# 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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Monday, September 16, 2024

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*
WALTER LIN, MD, MBA
TERRY L. MILLS, JR., MD, MMM
SOUJANYA R. PULLURU, MD
JAMES WALTON, DO, MBA
JENNIFER L. WILER, MD, MBA

PTAC MEMBER IN PARTIAL ATTENDANCE

JOSHUA M. LIAO, MD, MSc*

STAFF PRESENT

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

*Present via Zoom

A-G-E-N-D-A

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

9:04 a.m.

* CO-CHAIR HARDIN: Good morning, and welcome to this meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC. My name is Lauran Hardin, and I am the Co-Chair of PTAC along with Angelo Sinopoli.

Since 2020, PTAC has been exploring themes that have emerged from stakeholder submitted proposals over the years. Previous PTAC theme-based discussions included addressing the needs of patients with complex chronic conditions or serious illness, developing and implementing performance measures, encouraging rural participation, improving management of care transitions, and improving care delivery in integrating specialty care, particularly for total cost of care models.

At this public meeting, we've brought together various subject matter experts to gain perspectives on identifying a pathway toward maximizing participation in total cost of care models. How do we move toward the goal of maximizing participation in population-based total cost of care models?

We also know that this topic is of interest to the Innovation Center at CMS[1]. We are honored to have Dr. Liz Fowler, the Deputy Administrator of CMS, and Director of the Center for Medicare and Medicaid Innovation here with us today to give some opening remarks.

Dr. Fowler previously served as Executive Vice President of Programs at the Commonwealth Fund and Vice President for Global Health Policy at Johnson and Johnson. She was special assistant to President Obama on Healthcare and Economic Policy at the National Economic Council.

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

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

  Welcome, Liz.

1 Centers for Medicare & Medicaid Services

DR. FOWLER: Thank you, Dr. Hardin and Dr. Sinopoli, for your leadership of PTAC. I'm really pleased to be back here for the third meeting of 2024.

I'm not going to say too much here at the opening session, because there's a panel that takes place later this morning that's dedicated to the work of CMMI to advance accountable care strategies and support advanced primary care. And I believe I'm kicking off that session. So I will spare you having to hear me speak about these topics more than once.

But I do want to emphasize that the topic for this meeting is of great importance and significance to CMS Innovation Center, as you said, Dr. Hardin.

The pathway to meeting the ambitious 2030 goal that CMS has laid out to have all beneficiaries in traditional Medicare in care relationships with a provider who has accountability for quality outcomes and cost is an issue we spend a lot of time talking about, both within CMMI and CMS, and externally.

We know that value-based care and more specifically, as we're discussing today and

tomorrow, accountable care, delivers improved outcomes, a better care experience for patients, and can lead to lower health care costs.

For providers, payment innovation and incentives, like those in accountable care, can facilitate movement away from the fee-for-service revolving door or hamster wheel of 15-minute patient visits, which means providers can really spend more time focusing on patients that need more attention. And they can provide better care coordination and more patient-centered care.

The Innovation Center's 2021 strategy focused on five objectives to further the Center's vision of a health care system that achieves equitable outcomes through high-quality, affordable, person-centered care. The 2030 accountable care goal is central to achieving this vision and to our overall strategy.

Today more than half of Medicare beneficiaries are on Medicare Advantage plans, and those who choose not to join MA, and want to retain the full choice of providers, for them we want to make sure that traditional Medicare remains a viable option that provides high-quality accountable care.

And meeting this 2030 goal really requires a multi-pronged approach in coming together as a community of health professionals to understand the changes, opportunities, and challenges of an increasingly complex health system in order to move the needle on broad health system transformation.

I'm really looking forward to the discussion today, and we are so pleased to be invited back by PTAC for another CMS panel discussion at this meeting.

As I mentioned, I'll be kicking off the CMS panel where you'll hear from the Innovation Center senior leaders who've been working and leading different parts of our strategy and making progress towards that goal.

We'll be presenting on top priorities, including our vision for primary care, an update on our accountable care vision, our strategy for engaging specialists, and the hard work of aligning across different payers.

During the discussion today and tomorrow, PTAC is going to hear a lot about the definitions of what qualifies as accountable care. And we think this could be considered sort

of part one of the discussions. We plan to have a lot more to say about how we're thinking about that at the Learning and Action Network annual meeting in November in Baltimore.

But I want to highlight how we're thinking about measuring progress towards our accountable care goals, starting with how we define accountable care. And we're focused on that longitudinal care relationship which we define as longer than six months and with accountability for total cost of care and quality.

Six months means longer than a knee replacement or acute episode of care and really focused on providers who are addressing chronic health issues that can sometimes be hard to address in a first or single visit with a clinician.

We think we've made important progress here, and we'll speak more about that at the CMS panel. But today's focus should not just be on what we've done but where we're going in the future over the next five and a half years.

We look forward to hearing from all the speakers that you've lined up. It's going to

be a really important discussion and, again, we look forward to being part of it and thank you again for your partnership.

*** Welcome and Co-Chair Update - Identifying a Pathway Toward Maximizing Participation in Population-Based Total Cost of Care (PB-TCOC) Models Day 1**

CO-CHAIR HARDIN: Thank you so much, Dr. Fowler. We really appreciate your continued support and engagement, and we look forward to continuing to collaborate with you and the Innovation Center.

So for today's agenda, we will explore a range of topics related to identifying a pathway towards maximizing participation in population-based total cost of care models, including stakeholder perspectives on developing a pathway toward having all Medicare beneficiaries with Part A and B in care relationships with accountability for quality outcomes and total cost of care.

Envisioning future total cost of care models, the needs of different types of participating organizations, and necessary

components for success. Organizational structure, payment, and financial incentives for supporting accountable care relationships, developing a balanced portfolio of performance measures, and addressing challenges regarding data, attribution, benchmarking, and risk adjustment.

The background materials for this public meeting, including an environmental scan, are posted online on the ASPE[2] PTAC website's meeting page. Over the next two days, we will hear from many esteemed experts with a variety of perspectives, including the viewpoints of previous PTAC proposal submitters.

Later this morning, CMS and CMMI leadership will join us for a panel discussion and share their vision to achieve the goal of having all beneficiaries in an accountable care relationship by 2030.

I also want to mention that tomorrow afternoon we'll include a public comment period. Public comments are limited to three minutes each. If you would like to give an oral public comment tomorrow but have not yet registered to do so, please email ptacregistration@norc.org.

2 Assistant Secretary for Planning and Evaluation

That's p-t-a-c registration @ n-o-r-c .org.

The discussions, materials, and public comments from the September PTAC public meeting will all inform a report to the Secretary of HHS[3] on identifying a pathway towards maximizing participation in total cost of care models. Over the next two days, the Committee will discuss and shape our comments for the upcoming report.

Before we adjourn tomorrow, we'll announce a Request for Input which is an opportunity for stakeholders to provide written comments to the Committee on identifying a pathway towards maximizing participation in population-based total cost of care models.

Lastly, I'll note that, as always, the Committee is ready to review and receive proposals on possible innovative approaches and solutions related to care delivery, payment, or other policy issues from the public on a rolling basis.

We offer two proposals submission tracks for submitters allowing flexibility, depending on the level of the detail of their payment methodology. You can find information

3 Health and Human Services

about submitting a proposal on the ASPE PTAC website.

*** PTAC Member Introductions**

At this time, I would like my fellow PTAC members to please introduce themselves. Please share your name and organization, and if you would like, feel free to describe any experience you have with our topic. We'll go around the table, and then I'll ask our members joining remotely to introduce themselves.

So I'll start. I'm Lauran Hardin, and I'm Chief Integration Officer for HC2 Strategies and a nurse by training. I spent the majority of the last 20 years focused on care model and population health, initially care management and MSSP[4], pioneer ACO[5] and BPCI[6].

I was part of the team that started the National Center for Complex Health and Social Needs, and I've spent the last 15 years focused on underserved and complex populations and designing models to meet their needs.

Angelo, would you go next?

CO-CHAIR SINOPOLI: Yes, thank you,

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

Lauren. Angelo Sinopoli, I'm a pulmonary critical care physician by training. I've worked with several large integrated delivery systems and built clinically integrated networks, as well as enablement companies to support those networks and others. And I'm looking forward to the next two days.

CO-CHAIR HARDIN: And then let's go to Josh next. Apologies, Jim.

And Josh, you are muted. There you go.

DR. LIAO: Okay, just wanted to make sure we're going to the web. Good morning, everyone, Josh Liao. I'm an internal medicine physician by training and a professor of medicine and public health at University of Texas, Southwestern Medical Center.

Outside of work on this Committee, I've been really fortunate to work on physician-focused payment models in a variety of contexts, one, leading a portfolio of research and evaluation on the topics for episode-based and population-based models and how they interact.

In the past, I then served in a kind of leadership capacity to think about payment

strategy, and population health, and primary care networks for an integrated regional delivery system and through a variety of engagement with stakeholders and decision-makers.

CO-CHAIR HARDIN: Thank you, Josh.

And, Larry?

DR. KOSINSKI: Thank you, Lauren. I'm Larry Kosinski. I'm a gastroenterologist by training. And after a long career of 35 years in practice in the Chicagoland area, I have devoted the last 10 years of my life to value-based care solutions in the specialty space, specifically dealing with chronic disease.

I founded SonarMD which is a national value-based care solution now for patients with inflammatory bowel disease. And I'm now in my third year on the PTAC Committee.

CO-CHAIR HARDIN: Thank you, Larry.

And Jim, let's go to you.

DR. WALTON: Good morning, it's good to be here. My name's Jim Walton. I am a Dallas, Texas, general internal medicine physician retired from internal medicine practice at Waxahachie, Texas. And then I was a CEO. I'm

president of an ICO[7] in Dallas for about 10 years and just retired. It's good to be here.

DR. MILLS: Good morning, my name's Lee Mills. I'm a family physician by training. I currently am a consultant, but I spent four years as chief medical officer of a regional provider-owned health plan operating in the Medicare Advantage individual exchange commercial space.

