACOs of our clients. So it was a mixture, but we still went out to 90 days no matter what.

We led with a virtual-first telephonic approach. We launched the entire thing during the pandemic. And also because of cost it seemed to me, knowing what I knew about sending providers into the home from my time doing palliative care in the home, the cost per visit was I believe just too high.

So in order to get buy-in investment from the organization to tackle this broadly nationwide, we had to lead virtually.

I'll second Mary's comments about needing to be evidence-based. We really led with social determinants of health, because I would argue that social determinants of health and transitional care outcomes are inextricably linked.

And I'll show you a map later about the interventions that we did for the members, the patients, the beneficiaries were often around more than just making sure the referral was there. And someone mentioned this before. Lots of referrals get made when people are discharged and are in the transitional care period, whether that's hospital to home, SNF to home, LTAC[33] to home.

The real issue is whether or not something actually happens with those referrals. What you find among Medicare beneficiaries is that lots of them actually refuse the services that were recommended by the doctors and well-meaning practitioners that sent them out. They do that for several reasons.

They don't want strangers in their home. They're overwhelmed with their care

33 Long-term acute care

management, their personal care management, and other family issues. They're very concerned about co-pays the financial effects of this. They've been in a hospital, they've watched bills start to arrive or things that say this is not a bill arriving on the kitchen table.

And so, and they don't think they need them. So a lot of what we end up doing is actually convincing patients to accept the services that were recommended by the hospitalists at discharge. And I'll show you some of that. A lot of that is SDOH[34]-related.

Interdisciplinary team, tech and product resources are mentioned there. We customized our own homegrown EMR[35]. We were never integrated directly into the EMRs of any of our hospital clients. We pushed notes back to them as PDFs, but we were never fully integrated. We still made it work.

And we implemented and scaled quickly. Within eight months, we were live with over 8,000 patients who were discharged from nearly 75 hospitals in multiple states, and we

34 Social determinants of health
35 Electronic medical record

really worked on staffing that model effectively, telephonically.

And we just worked very quickly to plan, do, study, and act and rapid cycle improvement, which is really critical, especially as you're trying to grow that census, which at the beginning is so low. And I've seen that in multiple organizations.

So those are some design principles. The next slide will show you just how quickly we were able to get people engaged with us. The dark squares are folks who agreed to be engaged with us telephonically in the Transition to Home (TTH) program in the first 12 months. I've got a slightly larger version here on my desktop so I can see it well.

You know, you can see that we just, our average daily census grew month over month over month, to the point where we were at over 1,000 patients a day within the first nine or 12 months.

And that is really what enabled us to approach the break-even point and then surpass it for the amount of time we were able to keep this model going until the BPCI-A program

underwent, you know, seismic changes that didn't allow us to continue.

So, rapid engagement. Engaging members -- Medicare members who are involved in value-based care programs is incredibly complex and difficult for many reasons. One is getting the right contact information, getting them on the phone.

Actually having them consent. If it's not them consenting, who is consenting, and how is that documented? All of this is critical in Medicare, as you well know.

And in addition, one of the really difficult things for us was actually identification of people in the proper value-based program. And because that is a difficult, complex game, we end up essentially providing lots of these services to people who are not in the value-based care program, potentially diluting the effect.

But we're doing the right thing for people who are discharged from the hospital, whether it turns out they were a bundled payment patient at all or not.

And I don't know if John didn't

mention that, but I'm sure he's had that same experience, where lots of folks are initially attributed to the value-based care program. Then it turns out that their status has changed, and it turns out that they're not.

They were attributed to a physician perhaps who was a PCP who had attributable lives. Oh, but it turned out that actually by the end of the year, they're not.

And so you're constantly challenged with identification of people in the value-based care program. So the idea that it's easy to limit your intervention to them to get the maximum ROI and data output from that at the end is really very difficult, more difficult I think than any of us foresaw at the beginning.

So while there was a lot of expansion, there was additional expansion from the people who were not in BPCI-A that are not represented here on that list who we did serve, because that's the right thing to do for patients. The next slide, if you wouldn't mind. Thank you.

Just an example of who we ended up serving. Our average age well over 75, majority

female. A large proportion of dual eligible members, which I think is relevant when you're thinking about SDOH and equity components to these programs.

The percentage of people who were in Medicare through disability was also very high. So transitional care resources for folks with disabilities obviously key.

They're struggling to get home. They're struggling to get to the PT office and the therapy sessions. They're struggling to do a whole lot of things, including fill the refrigerator and get to the stove. So just a lot of disability issues dealt with.

And our average patient case mix adjustment you can see was about equal between the groups.

The next slide will just show you by diagnostic category for the bundles program who we were actually providing TTH services to. The vast majority to be expected sepsis, congestive heart failure, cardiac, renal, urinary tract infections. And you can see down the list.

A little bit of a distinction between the very surgical procedures at the bottom and

the more medical at the top. To be expected, I think, but that gives you a nice breakdown of who we were seeing.

The next slide really just shows you the initial results, which were that when you compared risk-adjusted benchmarks for readmission rates, because we have obviously all of the data on the entire cohort of BPCI-A members over many years, so we're able to establish that risk-adjusted cohort.

And you can see that in the TTH group, which we call TTH Engage, our actual relative readmission rate, 24 percent, compared to our risk-adjusted benchmark of 28 percent, which is a reduction of 14.8 percent. That held up at both 30 days and at 90 days.

We saw greater reductions in readmission rates in lower acuity patients. And I'll show you in a subsequent slide in a minute a little bit about how when you break down where people go, to John's point, the SNF readmission rates are the ones that are very difficult to drop.

So a lot of the readmission reduction came people who were going home, had those SDOH

needs. Often were a little bit lower acuity. And whenever we could get them into the PCP or the specialist, this was another key intervention for us, which has been proven many times before.

Which is why the seven-day follow-up is so important. Lots of people have challenges getting to those appointments. Lots of people don't think they need those appointments. And so doing this at a big scale made a difference.

And lastly, just that last comment about claims match rates for the BPCI files was really a challenge identifying who was actually a member of the value-based care program and who was not. It turned out to be a surprise challenge for us.

Quick follow-up slide just to show you the distinctions between those destinations. So the top grouping is the overall results, then you've got a group that goes home with home health, a group that goes to skilled nursing, and a group that goes to inpatient rehab.

And low and behold, right, our greatest effectiveness is really apparent when you compare 90-day performance of our work for

patients discharged to home health and IRFs. A lot more challenging when you look at the SNF rates.

The rehospitalizations among patients who use SNF services actually increased for both people that we engaged and people we did not. But to a lesser degree for those that we engaged. And that really represents a sort of, in my view, a special population of people who have needs that are probably both medical and social.

We know that a lot of folks end up in skilled nursing just because the discharge home is not as safe. There's not the care that's needed. Even with home health, it won't be enough. Their self-efficacy may be low.

And so, and it is possible that they were released from the hospital a little soon because they know that there's great care in the SNF, and so they may be primed for a higher readmission rate than folks who seem stable enough to go home.

And I think I have one or two quick slides just to finish up. Just to show you that readmission rates reduced in several of these

service-line groupings of the BPCI-A program, for those of you familiar with it. Medical and critical care, cardiac, GI[36], those service-line groupings that came along when we put the TTH program into practice. You can see the reductions from baseline to our intervention.

The next slide really just shows you that we made a ton of follow-up referrals. We guided people back to community-based organizations, PCPs, specialty providers, home health agencies. Again, to that comment of convincing people they needed help in the home. Pharmacy services.

You know, the number of people, as a geriatrician, I see this all the time, the number of people who don't pick up their medicines after discharge would surprise people perhaps if they are unfamiliar with the literature and this work. Lots of people have a ton of meds at home. They don't feel like they need to go and refill.

So getting them back to their medications, as well as other DME[37]. Thousands

36 Gastrointestinal
37 Durable medical equipment

upon thousands of follow-ups made nationally, and the next slide just shows you the map of all of the work that was done by us. And this is really an SDOH-focused map.

You know, the blue is people who got back to PCPs and specialists with our help. The green is transportation services that were provided to get to those follow-ups, because just having a follow-up is not enough.