Over my practice career, I have practiced within, helped operate or lead five different CMMI models and two different ACOs. So thanks, glad to be here.

DR. BOTSFORD: Good morning, I'm Lindsay Botsford. I'm a family physician in Houston, Texas, where I also serve as a regional medical director with Amazon One Medical.

I also serve as the chair of the Iora Health Network governing body, an ACO REACH[8] entity. I have been in a variety of different payment models including ACOs, MSSP track, and currently see patients as well.

DR. FELDSTEIN: Good morning, I'm Jay

7 Integrated Care Organization
8 Realizing Equity, Access, and Community Health

Feldstein. I've trained as an emergency medicine physician. I was in the health insurance world for 15 years handling commercial and government programs.

And for the last 10 years, I've been the president of Philadelphia College of Osteopathic Medicine trying to get our physician workforce ready for this new world of total cost of care and value-based care.

DR. WILER: Good morning, I'm Jennifer Wiler. I'm a tenured professor at the University of Colorado School of Medicine and practicing emergency physician. I've spent the last 20 years primarily on the delivery side working with small and large provider group practices in various leadership roles and also hospital executive leadership in quality and safety.

I'm also a co-founder of a health system innovation center where we partner with digital health start-ups to grow and scale their solutions to improve value in care and was also a co-developer of an Alternative Payment Model that this Committee considered and approved.

DR. LIN: Good morning, Walter Lin,

founder of Generation Clinical Partners. We are a group of providers in the Greater St. Louis area passionate about the care of the medically complex and seriously ill residing in senior living. We are involved with a number of different value-based programs, including specialized ACOs, Institutional Special Needs Plans, as well as the PACE[9] program.

DR. PULLURU: Good morning, Chinni Pulluru. I'm a family physician, practiced for about 15 years. I spent about 20 years in value-based care transformation leading clinical operation strategy and access, first at Duly Health in their subsidiary MSO[10], about 5,000 physicians, and then as chief clinical executive at Walmart Health.

I've developed and led an implementation across the risk continuum to produce, in both Medicare and commercial, to produce quality and financial outcomes. I also sit on the Board of Stellar Health and work with them in value-based care transformation. And most recently I've co-founded a genetics company.

9 Program for All-Inclusive Care for the Elderly
10 Management Services Organization

CO-CHAIR HARDIN: Thank you all so much. As you can see from this group, we have a diverse group of perspectives on value-based payment. And we appreciate each of your contributions.

So next let's move to our first presentation. Five PTAC members served on the Preliminary Comments Development Team, or PCDT, which has collaborated closely with staff to prepare for this meeting.

Angelo Sinopoli was the PCDT lead with participation from Jim Walton, Josh Liao, Lee Mills, and Chinni Pulluru. I'm thankful for the time and effort they put into organizing today's agenda. The PCDT will share some of their findings from the analysis to set the stage and goals for the meeting.

PTAC members, you will have an opportunity to ask questions afterwards. Now I will turn it over to Angelo.

*** PCDT Presentation - Identifying a Pathway Toward Maximizing Participation in PB-TCOC Models**

CO-CHAIR SINOPOLI: Thank you, Lauran. And I'd like to also start out by thanking my

fellow PCDT members and the ASPE team and NORC teams for all their time and hard work gathering this information and constructing this deck.

We hope this presentation will provide some background and context for the discussions with our presenters and panelists over the next two days.

So the objectives of this theme-based meeting are to discuss the vision for future accountable care relationships and identifying pathways toward having all Medicare beneficiaries with Parts A and B in some type of accountable relationship by 2030, and to understand the necessary components for success in developing population-based total cost of care models for different types of providers.

To discuss the organizational structure, payment, and financial incentives needed to support population-based total cost of care models, and to identify approaches for addressing key issues and challenges, such as performance measures, attribution, benchmarking, and risk adjustment related to facilitating accountable care relationships in population-based total cost of care models.

To set some context for this theme-based meeting, PTAC has received 35 proposals for physician-focused payment models. Nearly all of these proposals address the potential impact on cost and quality to some degree.

Committee members found that 20 of these proposals met Criterion 2, which was Quality and Cost, including five proposals that were determined to meet all 10 of the criteria established by the Secretary for physician-focused payment models.

Additionally, at least nine other proposals discussed the use of TCOC measures in their payment methodology and performance reporting.

Now to move on to give you a little bit of background, PTAC is using the following working definitions of an accountable care relationship. That is a relationship between a provider and a patient, or group of patients, that establishes that provider as accountable for quality and total cost of care, including the possibility of financial loss or risk, for an individual patient or group of patients for a defined period of time.

It would typically include accountability for quality and total cost of care for all of the patient's covered health care services. This definition will likely continue to evolve as the Committee collects additional information from stakeholders.

PTAC is using the following working definition of population-based total cost of care models. So that is an Alternative Payment Model in which participating entities assume accountability for quality and total cost of care and receive payments for all covered health care costs.

I'll note that in this model it does not include pharmacy-related costs at this time. But for a broadly defined population with varying health care needs during the course of year, within this context a population-based total cost of care model would not be an episode-based, a condition-specific, or a disease-specific specialty model.

However, these types of models could potentially be nested within a population-based total cost of care model. This definition will also likely continue to evolve as the Committee

collects additional information from stakeholders.

PTAC has identified the following key questions for identifying pathways toward having all Medicare beneficiaries with Parts A and B in accountable care relationships.

One is categorizing Medicare beneficiaries by the extent to which they are currently in care relationships with accountability for quality and total cost of care; for characterizing geographic areas by the extent to which their providers are participating in value-based care; identifying model characteristics associated with success; developing approaches, models, target time frames, and intermediate area status for increasing involvement in accountable care relationships for various categories of Medicare beneficiaries, example, dual eligibles; and identifying and addressing gaps and challenges.

As you can see from this graph from 2021, half of Medicare beneficiaries were in traditional fee-for-service. Half of those that were in traditional fee-for-service were in some

type of APM[11]. The vast majority of those were in an MSSP ACO with a smaller amount in a CMMI ACO, and then a small amount in other CMMI models.

This is just a reminder of the LAN framework for supporting the transition to Alternative Payment Models payment. And you can see as it progresses from left to right, moving from fee-for-service to Category 4, which are population-based payment models.

And this is just a reminder that PTAC at the moment is interested in Category 3B which are models of shared savings and downside risk, and population health models.

So as we take those definitions and those interests, and we look at the percentage of payments to providers by Alternative Payment Model category and payer type in 2022, in aggregate that was about 25 percent of all payments.

For commercial, it dropped to about 16 and a half percent, for Medicaid, 18.7 percent, for Medicare Advantage, about 39 percent. And for traditional Medicare, it was about 30 percent of all those payments going through a Category 3B

11 Alternative Payment Model

or Category 4.

As you can see from this graphic, multiple APM models have been tested over the last decade. Testing various CMMI and CMS models from 2012 to the present has significantly advanced our understanding of APM model design and adoption.

Over time these models have provided key insights into how value-based care can improve quality and reduce cost in health care. Although there have been many episodic bundles, as you can see from the lower half of this slide, the Committee is interested today in the population health and advanced primary care models.

The key contributions from the testing over these years has been a gradual shift towards risk with MSSP beginning with upside-only risk and then moving to pathways to success which pushed ACOs toward two-sided risk. Some of these have emphasized care coordination such as Primary Care First and CPC+[12]. Others have emphasized health equity such as Making Care Primary in the

12 Comprehensive Primary Care Plus

AHEAD[13] model.

The testing over the last decade has shown the importance of financial risk, care coordination, quality measurement, and flexibility to drive adoption and impact care outcomes.

This iterative testing has led to more sophisticated, tailored models that are better suited to diverse health care environments and needs. But much work needs to be done to determine which models work best and what components need to be integrated as we move to 2030.

This is a little bit more complicated graphic that demonstrates that, as we started out in 2012, we had 114 ACOs with 1.7 million beneficiaries. This started out as the standard MSSP model with Track 1, which was one-sided risk only, and Track 2, which was two-sided risk with a moderate level of downside risk.

In 2016 there was the addition of Track 3 which allowed for higher levels of downside risk than Track 2. In 2018 there was

13 States Advancing All-Payer Health Equity Approaches and Development

the addition of Track 1+ which had less downside risk than Tracks 2 or 3 and were designed to encourage more practices, especially small practices, to advance to performance-based risk.

In 2019 there was the development of Pathways to Success which had a basic track that started with one-sided risk, shifted to two-sided risk, then phasing in higher levels of risk over time.

There was also the enhanced track which had the highest two-sided risk option for more experienced and high-revenue ACOs. ACOs were automatically advanced to the next step on the glide path at the start of each performance year.

You can see that from 2012 to 2024 that we had increasing numbers of ACOs up until about 2018. Since then, we've had some decrease in the number of ACOs with a leveling off over the last few years. Despite that, we've had increased beneficiaries from 1.7 million beneficiaries to today, to 10.8 million beneficiaries.

So the key changes in CMMI model design over time was increasing financial

accountability, accommodating providers less able to take on risk, reducing provider burden, increasing the duration of the models, supporting low-revenue ACOs, incorporating health equity, and incorporation of specialists into the models.

The Committee thought about various inter-related factors affecting beneficiary practice alignment with APMs. Certainly the first factor to consider is the provider themselves. And things that may help predict their participation include the provider type, their panel size, their already existing level of clinical integration, and their previous experience with value-based care infrastructure and processes.

As we move further out to more of a community-level set of factors, such as the primary care provider capacity in that community, provider market consolidation, the number of providers that are actually employed, and the presence of community-based organizations that help these practices address the significant social determinants of health that may be in their market.

And, from a broader geographic factor,

the penetration of Medicare Advantage and the penetration of MSSP, the socioeconomic status and the Area Deprivation Index in the markets in which these practices exist, and the rurality of the geography in which they practice.

Certainly other enabling policies such as the predictability of the APM models in their area, the availability of APM models for different types of providers, and the relationships between APM models and other options in the community.

As you can see on the right, ACO participation was less likely in rural areas, less likely in the West, and less likely in lower MA penetration markets.