This is going to be made harder and harder by the demographics of the aging population today, how many people live alone, how many people don't have adult children living with them or spouses.

And then you can see food in red, housing in orange, and other. And so a really, really meaningful intervention in my opinion, and it felt good to make such a difference in people's lives across the nation.

And the last slide really just talks about the ROI a little bit. Apologies on the left, of that axis should not have a dollar sign there.

So what you see is how quickly we ramped our nursing telephone calls, our social

care coordinator, social worker calls, and how the readmission rate really finally at the bottom began to ramp up steadily from sort of month four or five through month 10, 11, and 12.

And when you look at savings calculated based on the number of readmissions prevented compared against historical multiplied by a multiplier, I think we used 26,000 per readmission to estimate total savings, you could see that while the cost continued to rise, operational costs and overhead at the bottom, eventually total savings at around month 10 began to surpass operational costs.

And that was really right before we put in a whole bunch of efficiency changes and program improvements that kept operational costs relatively flat as the number of readmissions prevented month-over-month really started to rise. And you're effecting in this program now 50, 60, 70, 80 readmissions prevented per month. Hundreds per year.

And my final comment on this is, goes back to some of the discussion you guys had already, I think one of the really difficult situations that I see in what I'll call the real

world here is that as folks are trying to reduce operational costs, use less expensive providers, use technologies and product solutions to deal with some of these things, they are looking at the ROI.

And I have yet to see in my tenure any ROI estimate of any clinical program, whether it be transitional care, palliative care, care management, that really surpasses maybe 2.5, 2.6x.

And when you're down in the 2-3x ROI numbers, and you're talking to boards of directors and investors and, you know, start-ups, they're really looking for 5, and 6, and 7x to get enough attention and overcome their skepticism.

And that's really where I feel like a lot of this work is challenged, because it takes, even with the -- even with non-MDs, even with non-MPs[38], these are expensive resources. Clinical care is not cheap. A computer AI-driven algorithm can't do these things to the degree that I think everybody wants.

And getting the ROI, I'm happy to

38 Medical providers

talk about that a little more detailed during the discussion. I think that's going to be a challenge going forward.

CO-CHAIR HARDIN: Thank you so much, Dr. Rothman, another really interesting presentation.

Now we'd like to welcome Dr. Lewis Sandy, who is co-founder of SuLu Consulting.

Welcome, Lew, please go ahead.

DR. SANDY: Well, thanks for having me. I really appreciate being on this panel and hearing from my co-panelists.

My remarks are really based on I've been involved in care transitions I think my whole career. I'm a general internist by training. I worked at Robert Wood Johnson Foundation to promote more effective chronic care models. And I just retired from UnitedHealth Group after a 20-year career there.

So my experience is based on I was Chief Medical Officer of United Healthcare on the payer side. Was extensively involved in work with Optum, particularly the Optum Care groups that are advancing value-based care in a multi-payer environment.

But I was thinking 35 years ago when I was doing primary care myself at the Harvard Community Health Plan, we were dealing with care transitions. There weren't any hospitalists.

We decided we ought to have a rounder system. Rather than each one of us going to see our own patients at the hospital, we ought to have a rounder that would see all the patients in our group. That was more efficient.

And then we had extensive discussions about who should see the patient after they left the hospital. Should it be their PCP, or should it be the rounder?

And then we had lots of nurse practitioners in our group. It never occurred to us to use nurse practitioners for this. I guess back then we didn't have Mary Naylor with us and her model or these other models. I guess we thought physicians had to do everything back then.

But anyway, my comments are really more kind of perspectives around this topic of what is the connection, the relationship between APMs and care transitions. And I think my key points are here on this slide as a summary.

You know, APMs can be helpful, can be neutral, or can hinder care transitions. And it's really a function of not so much the technical elements, though I'll speak to a few of these.

But is really more around your -- and these have come up in the previous sessions and commentators, what do you think this payment model is actually going to achieve? What's your theory about it? What do you think is really needed for an ideal care transition?

And then I was thinking even as I was listening today around there's kind of a couple different scenarios I think around care transitions that need to be put on the table here as well.

And some of these technical pieces, attribution, benchmarking, I was -- Angelo knows this, I was part of the Health Care [Payment] Learning and Action Network. One of the things I did in there was to specify some models of what actually John described, a kind of nested bundle within a population-based payment.

And I call these things like attribution and benchmarking component ware of

an APM. In general, the more specific the component ware is, the better. On things like attribution, the more prospective and specific, the better.

We just heard around the challenges of trying to figure out who's in and who's out of an APM. There's absolutely no way a retrospective attribution is going to do anything to influence the care model.

So you need short lines of sight between these components and incentives, and I think Grace Terrell on the previous panel mentioned this as well, that, you know, focus on what the work is, and then start aligning incentives around the work.

It's not to say you do need incentives, but you need resources to organize that work. But don't expect the incentives alone to drive the work.

And I think that the other elephant in the room that I want to put on the table is around sort of legacy fee-for-service. You know, the issue is fee-for-service by design essentially incentivizes widgets.

So if you want to create a more --

another widget for, you know, care transitions, you're going to rapidly get a bureaucratized, you know, widget production of a bunch of care transition services that will provide revenue to somebody, but may or may not improve the overall quality, affordability, or patient experience. So be careful about layering on something in a fee-for-service setting.

The theory of the payment model is really just being clear about what it is you think the relationship is between your payment model and your desired care model. Why do you think changing an incentive is going to do anything, and what could get in the way?

You know, the typical challenge is, again, I'm probably not saying anything you haven't heard before, but these are what I've heard. I'm in an APM? What's that? Most of the time, many providers have no idea they're operating inside an Alternative Payment Model.

They're particularly, you know, very common structure is to have the overall system in an APM, and then the providers are sitting there on a RVU-based, you know, productivity system inside of that. If they are aware

they're in an APM, they'd say, well, this is what we want you to do. They say, well, I don't know how to do that.

And that's been one of the hard-learned experiences over the years, is that even when you get alignment, it's like yeah, I should do this, really people may not want to admit it. They may not know actually how to do it.

So there's a lot of training and technical assistance needed that you might think is fairly obvious, but people don't know how to elicit care preferences. They don't know how to do medication reconciliation. They actually don't know how to coordinate care.

These are really skills that need to be taught, and people need to learn how to do them. And they take time to learn.

Another one that people may not voice in public, they say I don't want to -- you know, yes, this needs to be done, but I don't want to do it. Somebody else should be doing it. You know, usually a lower level of care. Some other care provider or some other entity.

And then this whole issue of care transitions, particularly for physicians,

sometimes runs into the problem of saying look, you know, yeah, it's important, but I have more important work to do. I got to see my patients, I've got other things I need to do. So why don't we go on to the next slide.

Those are just some things to think about. You know, this slide, we heard -- I'm not going to go through this, and we've heard -- seen various versions of it. But I wanted to put on the table around sort of idealized visions of care transitions versus sort of the essential, imperfect but implementable models.

I think one of the challenges is field, and when you also start to specify, you know, something like, you know, a service bundle directly focused on care transitions, it tends to get overloaded with too many elements.

And I think the key thing and particularly people that -- and institutions that work in population-based payments have learned to skinny down what are the essential elements of a care transition.

And we've already heard some of them today. You know, it's really essential to kind of rapidly connect with the patient and family,

as soon, you know, as soon as they get out of the hospital. Because they're often bewildered by what they're supposed to do or what's next.

They may have been told a bunch of stuff as they were walking out the door or being wheeled out the door. But they haven't processed 75 or 80 percent of what they heard, and they're bewildered. So sort of very rapid connections. Important to follow up.

I also think there's a really important difference in care transitions between stable patients, stable social, personal, and social determinant systems that are just moving from site to site versus a care transition that represents a real change in health status, social determinant status, or risk status.

Those are very different scenarios to account for in a care transition. So those are just some reflections on the idea of an ideal care transition. And not every -- just like not every gap in care is the same, not every care transition is the same either. Next slide.

Coming back to the ideas of attribution benchmarking component where simple, understandable, I just have had a feeling over

the years as much as it's really important to really try and get risk adjustment right to account for myriad other factors, there's a tradeoff there.

And many technically complex refinements and additional elements actually don't matter all that much. So I just think in general, keep your models as simple as possible. Attributions should be prospective.

Benchmarking, you know, who can argue really with benchmarking and you know, having the right benchmark to be judged against performance. If you set your benchmark wrong, people don't say, well, I can't hit that benchmark. If you set it too low, you can anchor performance in mediocrity.

So there's an art to those sorts of things. I think one of the big challenges in public programs, I heard Rick Gilfillan in the previous panel saying that private payers haven't been involved. I don't really think that's really so. I just think the private payers do it differently.

And one of the things that payers, private payers, have been able to do is sort of

refine and iterate over time how they do these things as they engage with the networks that they work with. So I just think it's a little different.

And then in terms of how do you measure or what do you -- how do you want to think about care transitions in an APM? From a sort of measurement point of view, I think it's a design choice about whether these are -- should be thought of as process metrics.

Are they quality metrics, or are they more prescriptive elements in an APM? Those are all design choices folks can make. Next slide.

I think I've mentioned these as I've gone along. Keep a short line of sight between an incentive and the desired behavior.

Ideally, and this is a real challenge for CMS and CMMI, which has tended to have to essentially specify a payment model and keep it fixed, even as both they as payers and care delivery actors learn it really is helpful to have ongoing iteration and refinement of APMs.

And then leaders, both on the payer side and care delivery side, should focus on what good care looks like, align the incentives

around that good care, and don't expect an APM by itself to drive behavior change.

So I think those are my comments. I think my next slide is really just a summation of what I have said. I won't go through this again. But again, I appreciate the chance to offer these reflections and look forward to the conversation.

CO-CHAIR HARDIN: Thank you so much, Dr. Sandy. All three presentations were very interesting in different directions and related directions. I know we have a lot of questions from our Committee. We're going to take questions until about 12:20, and then do summary and wrap-up.

So I'd like to invite my colleagues to turn their name tents up if they have a specific question. While they're thinking about that, I'm going to throw one question out.

So we have heard throughout the session today and yesterday about the importance of longitudinal relationship and longitudinal care. I'm curious how you thought about your teams, and are they displacing the existing system resources or building partnership? And

how did you consider that in design for long-term impact on the population?

DR. BIRKMEYER: Lauran, is that aimed at any one of the panelists?

CO-CHAIR HARDIN: So we've been talking about longitudinal care throughout the last two days. And as in Mary's session previously, she talked about how the transition team is building relationships with the existing system of care to maximize their capacity to continue to deliver this kind of care.

I'm curious how you're thinking about that with your interventions. So with Sound, or with, Marc, with your team that you're looking at or what you saw, Lew, with United Healthcare. How much are the teams landing and displacing versus integrating and maximizing?

DR. BIRKMEYER: Well, I can take a stab at that first, and I'm sure Marc has his own perspective as well.

I view sort of, you know, more specialized sort of acute care episode solutions as complementary rather than competing with sort of kind of longitudinal care. You know, they're both addressing separately needs that like are

not adequately addressed by the other.

You know, it's just a simple fact that for reasons of capacity, proximity, you know, clinical acuity, primary care physicians and their teams in the ambulatory setting are just not in the right place at the right time to drive like really impactful branch points that hospitals go down. That patients go down uniquely when they're acutely ill, and they're deciding between, you know, some, you know, and they're making really, really important choices. You know, rather than like what medication to be taking for their blood pressure.

Primary care physicians, obviously, are uniquely, you know, have the relationships longstanding that allow them basically to steer patients on a course that, you know, that really physicians or, you know, other non-physician specialists are just not positioned to take.

So the question is how do you make them work together? And obviously there's one component related to incentives and in terms of payment models, such that they're growing in the same direction.

And I think that we collectively have

gotten that wrong over time, because they're more competitive, you know, either they're in the more fixed time paradigm, anything else.

But you know, but it definitely is doable in our value-based payment arrangements that we have as a medical group with our largest national payers.

We have process-oriented incentives that are specifically tied to like kind of the mechanisms in the rates by which we plug back in patients with their PCPs. You know, that's obviously a pretty crude proxy, but it can be done.

DR. ROTHMAN: Yes, it's Marc. I would add that, so, fundamentally, we are never in competition with the primary care practitioners. We are not trying to take their patients from their panels. We are not trying to add billing that cannibalizes their opportunity to make a living. We are not trying to re-attribute these lives to some other entity. So there's an enormous amount of reassurance at the PCP level that we are not doing that. At the same time, we are also not trying to go deep into the post-acute and long-

term care and home health care space that local markets, that local organizations are fundamentally providing. I've been in that role in the past. My role is at Kindred Healthcare, I understand what that landscape looks like and how fragmented it is, so we are doing neither of those.

The thing that we're essentially doing is establishing the relationships with the patients at the right time and at the right frequency and becoming a trusted resources for that moment, whether that's a 10-day moment or a 90-day moment. And I vacillate back and forth as a professional in this discussion, you know, because there are days when, of course, I appreciate that all the care is local and needs to establish, you know, the relationship between the patient and the physician is critical and them having access and trust in their local networks.

At the same time, you see the variability, you recognize how incredibly stressed out and under-resourced these local practitioners really are, including, by the way, some of the post-acute care organizations who

can't get to referrals for transitional care members within 72 hours. And, you know, you often vacillate the other way and say they're actually not very good at that work, and I think Dr. Sandy said it, if I'm right, about how they don't necessarily know how to have that complex advanced care planning discussion at the right moment. They don't know how to find pharmacy resources to reduce polypharmacy and reduce the medication burden in the post-discharge period.

And so you're offering services and expertise that may not even actually exist in the local market, and so sometimes I push very hard to, I hate to use the word, but sometimes we're going around a lot of local resources in an attempt to try to knit together something that is cohesive for the patient in a very disorganized world that transitional care occupies. Even in their local market, even if they've gotten a phone call from a home health agency, it doesn't mean that their world has become organized for transitional care.

CO-CHAIR HARDIN: And then, Lew, did you want to add anything?

DR. SANDY: Yes, I would just add the

same themes that I think, you know, we have an idealized and romantic notion that, you know, the care delivery systems will take care of the patients and their families, and they do the best they can. And for some patients, it works great, but, for many others, we have to be aware of the tremendous amount of fragmentation and people being lost and falling through the cracks. And, you know, certainly, in the commercial space, you know, who has the longitudinal relationship with the patient?

Unfortunately, it's the payer who may be the only one if somebody sort of navigates around in a fairly fragmented system. And if everything is great, the role of the payer can be kind of superfluous. But if everything is not great, there can be a role for the payer.

And then the same thing with a highly-functioning ACO. A highly-functioning ACO should be the quarterback and coordinator, but there's variability there.

CO-CHAIR HARDIN: Thank you for addressing that question. Next, we'll go to Larry.

DR. KOSINSKI: Well, I have a couple

of comments and then a question for Dr. Birkmeyer. Actually, my comments are from Dr. Birkmeyer's presentation, as well.

I was initially very surprised by the comment that 25 percent of your BPCI-A patients expired during the 90-day period. But then, in looking at the list of diagnoses for the BPCIs in a later presentation, it did make sense. But it was shocking at first.

I was also caught by your comment about how the percentage of revenue for a specialist, if I'm understanding you correctly, the percentage of revenue for a specialist that is derived from inpatient work represents a very, very small portion of their total revenue, even if it's driven by procedures. And I'm a gastroenterologist, and I totally agree with you that, if you look at the revenue by work RVU for inpatient work versus work elsewhere, it's a small fraction. So we do need to change our payment model so that we're paying for what we need physicians to focus on.

And so that brings me to my question for you around nesting. I love the concept of nesting and believe in it strongly. Have you,

in your design around nesting, have you brought in any outpatient services, longitudinal services into your nesting models to maybe help push some of the revenue to the inpatient side to make these services a little bit more appealing to your specialists?

DR. BIRKMEYER: So thank you, Larry. Those were all really great questions and relevant to how your group designs, you know, the future nested bundled payments. You know, just reacting to your comments, we sometimes have sort of this monolithic view of sort of what bundled payment patient populations look like, but there's this fundamental dichotomy between elective surgery, you know, and it's disproportionately orthopedic surgery, and sort of the large majority of it, that's like acute medical illness, those are completely different worlds, different waivers, and, you know, I think they published literature on what's happened as a result of the BPCI-A program has been fundamentally different in those places.