So we're going to move on now to some analysis from ASPE. So ASPE did an analysis on characteristics of the beneficiaries attributed to APMs and the geographic participation in APMs. Some of the research questions included which providers are participating in various types of APMs, and where are these providers located, and how has it changed over the last decade?

How does provider participation affect the number and characteristics of beneficiaries

and APMs? And what opportunities exist to increase participation in APMs across all geographic regions?

The goals of the study were to examine trends in Medicare fee-for-service beneficiaries attributed to APMs; analyze demographics, rise scores, health care spending and utilization patterns; and examine the geographic distribution of APM participation by county and socioeconomic status.

The samples used were Medicare fee-for-service beneficiaries from 2012 to 2022 with 30 million beneficiaries per year. The data on beneficiaries align with 21 APMs, but did not include BPCI or CJR[14], and excludes beneficiaries that were in MA for any part of any year during that time period.

The ASPE analysis included data that were attributed to 21 APMs as listed below. MSSP, CMMI ACOs, advanced primary care models, the Maryland and Vermont Global Payment models, chronic condition models, and other CMMI models.

So as we look at these Medicare beneficiaries more deeply, we find that of the 30

14 Comprehensive Care for Joint Replacement

million beneficiaries in Medicare with Parts A and B, that about half of those were in some type of APM as mentioned previously.

As we look at those beneficiaries, what we find is that the vast majority of those, in this case, 36.8 percent, were in MSSP. Only five percent were in other CMMI models like REACH models.

And then when you moved on to other CMMI models, there were very small percentages of beneficiaries participating with the exception of Advanced Primary Care which is about 5.6 percent.

So the characteristics of beneficiaries who were attributed to APMs in 2021, in MSSP, CMMI, ACOs, and advanced primary care models, were more like likely to be white, female, and living in metropolitan areas.

Beneficiaries in chronic conditions models were more likely to be Black, Hispanic, male, and to have significantly higher mortality and higher average risk scores.

In 2021 roughly 38 percent of fee-for-service beneficiaries had no history of APM attribution from 2012 to 2020. They were more likely to be Black or Hispanic, dual eligible,

living in micropolitan or rural areas, and to have lower risk scores.

This is just a heat map to represent the growth of APM penetration between 2013 and 2022. You can see on the left in 2013 there was a penetration of about 15 percent across the country with scattered participation mostly on the East Coast and Midwest.

As we move to 2022 on the right, you can see much more penetration in 2022 of about 49 percent, but still most of that participation along the East Coast and the Midwest, with less participation on the West Coast and certainly less participation in the states that certainly had more rural geographies.

There's continued to be an increased participation in APMs year over year between 2012 and 2022. Even in the rural areas and micropolitan areas, you can see the significant increase but still, because of where they started, lag behind, so certainly in the rural areas an opportunity to focus on increasing participation in those markets.

This is another heat map that looks at the significant variation in APM penetration

rights and Area Deprivation Index. And as you can see, there's a correlation in that the higher the ADI along that bottom axis, the lower participation in APM models. And contrary, the areas that have higher participation in APM models, there's a lower ADI rating.

And as you can see from the heat map, again, those areas of the country that have higher ADI penetration is mostly the East Coast and the Midwest with less ADI issues on the West Coast and some of the rural states.

Another interesting factor in participating with APM models is that what we see is that beneficiaries entering an APM model on average have more diagnoses of cardiovascular risk factors, chronic kidney disease, and some other chronic conditions within the first two years of participation. The highest rate being in first year but continued increased diagnosis in the second year which is higher when compared with those that did not participate in an APM.

So key takeaways from this ASPE analysis include nearly half of all Medicare fee-for-service beneficiaries were not in APMs in 2021. There has been significant growth and

variation in APMs over the last decade among Medicare fee-for-service beneficiaries across the United States.

Rural counties are still significantly behind in APM participation. Many high ADI counties still have low APM penetration rates and can be a potential target for CMMI health equity models. And APM participation on average increases the diagnosis of certain cardiovascular risk factors and chronic conditions.

So we're going to talk now about some potential factors for forming a vision for future models and the necessary components within those models.

So the potential factors for forming a vision included the ability to implement a comprehensive framework for population-based total cost of care encompassing population-based models and advanced primary care models, develop multiple pathways with varying levels of risk for different types of organizations to encourage participation in population-based total cost of care models, to align incentives across population models, other Medicare accountable care programs, and all payers to encourage high-

value care in all settings.

To ensure consistency and longevity in population-based total cost of care models, to involve primary and specialty care providers with clear and complementary roles in accountable care relationships, and to address disparities and health-related social needs by incorporating health equity-related objectives.

Potential components for successful models include facilitating participation of a full range of providers in different geographic areas, integrating specialists with a multi-disciplinary patient care team to maintaining patient choice, attributing each patient to an entity or provider that is accountable for their quality outcomes and total cost of care.

Providers must have sufficient data to manage their patient care and to ensure timely and usable data at an organization, practice, or provider level to determine their performance.

Other components include providing clear incentives for value-based payment, paired with disincentives for fee-for-service payment, questions like should financial risk and savings be shared downstream at the individual provider

level, should downsizing risk be incorporated where appropriate, aligning financial incentives across all types of providers, ensuring predictability and adequacy of payments that allows providers and practices to invest in longer-term care transformation activities.

And this slide just depicts the need to consider multiple participation tracks based on the nature and size of the organization participating in the APM.

As we can see, moving from the small low-revenue PCP[15] practices on the left to larger high-revenue integrated systems on the right, there's likely to be an increasing ability for those organizations to take downside risk and to develop the required expertise and analytics to be successful. And so as we think about various models, we need to take these factors into consideration.

So we'll move to potential milestones. So as we think about milestones and components needed to achieve the accountable care relationship goal for 2030, milestone one would be to create a widespread participation in these

15 Primary care provider

models to make accountable care a financially viable choice, to adapt the level of financial risk based on organizational characteristics, simplify administrative and technical burden of participation, increase participation in high Area Deprivation Index areas to also support care transformation, to meaningfully engage and integrate primary and specialty care providers in population-based models, to provide technical assistance and resources to build infrastructure, to address technical issues related to attribution, benchmarking, and risk adjustment, to identify and provide health-related social needs to applicable beneficiaries.

And the third might be to increase the predictability of population-based total cost of care model elements such as standardized technical aspects of calculations where possible, consider introducing a multi-payer framework into population-based total cost of care models, require all models to collect the same or similar data elements regarding social determinants of health.

So we'll move on to addressing some of the technical issues and challenges. So we have

earlier discussed the potential broad provider and community factors that facilitate or impair participation in APMs such as provider types and community factors that facilitate or impair participation in APMs.

The technical topics are in the middle, and these technical topics are in the shaded area and emphasize the components needed to be addressed from learnings from the past decade of testing to develop processes, infrastructure, and policy to facilitate participation across multiple practice types and geographies to be successful in total cost of care models.

We hope to get some insights today from our presenters and panelists to make recommendations regarding policy to support these issues.

Challenges for increasing participation in total cost of care models include complexity of the number and types of APMs. The duration of many APMs is not long enough to allow successful implementation.

The administrative and infrastructure burden to participation, particularly for small

and rural practices, traditional fee-for-service is profitable and does not include risk bearing. Health equity is not a central component of many models. Practices may face challenges with expertise, technology, and cost to participate in APMs. We need to develop new infrastructure.

Financial downside risk involved with cost sharing in some APMs is prohibited. And the ability to collect and analyze the necessary performance data is difficult. Barriers are particularly acute for small low-revenue rural practices as mentioned before.

Other potential barriers include the size of the practice and patient population. Practices with fewer providers, fewer Medicare beneficiaries within their practices, and a lower proportion of PCPs who are less likely to participate in payment reform programs.

The costs associated with ACO participation, Rural Health Clinics, for example, that joined an ACO, experienced a substantial increase in their mean cost per visit over two years compared to RHCs[16] that did not join an ACO.

ACO participation decisions may be

16 Rural Health Clinics

primarily made by other organizations. This is a reminder that the majority of physicians today are employed reaching about 77 percent in 2024.

So perspectives on developing a pathway towards a 2030 goal of having all beneficiaries in care relationships with accountability for quality and outcomes in TCOC is the purpose of this public meeting today.

Stakeholder perspectives on the pathway towards developing population-based total cost of care, organizational structure, payment and financial incentives for supporting accountable care relationships, developing a balanced portfolio of performance measures for population-based models, and addressing challenges regarding data, benchmarking, and risk adjustment.

And that's the end of my presentation, Lauran.

CO-CHAIR HARDIN: Thank you, Angelo, and the PCDT team. That was an incredible presentation and wonderful research as well by ASPE and NORC.

Do any of our Committee members have additional comments or any of the members from

the PCDT want to add additional comments to Angelo's presentation? And if to, put your name tent up or raise your hand on Zoom.

Jim, go ahead.

(Simultaneous speaking.)

CO-CHAIR HARDIN: Chinni, go ahead.

DR. PULLURU: Thank you, Angelo, that was awesome. So, you know, this isn't a question, but it's a comment on what was presented that I think is really important, is that as we look to get more participation in models, especially as people -- we want people in Medicare to go from fee-for-service to accountability, especially at risk, the important thing to realize is that it doesn't exist in silo, and it exists in the context of Medicare Advantage, social vulnerability, and other factors that are provider-based.

And I think that was the thing that Angelo's presentation very clearly articulated, that we have to look at it in context.

CO-CHAIR HARDIN: And, Jim?

DR. WALTON: Thank you. Thank you, it was great. It's been great working with you, and the PCD team. Really, it was a wonderful study

by all involved, and thanks for your leadership.

CO-CHAIR SINOPOLI: Thank you.

DR. WALTON: -- and your comments.

I was struck by the slides 20 and 21 -- 21 and 22. And the idea that APMs are finding more chronic diseases is encouraging all, you know, us all that the models are probably working, in so much as helping find more chronic illness in American elders and dual eligibles. And, I think, to some extent that point might need to be elevated.

What's interesting is when we look at regional differences, if that is indeed the case, then differences in participation in APMs between regions would be significant. Because you're not finding as much disease out in the field.

And what we know is that a lot of the, and the heat map was amazing, right, and it tells us that we have some place to go look. And we see this correlation between high ADI regions, or areas, or counties, and lower participation. And we see a trend there, and it probably is significant since we reported it.

And as such, it could be that there's an association between high ADI and high social

determinants of needs, higher frustration with providers, because they have less capacity to absorb that challenge. And so they opt not to participate.

And we know, based on, you know, my experience, when you develop an APM, an ACO contract, we end up with resources to providers to augment what they do day in and day out with every patient.

So as doctors chose to opt out of that because of the complexity of change, or the lack of resources in a community that addresses social determinants of health, that then I think has given us the opportunity, I suppose, to talk further about the non-medical determinants of health residing within a high ADI community and the providers.

The FQHC[17] is a perfect example. You mentioned that their costs went up significantly by participating, while their rates are their potential compensation to pay themselves back from shared savings, doesn't materialize. Maybe because they don't document quality very good, or

17 Federally Qualified Health Center

maybe because they don't have access to admissions, and discharges, and transfer data. Because the HIE[18] isn't working in the community, or they just never had one.

So you see I'm pontificating, right. So I think the changes that are required in the practice of medicine inside APMs is stressful for physicians and providers. But it's necessary, because it's actually -- something's happening. But we see a disparity in participation which is saying, in my community, we can't achieve this.

I was in rural Oklahoma a few weeks ago and found a clinic. And FQHC says could you help -- and I asked them to be here today, I said you help us get access to LGB -- GLP1[19] drugs? They just have a limited access in the pharmacy, because they're out in rural America. And also maybe the costs are tied to demand and supply.

So therefore, they may suggest that their -- that might suggest that their diabetes control data might be skewed, you know, this year versus last year. And maybe they didn't make as much progress, because they had less access to

18 Health information exchange
19 Glucagon-like Peptide-1 Receptor Agonists

drugs.

So I think that this an amazing study, and I'm excited about where this is going to take us.

CO-CHAIR HARDIN: And again I think we could make many comments and continue the dialogue, but unfortunately, we have to move to break. But I want to again thank the PCDT, and Angelo for your leadership, for this very comprehensive and helpful analysis.

So at this time, we have a break until 10:00 a.m. Eastern. So please join us then, as we have a great lineup for our first panel discussion on perspectives on developing a pathway towards the 2030 goal of all beneficiaries in a care relationship with accountability for quality outcomes and total cost of care.

We'll see you back at 10:00 a.m.

(Whereupon, the above-entitled matter went off the record at 9:55 a.m. and resumed at 10:01 a.m.)

*** Panel Discussion: Perspectives on Developing a Pathway Toward the 2030 Goal of Having All Beneficiaries in**

**Care Relationships with Accountability for Quality, Outcomes, and TCOC**

CO-CHAIR HARDIN: Welcome back. Angelo and the PCDT shared our starting point for this public meeting and some of the questions we want to explore, and now I'm excited to welcome our first panel discussion. At this time, I ask our panelists to go ahead and turn on video if you haven't done so already.

In this session, we have invited four esteemed experts to discuss their perspectives on developing a pathway toward the 2030 goal of having all beneficiaries in a care relationship with accountability for quality, outcomes and TCOC. After each panelist offers a brief overview of their work, I will facilitate the discussion by asking each panelist questions on the topic. The full biographies of our panelists can be found online along with other materials for today's meeting.

I'll briefly introduce each of our guests and give them a few minutes each to introduce themselves. After all four introductions, we'll have plenty of time to ask questions and engage in what we hope will be a

very robust discussion.

First, we have Dr. Michael McWilliams, who is the Warren Alpert Foundation Professor of Health Care Policy and Professor of Medicine in the Department of Health Care Policy at Harvard Medical School. Michael, welcome. Please go ahead.

DR. McWILLIAMS: Thanks very much. It's really a pleasure to be with you all today and before getting onto the substance, I just want to reiterate what's in my disclaimer here, which is that I am here with you today as me, as a professor and not in my capacity as an advisor to the Innovation Center. If you could just forward to the next slide.

I know the main theme today is participation, but I do want to just level set a bit and note that the goal, the ultimate goal, isn't participation per se, it's we want success, right, and we can debate what success means.

But I think it's important for us to talk about participation, not as if we've already figured out the payment models entirely and we just sort of need to coax providers into them or help them succeed, although those things are very

important, whether that's through temporary participation bonuses or more technical assistance. I think it's also really important to think about participation as an outcome or marker of sound model design. Because a big reason why we're sort of stuck at 50 percent participation is that the models have basically been designed in a way that can never be advantageous to more than roughly half of providers, even if all providers are capable of succeeding, of generating savings.

I tend to think about the goal less as sort of reaching 100 percent participation and more as designing a population-based payment system that gives all providers a chance to gain from doing what it is that we want them to do.

Second sort of high-level point here is that ideally, we could articulate a long-term vision for how we want the payment system to be designed and then backs off. A lot of the activity so far has been framed in a sort of more test and scale mindset in which we seek to try a bunch of things, see what moves the needle, and then with an eye to expand on what does. That kind of assumes that short-term progress should

dictate long-term policy. I think that mindset has made reform and discussions a little bit more myopic and more atheoretical than it ought to be. And it also fails to acknowledge that there are trade-offs involved. At some point, roads will diverge, and we'll need to choose a path.

So instead, I think we can and should think through how various approaches might play out a bit more, try to arrive at an informed direction, then head in that direction in a more deliberate fashion and still while evaluating and recalibrating and pivoting as needed along the way.

As an aside, I would say the same about sort of broader Medicare reforms. We really just need to have more discussions about what we want the program to look like and why.

Next sort of high-level point, the complexity in the models has gotten really out of hand. This has been sort of brewing for a while. The model proliferation has been a problem, just the sheer number of models, but also each model can get really complicated in its own right. And I think this happens in part because when the destination isn't super clear, a model can take a

sort of circuitous route collecting baggage along the way and needing sort of rule changes on the fly. And then there's also been a tendency to pack each model full of its own quality metrics and requirements, and all this creates an administrative burden for providers that makes participation more costly.

So my general view is that at this point we should be focusing on fewer models and making them simpler and better and more harmonized.

As I've been alluding to, the design of the model is really critical. So, we get out of APMs what we design them to do. What we've seen so far, the modest savings, the selective participation, is all quite predictable based on the model design. I think this has been generally underappreciated in the policy debate with many people conflating the concept here with the execution and concluding that we should just abandon the concept rather than try to improve on the design.

And there's a ton of technical stuff here to dig into. Hopefully, we have time to do so. Very briefly, I've sort of listed some of

the main issues here with the shared savings program in mind. Savings rates probably need to be higher. Need to work on benchmarks, so that the incentives to participate and save are stronger. The goal is probably not to get everyone in a downside risk contract. In fact, downside risk can be counterproductive in a voluntary model. In contrast to MA plans, ACOs are pretty limited in how they can share savings with beneficiaries, so that's one direction we can think about is how can the savings be shared more directly with patients in more visible ways that can help expand ACO participation as providers sort of compete to attract patients. And then obviously, a lot of work to be done on risk adjustment.

And then, a few final points at the bottom here. Maybe I'll jump to the primary care payment reform bullet. Primary care payment reform has been a big topic of late, receiving a lot of attention, probably less attention on how it should fit in with the total cost of care population-based payment system. The key point there, I think, is we can go further with primary care payment reform in the context of an ACO

contract because there is less concern about cost shifting and the resources from an added payment should be used more efficiently. I think the recent ACO Flex model is a really good model to build on there.

In terms of the portfolio that we want, I tend to favor a streamlined portfolio with a foundational population-based payment system with a fairly limited set of episode-based payments.

And then finally, the multi-payer issue here is huge, and this comes up a lot. But I do want to just emphasize that it's also really important to get it right in Medicare, and if we can do that, that should help advance multi-payer alignment to the extent that better designed, more effective models are more likely to diffuse.

And then finally, I do want to just note that while some of my comments may be somewhat critical in nature, I wouldn't be a self-respecting academic if they weren't, I do want to commend CMS and the Innovation Center on all their hard work and the progress so far, which I do think has been really substantial. Also, note that there are probably some statutory

constraints at play here that probably require some congressional action at some point, and I think what motivates the role for CMMI that much more. So thanks very much.

CO-CHAIR HARDIN: Thank you so much, Michael. Next, we will go to Dr. Ezekiel Emanuel, who is the Vice Provost for Global Initiatives and Professor in the Department of Medical Ethics and Health Policy at the University of Pennsylvania. Zeke, please go ahead.

DR. EMANUEL: Yes, so from 2011 to today, I have sat Vice Provost. I'm a university professor at Penn, and I co-direct Penn's Healthcare Transformation Institute. I was in the White House working at OMB[20] and the National Economic Council on the Affordable Care Act among other health care initiatives. Particularly on that was, I think I can say, instrumental on things like bundle payments, the design of the ACOs and CMMI. I would say at that time, I had huge frustration when I called around, all right, should we put a particular payment model in, how little we knew about various payment models and

20 Office of Management and Budget

how little we had actually tested various payment models. We failed. The government failed. Lots of people failed.

On a usual day, I'm a specialist. I'm a breast oncologist, and I think one of the areas we have kind of ignored is specialty payment since it's so much of physician payment and generates so much of the system payment. I think that has to be incorporated here more systematically. Next slide.

I just want to talk about the issue of why we have gotten to 50 percent. I think a lot of us, policymakers, academics who don't actually run value-based payment programs, don't quite understand how difficult it is, especially for smaller groups, to transition. Providers with value-based payment have to change their financial and operation management, right. Under fee-for-service, they know how to make money. They know how much money they need to make, and they know what they need to do because they get paid for doing things.

Under value-based payment, they often get paid for not doing things and that, I think, is critical which means they have to take on risk

in a way that requires a much more sophisticated analysis which they're not experienced in. And one of the consequences is that they end up either having to affiliate with health systems or get MSO services or get consulting services, all of which are extremely expensive and take away a lot of their financial benefits by actually doing value-based payment well. And I think we don't fully appreciate how complex that is.