Second, excluding cardiac surgeons, acute care surgeons, trauma, and maybe one or two others, it's really the exception rather

than the rule that non-hospitalist specialists are earning most of their income in the hospital. It goes that, you know, those that are probably aren't doing it by choice, rather than need, particularly GI.

But to your last question, the large majority of our focus has been around, to the extent that we design kind of our care models and our participation around the BPCI and then BPCI-A program as it was designed, 90 percent of what my, you know, direct experience has been around sort of on inpatient or on inpatient-only bundles, you know, kind of the 10 percent exception to that is that, in the MA plan world, you know, we also began developing sort of explicit partnerships with risk-bearing primary care groups upstream of us that basically incentivize sort of the inpatient groups to take better care and to, you know, better manage resources around their patients. Even the hospital. We never found a scalable grade one-size-fits-all for what that would look like, but, you know, we certainly know what doesn't work.

But I would defer to Dr. Rothman

because I know Signify, in addition what Marc described, has, you know, had some experience in leveraging what it learned from the inpatient bundles, you know, to bundles that are more longitudinal in nature, and he may have some additional insights.

DR. ROTHMAN: Yes, I'm happy to chime in, Larry. Just two comments I'll make on nesting sort of specialist-driven nesting bundles inside larger bundles. The first is that I'm not the avowed expert on it, but, as a friend of Francois de Brantes, I'll push you all in his direction. I'm sure you know him well. And I spent a lot of time with him trying to bring those models to various locales throughout the country, state-based organizations, large academic medical centers. And really the critical thing there was showing people the variability in pricing. It was really the pricing transparency that specialists either avowedly disliked seeing or were happy to participate in and then sort of the third party.

The successful ones were driven by a third party. The state of Connecticut was a good example of this where they would use the

pricing transparency and the quality transparency to form those partnerships with the middle-performing groups, not only the best groups but the middle-performing groups, on those two axes to bring them into the fold and incentivize both the members to think about who they were selecting as their specialists but also the PCPs as to who they wanted to partner with.

And we had fairly good success. The challenges, I think, mostly were the complexity is really intense. And so we all know that PCPs are on their own, have their own axes of sort of maturity within APMs. When you move into the specialty groups, the sophistication that was demanded of them from an APM complexity perspective, both understanding it, contracting for it, showing them the data for it, and then bringing resources, that was really where the rubber met the road, and the biggest challenges, just the complexity, seem to be a small potential nut for the complexity we were demanding of them to participate in, not having been the initial attributors for ACOs, for example, for the last seven years and having

that experience. Very, very difficult in my experience.

CO-CHAIR HARDIN: Lew, did you want to add to that?

DR. SANDY: The only thing I'd add is there is another alternative on the outpatient side in sort of the management of specialists within an accountable care structure, which is, because the problem with the nested bundle on the outpatient side, if it's not a procedure, you're essentially just rolling up, you know, a year's worth of utilization into a bundle.

Another way to get it is to not do a bundled payment but, basically, start with sort of clinical pathways with specialists, here's what we want you to do on behalf of our population, dear gastroenterologist or cardiologist, and you can run a pathway-driven approach and still keep a fee-for-service payment structure. That's a simpler way to go.

CO-CHAIR HARDIN: Thank you. Jim.

DR. WALTON: Thank you. I was going to direct this initial question to Marc, but I think, John, you might have a -- and Dr. Sandy, both might be able to help with this. I was

struck by Marc's comment around the ROI topic, you know, with regards to the 1.5, 2.5x ROI versus, you know, something that's more desirable and gives a little bit more, let's call it margin of safety for making these kind of commitments. And what I was reflecting on when I thought about that was one of the things that we've talked about as a Committee is the absence of meaningful data connections and communication and data sharing between the different elements of the ecosystem for complex patients that need intense 90-day transitions after an acute episode.

And so I was wondering what your thoughts would be if there was some requirement, like in, let's call it the future nested model, and you were going to participate in that in some way with, let's say, a PCP-based ACO or otherwise or a big integrated delivery network. But the requirement -- one of the accountability requirements, in addition to your traditional accountability requirements for quality and cost, would be an infrastructure -- a sustainability of the infrastructure to connect with fill-in-the-blank, right. Not just between

PCPs and specialists but also home health and other entities, CBOs, that are in the community for social determinants.

How would you perceive those requirements as further eroding your ROI here?

DR. ROTHMAN: That's a great question. You know, it's interesting that you mention some of the interoperability of infrastructure that might be needed around things like SDOH because, actually, the transition to home program that we established was run and documented on a backbone, essentially a social care coordination, SDOH EMR platform. So it had no billing capabilities for, you know, CPT codes. You couldn't bill for a doctor's visit on it at all. It was established from an organization called Tab Health that we acquired, which essentially was trying to create a digital ecosystem for all of the community-based organizations out there in the world that were told when health care reform was first phased in that thou shalt communicate with each other, and you shall bring patients onto a common platform, and it turns out that's really complex, right, because a lot of them are

dual eligible, there's consent issues, privacy issues, getting a methadone clinic and a food pantry and an ambulette service to all coordinate their care on a single platform, very, very difficult. And so that's what that platform was designed to do.

And so, to some degree, our ability to push services to the community was greatly enhanced by that because we had that database built in for all the community-based organizations, all of the people doing the work spoke the language of community-based care. Because we were not connected to any of the hospitals, we had to recreate the assessments, so we put in all the medical -- so in that sense, there is potentially a cost savings if we were all connected. Some of the assessment work wouldn't have to be replicated.

I look at this as the big version of having your blood pressure taken 16 times in a single visit or asked the same three questions in a single visit by the MA[39], the RN, social worker, you know. On a larger scale, that happens in transitional care, right? Someone at

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the hospital asks you all the questions, the home health nurse asks you all the questions on the telephone, the PT[40] who gets to your house asks you, so maybe, maybe there's efficiency there.

But I agree with you the requirement to integrate all of that electronically would likely be very, very costly, at least that's what we saw because of the need to connect not just hospital to PCP practice, which I thought we were supposed to have cracked by now easily with all the exchanges; apparently, we're a little behind. Add to that the complexity of all the community-based organizations and all of those resources you need to improve transitional care that often are not medical, I think it will be incredibly cost, if not prohibitive, consequential and might erode the ROI even further. I think that's a good call-out that I didn't mention.

DR. BIRKMEYER: So I've got a couple of reactions to both questions. On the ROI front, I'm not sure if some physicians would take the same perspective on, you know, 2x, much

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less, you know, 5x, return on investment as a requirement for being all-in on current or future value-based payment models. You know, generally speaking, most of our physicians view that as a part of our identity and our mission and would do it for nothing. But Sound as an organization, you know, is just in a place where it can't lose money doing so. We found that natural history, i.e., just, you know, giving sort of physicians an exhortation that were in this program was completely ineffective in moving the needle on anything to really be impactful.

You know, there's a certain infrastructure that we had to build in terms of uncompensated physician time, non-physician helpers, IT infrastructure, data infrastructure, et cetera. And as we amortize that across our entire risk portfolio, our cost was about $200 per risk-based patient hospital discharge. So we just needed to be in a program, you know, that basically generated at least that much in savings, such that, like, worst case, it was break even, and we pulled out en masse from the BPCI-A program where not only could we not, you

know, support that infrastructure but we were overtly losing money.

With regards to interoperability, I couldn't agree more with Marc that it's, you know, it's super challenging. But if we're asked, we'd move towards a nested bundle framework. You know, I view those that are optimizing sort of the nested bundles, whether they're acute care hospitalists, they're hospitalists, they're Signify-like solutions, even the post-discharge-based, all those groups are functionally subcontractors to the ACO or the MSSP or the other contracted entity that really owns the risk on the entire population, and I think it's those groups that basically need to maintain and set the standards for that, you know, for that infrastructure and basically set minimum expectations for how their subcontractors will plug in.

In my experience, it's super challenging, but it's becoming incrementally less so over time.

CO-CHAIR HARDIN: We're going to go to Walter next, and, just as a reminder, we have about 10 minutes left.

DR. LIN: Well, thank you to the panelists for this outstanding panel. I know just from the PCDT[41] perspective, as we were putting together the agenda for this meeting, we paid special attention to this panel, actually, because it's comprised of representatives of organizations who actually have done this, who have skin in the game, are financially at risk, and have scaled model successfully.

So I think, just as a prior venture capitalist, I think about passing the market litmus test, and clearly Sound, Signify, and Optum have done so. So I wanted to just thank you for sharing your experiences.

My question is actually around Marc's response to Lauran's question earlier, sometimes of the need to work around the PCP rather than work with them, because PCPs have other competing priorities. Our group actually works closely with UnitedHealth Group, a home-based medical care for the seriously ill company, and we often find the same thing: the need to work around the PCP. And I think that actually bears some deeper exploration because, at some point,

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the episode in the bundle will end, you know, be it 60 days or 90 days and, ultimately, the PCP will need to be involved, like it or not.

And so I'm wondering if our panelists can give us some advice on how better to design programs to incentivize engagement of the PCP, you know. What would you suggest that we do to try to get to a state where we're not working around the PCP but rather have an activated and engaged PCP in the transitional care period?

DR. ROTHMAN: I'm happy to kick off. I guess I'm the one who throughout the round term, and it's something I've dealt with my entire career, you know. As a self-avowed SNFist, like I said, back in the Permanente days, I really made it a priority to ensure that PCPs know that we're doing work when we're doing it, not after we've done it. And I think, you know, in reality there's work quote happening around PCPs all day long, right. Some of it they've kicked out into the world through referrals.

They don't know when the work is happening. They don't know that you went for the scan today, they don't know that the results

were read, you know, tomorrow. They might, when they see you again in the office as a patient, grab the piece of paper and or grab the chart and say, oh, I see you had the scan, but they're not actually in the loop on a lot of things that are happening for their patients. I think there's that famous quote, right, which is that there's eight minutes in the office, and there's, you know, 10,000 minutes at home when you're managing your diabetes. They don't know when you're dosing your insulin, they don't know whether you're eating salty foods. You know, so sorry if I used the word around.

But I think the real key that I've always put into practice is to alert PCPs that you are present and interacting with their patients, and I always remember a leader in one of our groups when we had Epic put in, and I was in the nursing homes, and one of my main goals was to sort of lift the black box off post-acute care because I always thought that was a black box where people put their patients and then maybe they got a piece of them out at the end and pretended they sort of knew what happened but they didn't really know. And it was

interesting, the leader said to me, you don't -- they get a lot of email in Epic, like, don't add to their email load. And I remember saying that's completely the wrong approach here.

So I think the approach is transparency that we are present, the opportunity to contact us, the accountability that you can contact me when we're finished working with your patients, here's what we've done, here's that communique, do I have to fax or call or this, the phone number that says you can call me and ask me anytime, sort of not hiding behind structures that separate and silos that separate.

How do you mandate that? I don't know. I've always led with that intentionally, and that's worked throughout my career and even in this program. You know, making sure that people, right after we first engaged, they knew we were involved. If we recommended any changes, they heard from us, and then when we were done, we signed off, and we gave them our phone number too.

So establishing those relationships through accountability, transparency, and

presence and personal connection, I don't know how to mandate that. That's, I think, part of the problem here. You've got tons of players interacting with members all day long and maybe spitting out a note when it's over and having it plop in a fax machine. I don't know how to make that mandated.

Your thoughts on that, John?

DR. BIRKMEYER: I think that, in large part, the lack of coordination between ambulatory care providers and PCPs and sort of, you know, those groups that manage the acute care episode, is, like, not surprising given that the way that the Alternative Payment Models have been set up, you know. Primary care center ACOs and MSSPs, you know, largely took a stance that their most important clinical lever for driving success is coordinating care in a way that just keeps people out of hospitals, even in the first place. And I think they've accepted as the cost of doing business that, once patients get in the hospital, well, they're on the other side of the moon and, you know, we'll just see what happens until they exit on the other side.

Participants, like Signify and Sound, that have really been on the bundle payment side, you know, there was nothing about the way that those programs were structured that really required that we talk to ambulatory care providers except maybe at the margins. But if we're, as we , we move to a model where bundle payments are nested within ACOs, there's a chair inside of and even a structure, you know, that like forces those groups basically to work with one another, and I would view it as playing out very similarly to the way that Sound physicians and I suspect Signify works with its health system partners with whom they're collaborating on ACOs. For any of our big health system partners that have ACOs for which we're functionally serving as a subcontractor, we have, at least quarterly, JOCs[42] whereby we're, you know, where there's shared accountability, we are reviewing data, and we're getting into the weeds about what aspects of care aren't functioning optimally and how we can work together a little more closely. I would imagine that being just a natural byproduct of the

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various ways by which nested bundle payment programs could work going forward.

CO-CHAIR HARDIN: Lew, did you want to add a comment?

DR. SANDY: Yes. This dynamic is very common in primary care, and it really centers around trust and this idea, you know, if you don't trust these other entities and what they're doing, you'll experience it as being worked around. But if you do trust what's going on, you know, PCPs are super busy, so if you can trust what the entity is doing on behalf of my patients, speaking as a PCP, and it's doing something that I think is valuable to my patients and, ideally, makes my life as a PCP easier or at least doesn't make it harder, if you can establish those dynamics, it won't be experiences working around but it's essentially an adjunctive supportive service to the PCPs.

CO-CHAIR HARDIN: I want to thank each of you for your expert and very valuable perspectives. We really appreciate you taking the time to be part of this session.

At this time, we're going to have a break until 1:15 p.m. Eastern. When we return,

we'll have our public comment period and then the Committee's deliberation and discussion before we adjourn. See you then.

(Whereupon, the above-entitled matter went off the record at 12:20 p.m. and resumed at 1:18 p.m.)

*** Public Comment Period**

CO-CHAIR SINOPOLI: So welcome back. I don't believe we have any public commenters signed up. Okay. Good.

*** Committee Discussion**

So hearing none, then we'll end the public comment section, and we'll move directly to our Committee discussion.

So now the Committee members are going to discuss what we've learned yesterday and today from our guest presenters, panel discussions, and background materials. PTAC will submit a report to the Secretary of HHS with our comments and recommendations based on this public meeting.

Members, you have a document of potential topics for deliberations tucked into your binder to help you guide the conversations. If you have a comment or question, please flip

your name tent up or raise your hand in Webex.

Who would like to start with their comments? Lauran, thank you.

CO-CHAIR HARDIN: I'll get us started with a few trends from the early presenters. So what actually is enhancing care transitions, actually, and delivery, people mentioned some really interesting best practices, including bundles, pathways, transitioning guides, flags, and standard of care practices in reaching to other systems, so really utilizing tools, workflows, and best practices to build anticipatory care management and disease management. So proactively addressing the needs on a medical level for clients but also using that same framework for addressing social determinant of health needs.

There's a real trend of issues with health-related social needs driving complexity in care transitions and a need for integration of payment or thought about that with how do we finance that delivery system in the community itself? The concept of hubs was mentioned multiple times, either these care transition teams functioning as a virtual hub to link

people together or actual emergence of hubs in the community organizing and connecting providers across sectors.

And then the importance with workforce that we really need to look at diversity of roles, potential payment for teams or non-physicians when we look at care transitions, and the integration of digital options, for example, a digital care coach that can escalate to a person to extend the reach of these teams.

So a lot of very foundational and interesting concepts for us to consider.

CO-CHAIR SINOPOLI: Thank you, Lauran. A few high-level topics that I kept hearing over and over were operational scalability, the fact that 75 percent of physicians are employed today, as opposed to the 25 percent independent. I kept hearing team-based care and the need for teams, the need for team-based payment models, and integration across the system of care with systems thinking, and bringing up the question of who is the accountable entity, and how does the primary care provider or specialist fit into that new

schematic of what a system of care looks like?