So, what are the kinds of things, both from a design standpoint as Mike suggested, but also an implementation standpoint that would be sort of a bare minimum and make this transition better and helpful and incentivize a lot more practices, especially the independent ones, to do it. I think we have to make data much more readily available.

Right now, Medicare gives data back and its raw data, which is not information and not helpful to small practices. They need more timely, accurate, accessible, and actionable financial data, this is possible, easily possible. Rather than giving them raw data, they need something which will tell them how they're performing individually and collectively as a

group, their patients, and that's an absolutely essential element to give them confidence they're going to make money. If they can't have that confidence, they're going to sit on the sidelines. They're not going to go into these programs, especially if they're voluntary and not mandatory, and I think that's a critical issue.

I think on that path, CMS needs to facilitate the development and adoption of low-cost solutions. Solutions that are in the 10,000 to $25,000 range, not hundreds of thousands of dollars or millions of dollars as Acadia and all the similar programs are that are open source that can be used. And here, maybe Mike and I have a slight difference. I think one of the major ways of overcoming the multi-payer problem and being short, is to Medicare use its authorities to extend the same data platforms, providing the same kind of information across all the programs where they give money, MA and exchange plans.

This will mean a large portion of what physicians get and other providers get will be in the same format, so a large portion of their practice will have the same information. And they

can use that wedge, as they do in many other areas, to get standardization on the data, which I think is critical. They could also get standardization on the payment formats which again is going to be critical.

It will also create a marketplace for solutions for financial modeling for practices, which, again, I can't emphasize I think this is a fundamental lesion and unless we overcome it, we can provide a lot of different incentives but we'll either facilitate consolidation or people will still remain on the sidelines.

The final thing I'd like to say is I do agree with Michael, we need fewer, better design programs. Part of that design we need a lot more interaction with frontline physicians and some real assessment of how these programs change incentives for doctors and whether they inhibit them. The racheting down of the baseline is a perfect case of where I think this is really going to just dissuade people from participating because they can't make money on that.

With that, I'm going to pass it on.

CO-CHAIR HARDIN: Thank you so much, Zeke. I can tell from the Committee they're

already ready to ask additional questions and you will have the opportunity to do that. Next, we --

DR. EMANUEL: No problem.

CO-CHAIR HARDIN: Oh, I'm sorry.

DR. EMANUEL: No problem.

CO-CHAIR HARDIN: For both of you, for all of you actually. Next, we have Dr. Tim Ferris, who is the founding Senior Vice President of Value Based Performance for Mass General Brigham, inaugural Chief Transformation Officer for the National Health Service in England, and Adjunct Professor of Medicine at Harvard Medical School. As one of our original PTAC Committee members, we're thrilled to have Tim back joining us today. Please go ahead, Tim.

DR. FERRIS: Thank you so much. And I want to start off by complimenting all the work the PTAC Committee has done and particularly the ASPE work that we just saw. I thought it was excellent work. I learned a lot from it and was very pleased to see that the baton has been passed and the quality of the work they're doing has definitely gone up since I was a member of the Committee.

I'll go to the next slide, if you

will, and say that I'm not going to directly address my assignment. I'm going to think about a slightly bigger picture, which because Michael and Zeke did such a great job of going over the pieces. I want to talk about what I believe to be the biggest risk going forward to the value-based care initiatives and that is given the demographics of the United States, we are projected to have very significant capacity challenges in the delivery of health care to our populations. Most importantly, to the populations where the payer is primarily Medicare and Medicaid, and that problem is not, just to be clear, it is not getting smaller. It is getting bigger, and it's getting bigger and will continue to get bigger for the next 20 to 25 years.

That presents a real challenge, right, so I want to underscore something Angelo said, to make accountable care the financially viable model of care. Just to underscore that, so, how will we do that when the literal capacity that is available doesn't meet the needs of the populations? That's really critical. So who is - this is all about accountability and, I wrote here defining accountability, who is accountable

for the capacity of the health system. And I'll just project out there that right now we have a system that's set up to say, well, if we fund it, they will come, right? That's how we manage capacity in this country.

That's problematic when two of the major payers pay below, generally below, the costs of delivering services. So the costs of delivering services, the unit cost of the delivery of care is the core issue for me in value-based payment care delivery. And so, if health is increasingly determined by access and access is a function of capacity, then how are we going to make sure there is adequate capacity? To me, the solution, the only solution, to our capacity problems is to move from what is generally a one-to-one model of inputs to outputs in health care to a one-to-many model of inputs to outputs in health care. That means we need to undergo a very large and systemic technology moving health care to be much more of a technology enhanced service.

Now, what I don't see in all of this, and I want to take Michael's point, I see enormous good here. My job here is not to keep

complimenting all the good, my job is to point out risks. I think that's my job. And so I want to make sure that we all think about the capacity issues created through risk-based and accountability-based systems and remind everyone that the fundamental form of accountability in U.S. health care is that every delivery organization, whether it is a private practice, a nonprofit organization or a for-profit organization, is accountable as a business period full stop. And if you can't have a viable business because of the payment system, then you won't have those businesses, particularly in places that are serving the underserved. And so, what is the mechanism by which value-based care, incents the adoption of technology, that allows the transition from a one-to-one model of inputs to outputs to a one-to-many model of inputs to outputs? So that's the concern that I'm most focused on now.

I will say there are some smaller, more logistic things. I do think - the previous speakers talked about the burden. I think there is a substantial opportunity to use technology to lower the burden on both individual practices and

health systems. I do think quality metrics should not be aggregated at the payer level, that's not the relevant unit of delivery. The relevant unit of delivery is the practice or the health system, and that's where, across all payers, we need to aggregate quality metrics.

I do think, you know there's something called payment with evidence at CMS initiated quite a long time ago, but I don't think we should be -- providers shouldn't be delivering services where they're not measuring the outcomes of those services. And again, with technology today measuring those outcomes is not an expensive thing to do, it's just that we don't do it systematically.

And then my final comment is even though we're talking about value-based payment and incentives, underneath that we're still -- the chassis is still a fee-for-service system. I believe there are significant malalignments between what we pay for the delivery of services and the work required, the input costs to deliver those services. I'll give one example. The input costs in the delivery of the work necessary for an initial visit to a doctor is a 10-fold

multiple of the work for follow-up visits and yet, the payment is only slightly more for a new patient visit than a follow-up visit. That is payment nonalignment with work, is creating that systemic problem in the fee-for-service incentive system which roll through into the value-based care models and actually create distortions in the marketplace.

So with that, thank you very much and I look forward to the conversation.

CO-CHAIR HARDIN: Thank you so much, Tim. Very interesting. And last, we have Dr. Alice Chen, who is the Chief Health Officer at Centene. Welcome, Alice, please go ahead.

DR. CHEN: Thank you so much. Good morning. Thank you for having me. Many of the points that the other panelists have made resonate, really delighted to be part of this panel and look forward to the discussion.

As you mentioned, I'm Chief Health Officer at Centene, which is a government payer squarely in what I think of as a 3M space, so Medicaid, Marketplace, Medicare. We're the single largest payer in Medicaid and Marketplace, have about a million members in Medicare

Advantage, focused on duals.

I'm going to spend a little time about my background just so you have a sense of where I'm coming from vis-à-vis our other panelists. I think the bottom line is I come from this work as a PCP internist in withdrawal. I just gave up my panel of 18 years a little less than two years ago. My career has been focused on the safety net, but it's really embedded in practice, going through policy and now as a payer.

I'm a little bit of an outlier because most of my career has been focused on the safety net, so primarily Medicaid instead of Medicare. One thing I just want to call out, my very first job out of college back in 1990 was as a medical secretary at On Lok Senior Health Services, and I wish I could see you so I could see how many people actually know who On Lok is, but for those of you who don't, it was the original PACE model of care. So the first organization that went to HCFA[21] at the time to ask for capitation for duals.

So, I imprinted on a model of value-based care in its most fulsome manifestation in

21 Health Care Financing Administration

many ways. And spent a lot of time in the trenches as a medical director of a primary care clinic pre-ACA[22], pre-EHR[23], when 60 percent of our patients were uninsured. So in this resource constrained setting, I always think of necessity being the mother of invention. We discovered registries, chronic care management, set up systems for inreach and outreach, worked with Tom Bodenheimer around primary care redesign because frankly it was the right thing to do for our patients. We had no data on total cost of care.

We implemented eConsult to rationalize specialty care and then really was at the very beginning of shepherding mandatory CJR model implementation just as an aside. As painful as it was, it was good that it was mandatory so that's a little commentary, as well as the first very large P4P[24] program for our system through the 1115 waiver with about 57 different measures, which was quite overwhelming and has really informed this soap box I have around can we focus on a parsimonious set of measures that matter and I'll come to that in a sec.

22 Affordable Care Act
23 Electronic health record
24 Pay for Performance

I left, I was at UCSF[25] and San Francisco General, to go work for the State of California. On the policy front what was really interesting having been, again, in the trenches trying to make value-based care happen. Primarily, and you know I think of value-based care you know quality over cost is bifocal, and we were focused very much on quality because, again, I mentioned we didn't have total cost of care data, but were resource constraints that was a constant kind of in the background driver.

At the policy lever at the state, helped stand up the Office of Healthcare Affordability, the levers are really broad, you know. Setting up primary care, spend targets, again trying to shepherd the state towards a parsimonious set of measures. And then when I got to Covered California, that was where I felt like we could really make progress on this idea of alignment. So when I was at Covered California, we worked with Medi-Cal and CalPERS, which is the public benefits manager, for the State of California, to land on a parsimonious set of measures in order to create clarity for

25 University of California San Francisco

the payers that we contracted with and hopefully, through those payers down to the provider level. Because what we realized is all the purchasers, which together covered 42 percent of Californians, were contracting with largely the same payers, and then the payers were contracting with the same providers. But because there wasn't alignment, there was a lot of kind of diffusion of intent or voltage drop from purchaser to payer to provide.