We also heard some great comments from Mary Naylor, who outlined her model of transition of care. I thought that was very comprehensive and a well-tested model. She gave very specific metrics for measuring potential outcomes. It's a model that I think we should consider, this model as a package for integration into other models to be embedded into APMs or to be paid specifically, as she described, as a 60-day bundle payment either separately or embedded within another APM or ACO model.

We also continue to hear over and over about the need for data, particularly in the ambulatory setting, and the integration across various ambulatory units, including SNFs and nursing homes but also other community organizations, other for-profit organizations, how do we invest in developing some type of meaningful use model to integrate those various entities together to be able to share data better?

I'll stop there. Larry.

DR. KOSINSKI: Well, my comments from

the two-day meeting, my first one is that we need a transition to accountable care. And I think this really came out in the course of the meeting, is that we can't just move without going through a transition period, and we need to focus on that and focus on how we build hybrid solutions that take us gradually out of fee-for-service into value-based -- into accountable care. And the example, the best example were the TCM codes. Can we expand them to the use of multiple providers following a hospital admission, and then can we track that data over time to help build the payment model that will ultimately be the value-based model?

I think using that as an example of what we have to do across the board in these transitions. But, you know, that was my first takeaway.

The second one, and I said this yesterday, we have to stop using the word discharge and focus on, you know, not discharge summaries but the transition summary, the transitional care summary. And then, again, on the same flavor of transition is the transition to digital care and how we can't let the chaos

drive the solutions. We need to have an organized approach as to how digital therapies, as they get developed, become integrated into care.

I like the concept in the letter that we're going to send, that payment drives that, you know. Where the payment goes will drive who controls where that digital technology is deployed.

And then down the same theme, integrating nested solutions into population-based total cost of care models. But what I have to emphasize is that we can't just have these for inpatient care. To have an inpatient bundle as a nested solution just defies the reality that we live in that what happens in the outpatient setting can avoid that hospital admission or can alter that hospital admission, it can become a medical admission instead of a surgical admission. So we have to, when we build our nested models, our nested models have to bring in multiple specialists, but they also have to bring in the longitudinal care, not just focusing on the inpatient.

And the final one I'm going to pile

on to what was said already is the database. You know, I forget which one of our SMEs[43] mentioned it but said $30 billion dollars created a situation where now just about all of the hospitals in the country and medical practices in the country are digitalized. Maybe we need a second one to make sure we're all on the same database because the mistake we made in meaningful use was deploying this, and now we have all these silos of data all over the place, and we have tools now that may be able to bring those databases together, but it would have been nice to have that homogenized from the beginning.

And those are my points.

CO-CHAIR SINOPOLI: Thank you, Larry. Jen. Oh, Chinni, were you up first? Okay.

DR. PULLURU: There are a couple of things that stood out to me as we listened throughout the two days. The first one was that there's clearly a variation of application of transitional care, whether it's code-based or whether it's episode-based. And, you know, we heard one from Mary that was highly effective,

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we heard Signify speak to it, we heard Sound speak to it.

And so, I think that the take-home to me is that that variation is going to exist and needs to exist for scale. Josh and I were talking about this earlier but getting to consistency and what I would focus us on is, you know, how do you measure outcome, and what are the outcomes we hold people accountable for but still allow for the variations that all of our panelists demonstrated could work?

The second thing is the period of time, that I think that's another place where we might be able to find a common denominator, is when does the time start in what we would call transitions of care, and when does it end, and what do we call that episode of time? And I think defining whether it's 60 days at a start of a hospitalization, whether it's to home, to post-acute, and what those different parameters are is a place where our Committee could maybe provide, through this work, some definition.

The third I found really elucidating was the fact that there is a difference in thought on what is a payment model versus a

clinical model versus an operating model and, I think, us having complete clarity on what we're asking for and how one thing leads to another. The clinical models typically sit outside, but a payment model clearly leads to an operating model. So just having some clarity on what it is that we are asking organizations to do and how are we crafting that ask I think is important. What is a lever?

And the last thing that I would have liked to have gotten a little bit more clarity on and I think we need to do some thinking around is the connection to the PCP and that longitudinal care of all of these platforms. There's obviously this foundational data element in how people can real-time talk to each other and what transparency the PCP knows and how they can leverage that data, but there's also the relational component.

So as a third party, such as Signify or Sound, often is integrated or some of these other point-of-care type of integrations, how do you get the buy-in of the primary care group, and how do you get the buy-in of the hospital system to invite you in to sort of allow for

this sort of intervention to happen with various stakeholders? And I think that is still pretty nebulous, and, without that buy-in, you can't plug in to the continuity of care that really needs to happen.

CO-CHAIR SINOPOLI: Thank you. Great comments. Jen.

DR. WILER: I think these last two days have really been excellent, and I think the panels and the expertise that came together were really special. So, thank you to Walter and the team that did that.

I won't repeat previous comments and won't repeat my comments from yesterday. But I think, from just today, there were three principles I will call them and then four practical messages that I heard.

The first is we've currently got, from a principle perspective, we have an uneven playing field, and Rick talked about this, between Medicare Advantage, the ACO programs, and really the third wheel or the third rail is fee-for-service plus/minus incentives like MIPS. And we heard the recommendation today that there should be a strategy to bring these three paths

together because, if not, the market will move to the path of least resistance, and that's what we're seeing. We had a lot of experts talk to us about what that path of least resistance might look like and why it might not be the right path.

Second, I heard that, currently, our model incentives are too weak and that there's got to be a short line between the incentive and then, ultimately, the behavior that is desired or what that desired outcome is. And I think we spent a lot of time in our last session talking about integration of specialist care, talking about the disconnect between where the payment goes and then those who are actually delivering the work and how those feel disconnected, so it's not a true incentive.

And then also a corollary to that is that just the current focus, disproportionate focus, excuse me, on PCPs is not sufficient to move the lever on quality or cost.

Then from a practical perspective, I heard, this is amplifying what was previously said, but I think it's important enough to say that in the post-acute space, a structured

payment to incent infrastructure around implementation or integration or IE[44] interoperability is critical, even if it's just a focus in the post-acute space. But then we also heard conversation about how we will be unsuccessful leveraging community-based assets if we also don't extend that integration, and that requires a deliberate infrastructure, i.e., utility cost.

Next, we heard today and we've heard in previous sessions mandatory is necessary. Although that path to get there is just as important as the end point, we heard from our experts that the DRG system took 15 years to mature, so there is an opportunity to now better define where the goalposts are from that perspective.

We also heard that fee-for-service payments in the TCM space are inadequate to cover a care team, and we heard about wonderful care models but how the payment model does not incent what we know is a care model that actually delivers outcomes that we care about. And then we also heard from one of our speakers

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that bundled payments, including the BPCI program, are also inadequate to cover the kind of care that's necessary from a transitions perspective.

And the last that we didn't talk about too much, but Mary Naylor mentioned this, and I think it's worth stating that strengthening the transitions of care incentive and the star rating program for MAs is worth a look. It sounds like that could be potentially a just do it. Thank you.

CO-CHAIR SINOPOLI: Thank you for that. Jim.

DR. WALTON: I'm going to comment. My comments are going to try to kind of expand on a couple of points that Jen had made specifically around my perspective of physicians and how they may be thinking about some of these things, particularly starting with the primary care doctors who have been making investments of time and money, their own time and their own money, to build out networks that can compete in value-based agreements. So when they're receiving these attributions, we heard and we understand that they're often blinded to the

acute episode that is occurring with their patients. They're unaware and unable to respond to social determinants of health variables that clearly are major drivers for subpopulations leading to persisting health inequities. They're unable often to stage the patients that require transitions, to stage those patients at levels one through five, like you would CKD[45], in order to bring the appropriate amount of services to each stage so that you're not overdelivering on one and underdelivering on another.

There is technology that's available that seems to be able to help stage patients. We think that there is in big data sets the ability to use AI machine learning to predict in populations death in the next 12 months where that would maybe lead to palliative care referral much more reflexively as if the score, the AI score, was at a certain level, rather than doing 100 percent palliative care referrals for all transitions.

Readmissions at 90 days, you could identify those with data, better data. Same

45 Chronic kidney disease

thing for potential for ED visits or prescription compliance and adherence conflicts with the patient and the patient's family. That information, those analyses, are available in order to help create a higher level of efficiency in the care of patients that are in transitions from acute episodes.

The physicians that I'm aware of don't have the time, and we've coined the word in the work that I was doing head room, the physicians don't have the head room, the space in their heads, to consider what we've done over the last two days. And so it's up to us to interpret that, to somehow to distill it down, and then to come with recommendations of services that would provide for them some relief in order to address some of our workforce challenges with physicians in their burnout, let's use the term burnout, principally because they have other pressing concerns based on their history of work, right. There's lots of things on their mind that say this is much more important than stopping or slowing down this, to do something that really is evidence-based, like what Mary or Signify or Sound were able to

offer. And so their inability to take the time to critically assess these really brilliant ideas that we heard is really a liability for primary care doctors.

And then, and certainly not the least, we were talking about a little bit ago physicians are increasingly starting to shun complexity, the primary care doctors. You know, I need relief, I need head room, I need time, so I don't burn out so I can continue to work, but I need to stay out of that co-morbid complexity problem as much as possible. So that's not leaning in. It's not a lean-in; it's kind of a neutral position of not leaning out. And so we've got some real challenges and opportunities.

But one of the things that I thought about was that the physicians' intrinsic motivation, and one of the doctors that spoke to us, I think this was John Birkmeyer said this, that they would do it for almost break even if they could because it's the right thing to do. So we don't necessarily need to have this massive ROI per se for physicians to lean into this. Now, the corporations that they belong to

need the ROI. The doctors themselves may not need the ROI. So I think that this would apply to both employed and independent physicians, and this is, I think, what John, the point was made, I just can't lose money on it. I thought that was a powerful statement.

So when you think about it, framing, I thought of the doctor as a voter, the doctor as a consumer, the doctor as a parent, as a son or daughter, and I thought about what a doctor would think in those other roles, the other hats that they wear. And I think that the policy thought that we would have, that we could offer would be like, you know, what we would all agree with is that we ought to reduce waste, and we've got to prevent waste. And it gets to Larry's point, which is post-acute and pre-acute, the idea that we could actually work on both ends simultaneously or recommend working on both ends simultaneously might make some sense and appeal to physicians to begin to lean toward this issue even though their head room hasn't been addressed with the hope that the head room that they need would get addressed by the design.

So I think the physicians would

welcome help for their attributed patients in a value-based arrangement, in a probably what we thought about as the nested model, right, which is you have an ACO that principally is PCP-based but not exclusively, that could be flexible to have multiple specialty parts in that. And I think all those doctors and those ACOs would accept some help, but they would have some caveats on accepting that help. And I think if those caveats are not addressed, the doctors will slow it down, if not stop it, and it will be passive aggressive as doctors ultimately can do that really well, be passive aggressive.

So one of the things that we heard is that the work being -- I loved the comment of the last thing. Work being done around us. I thought the perspective that PCPs and doctors are having work done around them all the time on their patients. That's such a wonderful image. And, oftentimes, we see that as a universal good, someone working around my patient, working around me to help my patients, as long as I get a visibility. In fact, the biggest critique we get around this is I didn't get the note back about what they did. I don't know what they did

to my patient when I sent someone out for a consult.

So when we extend -- when we think about adding new actors into this play, we have a tendency to describe those actions, those decisions as becoming more disintegrated. But so that brings the point of the need to connect in order so it doesn't feel disintegrated where then you would get the slowing down of the physicians from participating.

And the second thing they need -- so they need line of sight, you know, synchronously or asynchronously, so that they just know that it's there, that someone is going to tell them what they're doing. And the second thing is they need signs of success, of satisfaction, the patients are actually satisfied, which then makes the doctor satisfied. And then, of course, the objective of lower ED cost and readmits and admits.

So I think physicians will lean into this. I think there's a way for that to happen. We talked about it being nested in the ACO would be an effective mechanism for doctors to buy in, but, at the end of the day, we're in a

transition. We're not going to all be -- so we have a fee-for-service world that's trying to get doctors to move to value by 2030, all Medicare patients are going to be in something like that. So we have this kind of window of time, and I thought the concept of pay for the right thing and the accountability, and I think this is what Walter had been saying is that, like, look, in the fee-for-service world we're in today, we need some accountability for doing TCM, building the code, and we think that we could probably frame that. And it occurred to me that the same points of accountability for the current fee-for-service would also be true for the future PMPM[46] or total cost of care. It's the same one, which is lower ER visits, lower readmissions, and lower acute episode complications.

The patients would like that, too, right. They would like the fact that they're not having to come -- we heard that, too. People want to be at home, and the best thing is to have a zero event with acute episodes. And, of course, we know that's not possible.

46 Per member per month

And, finally, and I'll shut up, is that it's really clear to me that when we heard from some of our presenters is that the margins on this business are there today because we're not communicating in an integrated way across the system. It's disparate and it's poor communication -- and it exists today. And I think we ignore that at our own peril because trying to connect all that needs to be connected to do this well, do it better, is going to be really expensive, and maintaining it is going to be expensive.

And I found out when running a company of a large physician organization, I could capitalize the start-up cost oftentimes, but it was that operating cost and the upgrades that would just eat my lunch. And then you're, kind of, you're married to it a little bit, and you kind of have to get through that. And, of course, at the rate of technology change, that becomes cost prohibitive for a lot of organizations.

So I think we really, I've hit on all those themes, and I'll leave it there for my colleagues to round this out.

CO-CHAIR SINOPOLI: Thank you, Jim. Lee.

DR. MILLS: Sure. Appreciate all those great points and agree with everything that's been said. A few more that come to mind. I'm going to pile on the consistent refrain going on now about the third or fourth PTAC model in a row, which is we've got to trend towards fewer voluntary and more mandatory models. I think two meetings ago the refrain was we must make it increasingly uncomfortable in the fee-for-service space, and I'm not sure I'm seeing much in the Medicare fee-for-service space making it increasingly untenable. So that's an opportunity.

I was again struck by the consistent refrain that we must do for the post-acute space and the community CBO space in data what we did for physician practices and hospitals in the last decade, realizing it was a decade and $40 billion dollars, but it's that important. I was really struck by the model that one of our speakers had just dividing up, I think it was John Birkmeyer, dividing up all the cost from admission to stable outpatient space, and only a

third of the cost is in the hospital. It seems like much of the focus is on the hospital-centric side, and it's DRG paid, it's already prospective. I mean, there's just not much scratch there left. There's always ways you can always do better, but from discharge to stable outpatient care space is essentially untapped and untouched, and that needs the data to be effective at that. So that was pretty compelling to me.

I was struck by, yes, that was the theme and I understand that, but speaker after speaker just spoke to the incredible complexity of the transition activity. And most of them spoke about having and demonstrating success but with a dedicated single-focus organization. And that's not to say it can't be done. Many of us have done this, and it's just a part of our practice. We knew our patients, knew our families, did our transitions of care for our practices, but that's a model that increasingly doesn't exist in modern health care. And so I think we have to respect that and think about how we can have many different styles, and I think we heard more that the exact composition

of who takes care of it is not as important as what gets done. And that just speaks to the team composition. Everybody spoke to the centrality of a team doing this, and we heard several different models. It doesn't seem to matter much who the lead or quarterback position of the team is much more than it does what are the functions that take place in this transition activity.

So to a degree, and I admit it's done lots of quality improvement work, with all due respect to each of us, sometimes getting the physician out of it is how you do highly reliable scripted work repetitively and rise to raise quality, and so, to a degree, this is about health equity and social determinants and connecting to communities and really digging deep in the patient's living environment. Frankly, the clinician is less important than the team you wrap around this, and that actually matches up with our workforce demands which is important to think about how we do this. That means there's really not a good linkage to a fee-for-service system then because, of course, fee-for-service CPT codes are all dropped by a

billing professional, and there's only three Medicare billing professionals by and large, right. So that was all pretty compelling and convicting to me.

And then, lastly, I was again struck by people who commented on just the upside incentives and downside risks, especially in MIPS, are just not sufficient to drive behavior. And we have certainly experienced that, as well. I think most of us would say something instinctual. It's going to take 30 to 40 percent upside minimum to really change behavior and pursue it. I know in the total cost of care capitated model that I help operate every day for 150,000 beneficiaries, our model has basically 100 percent upside and 100 percent downside risk-adjusted based on utilization quality. And even that changes behavior only slowly.