And so I took that experience with me when I came to Centene last January, and I walked in the door with a lofty goal of driving population health agnostic of line of business. And I will say I had a rude awakening from a payer perspective. Medicare VBC[26] is fundamentally different from Medicaid, which is again different from Marketplace. A lot of it has to do with the provider landscape and capabilities, how much clarity there is in terms of what you're driving towards for better or for worse. In Medicare Advantage, STARS performance is the North Star, so there is zero doubt about what you're driving towards. And then there's also the issue of

26 Value-based care

churn.

Let me just move to the next slide so we can start the discussion. While there are a lot of things that we can address in order to make value-based care and accountable care more feasible, I think a relatively low-hanging fruit would be measure alignment and focus. As a company, we track 170 measures across the 3Ms and UDS[27], which is for those of you who don't know, is the measure set for community health centers. As the single largest Medicaid payer, we are partnering with community health centers, FQHCs, because they are such a critical part of the safety net primary care landscape.

Out of 170 measures, aside from CAHPS[28], there are four that are common across all programs. What we've done is in terms of our value-based care or strategy is, again, by line of business, Medicare is focused on STARS, Marketplace is focused on Marketplace QRS[29], and Medicaid is focused on primarily the state withhold measures and hopefully in the future, MAC[30] QRS, but internally we've tied employee

27 Uniform Data System
28 Consumer Assessment of Healthcare Providers and Systems
29 Quality Rating System
30 Medicaid and CHIP

incentives to quality performance on these four measures that span all four lines of business, as well as because we are the largest Medicaid payer pre-, post- and well child visits.

So trying to figure out from a payer perspective, how we create greater clarity and simplicity and easy button for providers very much depends, for us as a 3M payer, on clarity from CMS.

So, I will pause there and look forward to the discussion.

CO-CHAIR HARDIN: Thank you so much, Alice, wonderful presentation. These were great introductions so, next, we're going to move on to some questions. In the interest of ensuring balance across different perspectives and questions, we encourage each of you to keep your response to a few moments and, Committee members, I want to encourage you to tip your table tents up when you're ready to ask questions. I know I can see you chomping at the bit to jump in, so please feel free to do that.

But I'll kick us off with one overriding question. What should be the vision for developing total costs of care models that

can help to ensure that every Medicare beneficiary with Parts A and B is in a care relationship with accountability for quality and total cost of care? And let's start with Michael and then go to Tim.

DR. McWILLIAMS: Great, thank you. I did want to just loop back and say that I think Zeke and I are actually in violent agreement about multi-payer alignment and where the focus should be in terms of where the federal dollars are. I think it's just important that we acknowledge that even if we didn't have the multi-payer problem, that the models currently are probably not in a state where we get what we want from them and so we need to sort of work on those things, but trying to wind across Medicaid, the Marketplace, and Medicare seems to be where the focus should be.

In terms of vision, I mean I think ultimately what we want here is more efficient and more flexible care delivery. I think sometimes in conversations about payment reform, the framing can get a little contorted and imbued with a little bit of magical thinking, and while we certainly should hope for some direct benefits

for patients from efficiency and flexibility, not being subjected to harmful procedures, being able to get remote case management instead of having to come to the office or getting home care instead of facility care.

I think there's a broader system goal here in which people benefit more indirectly that we shouldn't lose sight of, which is lowering the cost of health care, and just to pick up on one of Tim's points. If we can do that, then with all this great stuff coming down the pipeline, we just have more money to spend on valuable things, whether that's health care, things like GLP-1s, or non-health care things like food and housing. If we can just figure out a way to try to wring some of the waste out of the system through the payment system through payment reform, everyone wins. And so, I think that just deserves reiteration in terms of sort of what the ultimate vision and goal is.

And then in terms of accomplishing that, I think we've already hit the high points in terms of the pieces, maybe digging into them a little bit more on the model design front and, as Zeke mentioned, getting the benchmarks right is

probably the foremost thing to do and there are a couple dimensions that we really need to work on more there.

One is the sort of rachet effect that Zeke alluded to where if an ACO lowers spending, its benchmark comes down. The shared savings program this year introduced a prior savings adjustment that helps mitigate at least some of that during the sort of rebasing between contracts. But also, I think a lesser appreciated part of this is ensuring that the benchmarks accommodate more participation by basically allowing every provider a chance to get under their benchmark. And that can't happen if we grow benchmarks at realized rates of spending growth because then the benchmarks just are continually dragged down as providers save, and then the model can never be appealing to more than roughly half of providers.

And so there are various ways to approach this, but I do think these are the types of things that we need to be talking about, and they get pretty technical. One way is to have a sort of preset administrative benchmark trend that's just fixed over time to help that sort of

wedge between benchmarks and claims expenditures emerge as ACOs save. The shared savings program introduced the accountable care perspective trend this year to sort of introduce that, or we can have add-on payments so that might look like a permanent APM bonus or an enhanced primary care capitation payment that's sort of permanently in place for participants in ACO programs or a combination of the approaches.

But I think we kind of need to think about how do we think benchmarks should be set 10 or 15 years down the road that might involve sort of like a risk adjusted rate book but not one that's said, like average realized spending and then ask the question how do we get there? And then there, you know, the rest of the pieces like savings rates and you know risk adjustment deserves a lot of attention right now.

But I think this conversation gets pretty technical pretty fast. This may not be the forum to do that, but these are the conversations that we do need to be having.

CO-CHAIR HARDIN: Zeke, did you want to comment on that or ask a question?

DR. EMANUEL: You wanted Tim to -- I

just want to get in before you move on.

CO-CHAIR HARDIN: Oh definitely, we'll make sure.

(Simultaneous speaking.)

DR. EMANUEL: I can see Tim is also chomping at the bit so.

(Laughter.)

CO-CHAIR HARDIN: This is great. This is exactly what we want to see.

DR. EMANUEL: I don't want to stand between him and the race.

CO-CHAIR HARDIN: Great. Go ahead, Tim.

DR. FERRIS: Sorry, I'm hearing an echo. Okay, I just want to, if people have spare time, looking back at the recording of what Michael just said would be well worth their time because it was really, really important and I couldn't agree more with what Michael just said. I will put out there, Michael, just to have the conversation that the benchmark should be general inflation.

Health care rises at twice inflation. If it rose at general inflation, it would not be confiscatory, and none of the problems created by

health care for the rest of society would exist if it simply rose at inflation which it has not done in the past 50 years.

With that aside, because I think Michael answered the question very well, I wanted to go in a little deeper about the implications inside a delivery organization of being in value-based contracts and just say that I think it is -- and actually Don Berwick wrote a paper for the New England Journal about this, I think in '99 or 2000, which is clinicians shouldn't be directly exposed to incentives on total costs of care for populations. That is a very problematic place for a clinician to be and so internal to an organization, the bigger the organization the better because the more stable the population, the more predictable the expenses. It looks like Zeke might have an issue with that, but just saying that I believe it is for the executives within a provider organization to have incentives in their pay around total costs of care for population, but then they need to transform those incentives into quality outcomes and medical management decisions for the providers within that organization. I wrote a paper about this a

dozen years ago that sort of explained the layers of transforming the total cost of care incentives at the highest level down to physician-level incentives.

So, I just wanted to emphasize that important piece of this puzzle.

CO-CHAIR HARDIN: Thank you so much, Tim. And Zeke, I want you to go ahead and please, part of bringing all of you together with your brilliant perspectives is the dialogue and interactions so please, everyone, feel free to jump in. Zeke, please go ahead.

DR. EMANUEL: So, again, I just want to iterate I think what I disagree with, Tim, is that bigger is always better. There's a capacity, a maximum size. I don't know what it is. I suspect it's around 40 or 50,000 people that the group needs to be, that's a sort of minimum. I don't know what the maximum is. Anyway, I do think there are several things that need to be addressed simultaneously, and I think disengaging them and only focusing on payment is going to be a mistake.

Payment is critical but as Michael said, you know, risk adjustment is critical here

too so if you're going to have a, and here I'll put out on my card, primary care doctors need to be capitated, and they need to be capitated consistently across the groups, and you need to take into account the problems mentioned by both Michael and Tim which is the problems of our fee-for-service system is just screwed up. We have to take the top 250, 300, 400 some number of the billing codes, and we need to reevaluate them because they influence, and it's really only 200 or 300, it's not, you know, 10,000 that we use because those account for 90 percent. That capitation, I think, is critical. It has to have bonuses for quality. You have to measure quality in a standardized form, and I think both Tim and Alice talked about this, way too many quality metrics, too many payers, CMS needs to use its power that it's paying all these people to make everything consistent. And as Tim said, 100 percent, it's got to be at the provider level not at the payer level. So, CMS has power, and they need to use that power to standardize these things.

Then there comes in, so you've got a capitation, you've got standardized quality

metrics across a wide swath of payers. You need risk adjustment now here I can say definitively because we are doing machine learning-based risk adjustment, and CMS is fully aware of this, we can improve the HCC[31] score three- to four-fold with the simplest, simplest machine learning program using the simplest data that Medicare uses. HCC is broken, and they have to get off it. It just, we cannot continue with it. It's not state-of-the-art, and it creates all sorts of perverse incentives.

Risk adjustment isn't going to work until you cream off the top 5 percent for a reinsurance program because they drive 45 to 50 percent of spending, and it makes a huge difference to doctors if you cream that off. I mean not just doctors, but health system.

And the last thing, I think you're going to establish this risk adjusted capitated payment with a reinsurance program for the top 5 percent. You have to combine that with bundles and reference pricing, I think, for as many specialties as you can, certainly procedure-based specialties. We've got enough data on hips and

31 Hierarchical Condition Category

knees. We're going through to get bundles on spines and cataract surgery. Lots of the very common surgeries need to be bundled. Are you going to get the bundles for, you know, you probably can get the bundles for stent placement and things like that. I don't know another way to get the specialties in, you're not going to capitate them, but you've got to get them in on the bundles to lower where that bundle payment has specialty involved. And I think that combination is where we're going, and to standardize it across as many payers as possible is the only way forward at the moment.

DR. CHEN: Can I just jump in with a couple of additional comments given what people have said, which is I couldn't agree more that clinicians shouldn't be exposed to direct total cost of care pressures and that does assume, I think as Zeke said, like a certain size and sophistication that just isn't there for a lot of providers. And then you have this whole layer of intermediaries who come in, and I think the jury is out in terms of the role of these groups and the total value add both to the practice and the system, but I think we're seeing that happen not

just in the Medicare space but increasing in the safety net space.

The other thing I just wanted to pull on was I love the idea of quality being aggregated at the practice level. Frankly, I say to my payer colleagues all the time, care happens in the provider space in the community. We are not providers, and I think in my experience as a purchaser, a payer, and provider, when you start mixing up your levers with someone else's, you just start swirling and so just trying to remember like what are the levers at the purchaser level in terms of contracting with health plans. What are the levers at the payer level in contracting and supporting providers, and what are your levers at the provider level? I think it would actually do a lot to take waste out of system in terms of the amount of energy that goes into each payer trying to optimize its data collection in terms of HEDIS[32] measures, supplemental data, chart chase things like that. It also does have the potential for unintended consequences, and I do think, I forget who mentioned risk adjustment, but from a payer

32 Healthcare Effectiveness Data and Information Set

perspective I'll just say once you have a score as labeled on the forehead of each provider, the next thing obviously is to selectively contract with those who have the highest quality scores. The issue being obviously there's the tension of network adequacy and essential providers and things like that, but I worry about the safety net providers in particular who, for a whole variety of reasons, are unable to perform at the same level.

CO-CHAIR HARDIN: So helpful. Go ahead, Michael.

DR. McWILLIAMS: So, I just wanted to do some combination of piling on and maybe trying to cinch one of the points that came up here, which is -- and it's sort of I think we hear a lot of conversation about -- I need to figure out how to lower my hand here. It's often said that people are frustrated with how the incentives aren't making their way down to the physician level, and I think Zeke and Tim and Alice all just said that maybe that's actually not what we want to have happen.

We certainly don't want physicians exposed to fee-for-service incentives purely, and

something more like salary is probably more desirable, but we don't want the incentives in an organizational contract to just be devolved down to physician level because that defeats the purpose of having an organization which is to pool risk and to get organizations to do things that individuals cannot. I think that's just a really important point that I just wanted to cinch there.

CO-CHAIR HARDIN: Excellent. I'm going to go on to our next broad question. You've already started to tap into this. So, why have some providers not been signing up to participate in total cost of care models, and what can be done to address barriers to participation? We thought we'd start with Zeke and then go to Alice.

DR. EMANUEL: So, I mean, look I've already weighed in almost all of my bit. Look, you have to being with giving them enough data and a reliable financial model that they don't have to pay through the nose for. I think Michael just talked about or Tim, someone talked about all the -- no, Alice was the one, getting confused here, about the financial

intermediaries. Those intermediaries are really expensive, and they take a lot of the savings, and they take the incentive away from participating. And I think if Medicare gave away or made very cheap a lot of the data that is needed and the financial model that could be built on it, so people could pay in the 10,000 or $20,000 range rather than the half-million-dollar range, that is a very important thing. People need to have a model, a financial model that they can then understand if they change their clinical practice this is the implications on the financial model. They don't have that, they ain't gonna do this, it's just that simple.

And so I think – and ee don't have that financial model out there. When we've talked to CMS about it, their first reaction is we give out raw data. Raw data, it's not something doctors can use. They need it processed for them, and they shouldn't have to pay a lot of money for that processing, and then above the processing they need models. If I change my clinical practice this way, what are the financial implications? That's not obvious in a value-based payment world or a capitated

world. And so those are the two things I would say to begin with.

And then I think I want to emphasize things that others have said, which is we've got to have a benchmark established where primary care doctors especially can make money. I mean specialists are already making a lot of money, but the primary care doctors need to have a benchmark where they can see how they can make money, and they can make a substantial amount by providing more as bonuses by providing high-quality care. If they can increase by 50 percent their income, that's a very big incentive for them, and screwing around with 10 percent just it's screwing around, it's just not going to do it from an incentive standpoint given all the work they're going to have to put in to transforming their processes of care.

DR. CHEN: Yeah, I would second, third, and fourth Zeke on data. I think data is foundational. I do think as a plan we are working very hard on trying to figure how do we get the right data at the right time to the right people. I think, you know It's interesting. I think in the U.S. health care ecosystem, payer

and provider tensions are large and sometimes unrelenting, and I heard a great quote recently, which is you squeeze a vendor and you hug a partner. And I do think that in terms of payer/provider relations, we need more hugging and less squeezing. I know that's Pollyannaish and easier said than done, but I do think that particularly for us in the Medicaid space, there just aren't that many margins to go around and so it is essentially by necessity. It's like you have to partner, so I do think data on timely, actionable, relevant data that people then actually have to have capabilities on.

So, I think from the delivery system side I would say one of the big barriers is, I mean, primary care is exhausted. You have primary care providers who are just burnt out. Supply exceeds demand, and it is really hard in that setting when you are just trying to get the people you've been caring for 10 or 20 years in the door, to think about people who aren't coming in, let alone people who are assigned to you, but you've never even laid eyes on. I think the capabilities in terms of just the plain old primary care redesign, I mean, again, you're

giving me flashbacks to 20 years ago around through next available, same-day access, team-based care, leveraging technology. I do think leveraging technology is a huge, huge piece of it. That was where eConsult became kind of our solution to a huge supply demand mismatch for specialty care. With that said, I just want to put a note of caution in terms of technology as I do worry particularly with telehealth that we will move towards a future where poor people get virtual care, and rich people get the care they need, at the time they need it, in the form they need or they want it. Right, so I think technology is an enabler. We need to lean very, very hard into it, but there is an equity aspect of it that I don't want to lose track of.

CO-CHAIR HARDIN: Very important points. Tim, Michael, do you want to comment on that question?

DR. McWILLIAMS: I agree with everything that's been said, and may I add just a couple other potential sources of sort of friction or slowness in the participation curve. One, just picking up on what Alice just said, because of the way that we've traditionally set

benchmarks according to sort of an organization's own history, for providers that serve historically disadvantaged populations and therefore for whom we may underspend, it may be really unattractive to enter a payment model in which that sort of historically low spending is entrenched. And so, that goes, in my view, to sort of a new frontier in risk adjustment which we, I don't think, should think about as improving the statistical or predictive accuracy alone, but also thinking about where we want spending to be, where it ought to be for some populations and not where it's been. And so that's one thing that I think could help bring in some providers who otherwise just wouldn't, the models would be unappealing.

And then, similarly with risk adjustment, you know, if you think about how the ACO programs have handled coding incentives, it's to cap risk or growth. And obviously, for the providers who have not gotten good at the coding game yet, then they just might want to sit on the sidelines a little longer until they find the resources to invest in that capacity as opposed to a risk adjustment system that would level the

playing field for them so to speak from the get-go.

CO-CHAIR HARDIN: Thank you. Tim, please go ahead. You are muted.

DR. FERRIS: Thank you. Sorry about that. People may not be aware of the power of the predictive capability of LLMs[33], but I'm just going to cite one important reference. A group of researchers in Denmark took the population of Denmark, 15 million people, and compared actuarial approaches to statistical approaches to LLM approaches and just compared them.

Actuaries got it right 8 percent of the time. Statisticians got it right 23 percent of the time, and the LLM got it right 43 percent of the time. That is a massive performance difference, and there is really no excuse for not using LLMs for risk assessment and risk adjustment at this point, given the really dramatic differences in performance.

And then, could I just say that it is such a pleasure for me to be on this call with Alice Chen, because when she published her paper on eConsults, I read that paper, and I said this

33 Large language model

is the future of health care, and I immediately implemented it at Mass General Hospital. I've never done that where I read a paper and I said, this is the future and then just did it, so, Alice, you're one of my heroes, so thank you.

DR. CHEN: And you were totally ahead of the curve because I will say that initially the only people who were interested in eConsult were safety net settings. I think you were the first non-safety net group that I know of.

CO-CHAIR HARDIN: I'll just add to that, Alice, I followed On Lok, changed everything. Michael, please go ahead.

DR. McWILLIAMS: I just wanted to follow up on something both Tim and Zeke have touched on in terms of risk adjustment, and that is that going forward it's just going to be criminal not to use these new predictive techniques that we have absolutely. A regular linear regression OLS[34] is just going to be a thing of the past in many cases. I'll become a relic since that's what I was trained to do.

But I do want to note a couple of things. One, it's not necessarily better to be

34 Ordinary least squares

more predictive if the inputs are the same, and they're manipulatable, that just sort of rachets up the incentives to code, and also the HCC model has this problem that more profligate providers get paid more because if you do more stuff, they're more claims and more diagnoses and so that sort of destroys the payment incentives in a population-based payment model. So we have to be careful about using things like $R^2$ or predictiveness as sort of like the North Star of risk adjustment. And then, just sort of thinking about equity considerations, again what's right and what's better may not be more predictive, and so we need to think about getting new inputs that aren't manipulatable and also thinking about bringing in other information about what's right from a social values perspective in setting payment.

CO-CHAIR HARDIN: Key points. Walter, I'm going to go to you and, PTAC members, I want to encourage you I'm opening it up for you to start asking questions. Walter, please go ahead.

DR. LIN: This has been a really phenomenal session, and I just really appreciate all of our subject matter experts coming and

sharing their expertise with us.

I actually wanted to go back to the very beginning because I think Michael started this whole panel discussion with a very thought-provoking question, which is participation is only one measure of success. I think where I'm coming from is here at PTAC we've taken this goal that CMS has set of 100 percent accountable care by 2030 to heart and in many ways, that's been a North Star guiding many of our discussions and public meetings. And so, I'm just kind of curious both from Michael and other panelists, what are the other goals of success if not participation? Perhaps I'll weave into this question a statistic that Zeke brought up which was the top 5 percent most expensive Medicare beneficiaries account for over 40 percent of the costs. On the flip side of that, I think MedPAC[35] has published data, as well as ASPE, that the least costly 50 percent of Medicare beneficiaries account for about 3 percent of costs. So, perhaps a goal of success might be more cost-focused rather than just general participation. Love to hear everyone's thoughts.