So thank you.

CO-CHAIR SINOPOLI: Thank you, Lee. I want to check with Audrey and see if she has any questions for us or clarifications. No. Okay.

All right. Well, great. This was a

great day, great two days. And did somebody else have a question?

DR. LIAO: Actually, I had just a couple of comments if we have time. I'll just supplement very briefly because I agree with many of the things that were said. I think one of the things that really struck me was the diversity of different ways people are managing care transitions. You know, we're gathering here under the heading of improving the management of care transitions in these population-based models and agree with what Lee said that there's just so many different ways in that period.

I was also struck with what Grace mentioned about the linkage between the payment model, the operational model, and the kind of patient care model. We're obviously thinking about it from a payment perspective, but I think realizing those interactions, how payment models either support or don't support what we want operationally or a patient care I think is very important.

And the reason I say that is I was just struck also by all the other organizations.

They're all doing things a little bit differently. Some are very hammered out very specifically. They even very constructively and pleasantly disagreed with each other on certain things and the way they did, but they've all been driving outcomes that they're proud of.

And so I'm left with kind of those two things that I heard around paying for the right things and paying, you know, clinicians right. And in the diversity of all the different ways that we can manage care transitions, I guess I am left with the sense of, in that diversity, some are using TCM CPT codes, maybe not 100 percent but I guess, if you're an APM, using it more. Some don't think that's right. They're doing all the activities, but they're not billing them. Some operate through bundled payments for 90 days, some drop those bundles and ACOs, some are suggesting a 60-day case rate. Yes, you know, and I think we just need to recognize that, if we are okay with the diversity of patient care models and operational models, maybe we ought to be okay with some variation in the payment approaches, as well. And the moment we move to something

that's clean, that's refined, that's simple, we are necessarily saying we are narrowing what we think the patient care and operational model should be.

I don't know that we're there today. Maybe that's something that's aspirational, but I think we should grapple with as we think about payment incentives.

CO-CHAIR SINOPOLI: Great. Thank you, Josh. Lindsay.

DR. BOTSFORD: I'll be brief because a lot of great points have been made. I think just a couple that I heard that I want to make sure we captured are I think that the suggestion that the idea of, you know, as we think about testing which payment model is right or which care model is right, when we think about testing implementation, if we take the investment, the up-front investment off the table and pay up front and then track results, as opposed to expecting to see results and then give payment back, that could be a way to accelerate movement to where we need to be. I think especially that was shared in the context of if you're within an ACO or a system where there's already

accountability either through full risk or where there are incentives to reduce utilization, it could reduce the barriers to getting some things tested.

And I think the second point that maybe hasn't been raised as much but, you know, as we think about measuring success of care transitions, in addition to the measurements of reducing cost and increasing quality, thinking about adding the patient experience as a part of our measurement of success would be something to keep in mind.

And then, similarly, from the patient perspective, in terms of reducing barriers to utilizing and accessing these services, ensuring there can be decreased patient responsibility for high-value activities. So if we -- I think the preponderance of evidence is that transitional care activities are high-value things. We should decrease the barriers for patients to want to access these services and think about ways we could reduce barriers there.

I think the other piece around one of the barriers to effectiveness in this is the attribution. So from a patient perceptive, how

could we incentivize a patient's choice of attribution into one of these entities that's providing these services could simplify that, as well? Thank you.

CO-CHAIR SINOPOLI: Thank you, Lindsay. That's great. Walter.

DR. LIN: Thank you. You know, one of my old mentors used to say a good way to structure comments is, first, point with pride; second, view with alarm; and, third, end with hope. So in that vein, I'm going to try to make my closing remarks around that structure.

So first, point with pride. You know, I am super pleased with how the last two days have went in this PTAC meeting, and I just want to acknowledge all the really hard work that ASPE and NORC staff have put into this. You know, I think it's been just a tremendous day of hearing from experts and also the presentation they put together that I had the fortune to present at the very beginning previewed a lot of the themes that we heard over the ensuing two days. So I just want to thank you, extend a sincere round of thanks to both ASPE and NORC staff.

In terms of viewing with alarm, there were a few things today that made me pause. You know, I agree with a lot of the comments that have been already made, and I won't rehash them but just a couple of points in addition that I would make.

One, you know, the whole idea that we have highly successful participants of value-based programs, like Sound and like Signify, those that have scaled a model, passed the market litmus test, were doing well both clinically and financially, everything that we would want from a model, that they had to withdraw from a model program is a bit disconcerting to me, right. I mean, I think you think about all the investments that John Birkmeyer talked about Sound making to make that program work, I'm not sure if they're continuing it or not but, from the sounds of it, they couldn't make it work under the new rules, right.

And so I think, as we think about this, PTAC has been so focused on kind of figuring out payment models to foster good clinical models. But I think the point that, I

think it was Grace that made, we need to go beyond that. It needs to be a scalable operating model that we need to think about it, and how do we encourage providers and other players to make the investment to transition to value-based care without moving the goalpost or pulling the rug out at a later date when they're succeeding, you know?

And so I think that was a bit concerning to me, and I was kind of pondering about that. And I know PTAC will be discussing the transition to value-based care over our ensuing meetings, but that is something that we want to think about because if we can't, I don't want to use the word guarantee, but if we can't ensure somehow that the providers or other organizations who make the investment to transition to value-based care can continue to reap the benefits of those investments down the line, I think that would make that transition very, very difficult. So that's one.

The other point I would make in terms of viewing with alarm is some of the comments that Rick and others made about the level playing field with Medicare Advantage.

Specifically, there are a couple of examples that have come up over the past two days around that. One example that was discussed yesterday during the acute/post-acute session was around the three-day waiver for SNF benefits. Right now, Medicare Advantage and Medicare beneficiaries and two-sided risk ACOs can enjoy the benefits of that waiver but not under traditional fee-for-service Medicare, right. So that's just one example of a playing field that's not level.

Another example is something that Dr. Birkmeyer brought up around the ratchet effect of bundle payments. So we have these programs where you have a ratchet effect, and your baseline is reset based on your good performance, and that can only go so far. We've heard other SMEs talk about this at prior sessions, as well. And I don't think that's necessarily something that Medicare Advantage has to deal with, right. And so, you know, I wonder if we're kind of designing into the system, into some of these pilots, a failure point, if you will. And so that was also a bit concerning.

Finally, end with hope. You know, I think that these two days have renewed my enthusiasm for focusing on care transitions. There's ample evidence, as we've heard again and again from our experts, of the efficacy of these programs, and there are many of them out there, including the ones that were presented to us, and they've all shown really great clinical results. We have payment models that have shown to be a success. And, you know, I think we have a lot of learnings that we can build on.

And, ultimately, you know, I think where I'm left with in all this is focusing more and more on paying for outcomes rather than paying the providers for services because if you're paying for transition care services, isn't that just another form of paying fee-for-service? So I think, ultimately, we should be thinking about how we can encourage future models to have a very focused lens of paying for outcomes.

*** Closing Remarks**

CO-CHAIR SINOPOLI: Thank you, Walter. Those were great comments, and I want to reiterate some of the things you said in

terms of just thanking everybody today. I appreciate everybody's time, particularly our expert presenters and panelists who donated their time to prepare and to spend time with us today presenting, to all my colleagues around the table who really contributed to making these last two days successful, and I think particularly to ASPE and NORC who do all the hard work behind the scenes and really make our lives very easy in terms of trying to run these meetings and move value-based care forward. So I'll just leave with those appreciations.

We've explored many different facets of how population-based models can incur smooth care transitions for patients over the last two days. We'll continue to gather information on our themes through a Request for Input on our topic. We're posting it on the ASPE PTAC website and sending it out through the PTAC listserv. You can offer your input on our questions by July 14. The Committee will work to issue a report to the Secretary with our recommendations from this public meeting.

*** Adjourn**

And with that, the meeting is

adjourned. So, thanks to everybody.

(Whereupon, the above-entitled matter went off the record at 2:02 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: 06-13-23

Place: Washington, DC

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

Neal R Gross

Court Reporter