35 Medicare Payment Advisory Commission

DR. McWILLIAMS: So, I guess I would say that certainly you can't have a successful voluntary payment system if no one is participating. So, this is like really important goal and metric, but I do think it's worthwhile taking a step back and wondering whether the model is designed in a way to really accommodate high participation and other sort of more ultimate social goals like spending less on health care where it's wasteful and more on other things or more on high-value health care. I guess I would reframe this as sort of thinking about participation as a marker of success, a correlate, but we do have to think about how we're designing the payment system in a voluntary population-based model in such a way that it gives providers an opportunity, and it's not clear to me that the models have given providers a huge opportunity to date.

CO-CHAIR HARDIN: Tim, please go ahead and then Zeke. You're muted, Tim.

DR. FERRIS: I keep doing that, sorry. I'll just put it out there and restate something that I said before. While I agree with everything Michael just said, I'll be maybe a little bolder

and just say the outcome that we're looking for is health care costs to rise at inflation period. General inflation. That should be our goal, and that's the denominator. The numerator, of course, is better health, but since we're focusing on total costs of care here, I think total costs of care should rise at general inflation, that would be a massive victory for the country and achieve all of the future predictions about the impact of health care spending on the U.S. budget would go away if it were simply true that health care rose at general inflation.

CO-CHAIR HARDIN: Zeke, go ahead.

DR. EMANUEL: I would say that participation is one metric. The other two or three I would agree with Michael, you need financially successful providers. The vast majority, 85 percent, 90 percent have to be financially successful. And the reason is we can't repeat the mid-1990s when managed care came in, lower payments and a bunch of docs went belly up. We don't have enough primary care doctors as Tim started with. The system doesn't have the capacity to have a lot of our providers go belly

up so, financial success has to be there, and we have to design the system with that in mind because that goes along with participation.

The other thing is, I think many of us have said, you know, you need to deliver high-quality on a core set of metrics. And we can argue all day about the core set of metrics, but you've got to look at the common things and the common things that cause a lot of disease down the line. So, hypertension, number one thing we did over the last 60 years that brought mortality down, control hypertension. Today, we're doing an absolutely abysmal job as the standards have come down to 120/80, that has to be the metric. We're at 24 percent, I believe the CDC[36]'s latest data on hitting that metric, and we have to hold all the groups accountable to that metric. Same thing with diabetes, five critical things. Those both have very long-term downsides.

And then there are very specific things for very specific populations. We can't have a proliferation of 64 outcome measures, but I think five or six that are really big and impactful and easily measured, you know, is the

36 Centers for Disease Control and Prevention

HbA1c over 7 or under 7? Is the blood pressure controlled? Is the cholesterol controlled? These aren't complicated, they really aren't, and I think having that high-quality on a few core chronic illnesses that are very prevalent.

I love Tim's pounding away at, you know, if we just keep health care cost increases to inflation, the world will change. Now, we have done that very well or at least we kept it to the growth of the GDP[37], which is a different metric. We've done that very well for 15 years, but all the predictions are for everything is coming unglued in the next decade, and I think keeping that as a metric, we're not going to increase the amount we pay more than inflation, and that's the end of the day. We're going to have just live with it.

DR. CHEN: Do you mind if I jump in before we change --

CO-CHAIR HARDIN: Please go ahead, Alice.

DR. CHEN: Topic or another question. I think this is a really critical question because health care is full of really good test

37 Gross domestic product

takers, and if you say the goal is participation, we'll figure out how to participate. I mean I remember 10 or 15 years or talking to a friend and partners, and they were saying 50 percent of our patients are in some value-based arrangement, and I was like but what percent of your revenue is at risk? I was like a penny a patient, I mean I'm exaggerating, but it was not a lot of revenue at risk, and then getting to Covered California in our contracts, we said our payers have to 30, 20, 30 then 40 percent of their contracts with PCPs in HCPLAN[38] three or four. But like the devil's in the details, right? So, I think people hit these marks and even here at Centene just having the internal conversation, where we have 45 percent of our Medicaid providers, 46 percent of our Medicare providers, but again, if you're measuring it by actual outcome, is the total cost of care stabilizing? Are we doing better in terms of clinical outcomes? The answer is no. And so, I think that's where you see a lot of states in particular leaning into the Massachusetts Health Policy Commission, California has the Office of Healthcare

38 Health Care Payment Learning and Action Network

Affordability.

It's like we need multiple tacks because frankly and I forget who said this in the beginning, but value-based care needs to really mature. I think part of it is that partnership model, like how do we really align incentives between purchasers, payers, and providers to really drive the outcomes we want in a singular way, and there are going to be other avenues. So setting cost targets, setting mandatory measure sets, a number of the state transformation collaboratives in HCPLAN are again landing on a parsimonious set of measures that they're trying to put through their Departments of Insurance or their Medicaid, like really trying to do some convergence because ultimately, I think we need to hold ourselves accountable for the outcomes, not just participation.

CO-CHAIR HARDIN: Thank you so much. We're going to go to Chinni and then, Larry, be prepped and then Jay. Go ahead, Chinni.

DR. PULLURU: Thank you for the panel. This has been an incredible dialogue. A quick question that I wanted to actually first ask of Tim and then would love the rest of the panel to

weigh in. I want to double click on something you had said, Tim, that clinicians should not be exposed to incentives in total cost of care. Having led a large, multispecialty group through transformation into value-based care, where 95 percent of our revenue came from fee-for-service and only 5 percent came from value-based care incentives or value-based care revenue. We were allowed to do 30 percent of our primary care and hospitalist income in a bonus structure and 15 percent on specialty, including our spine surgeons, retinal surgeons. So, that was really powerful for us in transforming the organization into thinking about total cost of care because we did have total cost of care platforms we were trying to implement.

So, I guess the question to you is that experience has shaped, at least for me, the fact that providers do need, or physicians do need to have some money on the line here. The other thing that I'm concerned about is that we do capitate primary care but we don't allow the incentives for actions to flow down to the providers that the people in the middle will ultimately take the benefit of the money that's

produced by bending the cost curves, so I'd love to hear your opinions on that.

DR. FERRIS: Great, and I don't have my mute on this time. It's a great question and the answer, unfortunately, for me I'm sure someone smarter than me can explain it in a simpler way. I'm happy to get you the paper, it's Brian Powers, et at. on aligning incentives. It was basically the construction of what we call the internal performance framework. And basically, what we did, and this is directly related to what Alice said about what was going on in Massachusetts, and the Massachusetts Health Policy Commission. Once we had all commercial payers, all Medicare business and all Medicaid business, all were risk contracts, basically everything we did had to be in the context of a risk contract, but nothing lined up in terms of the incentives. So, we created an internal performance framework that created a set of metrics, different for primary care, specialty care, procedure-based care, across that health system. And so, yes, our clinicians did have incentives, but how we performed in those contracts, like literally the contractual basis,

and how we built the incentives were different.

Now, they were aligned, and there was a lot of angst from my CFO about, Tim, the farther you remove yourself from the contractual target, the more anxious I become that how we perform in the contracts will be different than how we perform. I said, you know what, it's going to work out in the wash as long as we keep the North Star of better outcomes and more efficient delivery of care, and honestly, it doesn't matter what the payers are incenting us on if we construct this. It turns out it worked incredibly well after the first couple of years of a lot of anxiety. We've actually, my former group, has performed for over a decade actually quite well in these contracts across all types of payers. And so, it is a complex process of translating the higher-level metrics and some of the detailed metrics into what is it the provider thinks is best for patient care.

And can I just add as a codicil to that, that actually the internal process of saying what do we think we should be measured on was a very healthy process because it actually got people in the room saying, okay, the payers

think it's this, we don't think -- it's not that they're completely off target, but that's actually not the right way to measure, for example, hypertension in our populations. We have much better data on this that we can extract from our electronic medical records. Why don't we make a better metric on what we have a shared agreement on as an outcome. I'm sorry, that was a bit of a long answer, but the real answer is actually quite detailed and is in the paper.

CO-CHAIR HARDIN: Go ahead, Alice.

DR. CHEN: At the risk of just like piling on and echoing, I just have to say I do think the role of clinical leadership is both translating and being nuanced about what you pass through and not, because you want to tap into the psychological raison d'etre of providers and, like I say to my payer colleagues all the time, we don't want to contract with a provider who the first thing they do look is their insurance card and what line of business. I mean you want providers who take care of patients, but then how do you then align the incentives for us coming from purchasers, government, through us to our provider partners in a way that really, again,

makes sense on the provider side, but also allows us to succeed. I mean that's where a lot of the conversation is for us.

CO-CHAIR HARDIN: Michael, go ahead.

DR. McWILLIAMS: I do think we need to be careful here. There are some real downsides in passing through risk to the individual physician level. It gets very noisy, risk adjustment falls apart. It can be demoralizing. You end up introducing financial conflicts of interest at the sharp point of care, where perhaps they ought not to reside, and we'd rather have physicians' intrinsic motivation pushed back against organizational incentive. So, they're just -- things can go badly when this is done.

I think also it's important to think about what it is that's eliciting the behavioral change. As a physician, I've always just been exposed to very symbolic financial incentives on the quality or cost front. So, these are fairly meaningless from a financial perspective, but they can nevertheless elicit behavioral change because physicians are super competitive with themselves and others, and they pay attention to data. And they open their eyes to various things.

There have been papers in the economics literature that shows that just presenting data to providers actually can change their behavior. That was sort of the story behind surgeon report cards, for example, in large part.

And so, I think it goes to something that Alice just mentioned, which is we should be thinking about this debate about how much to pass along to individual physicians, but we also really ought to be thinking about the science of management and updating that and not having it be too tailoristic and using behavioral insights in trying to tap into people's professionalism.

CO-CHAIR HARDIN: Zeke, did you want to add on?

DR. EMANUEL: No.

CO-CHAIR HARDIN: Okay, Larry, please go ahead.

DR. KOSINSKI: Well, I have to pile onto what Walter said, this has been just a fantastic session. What I've loved is the interaction between the four of you, and that's something we don't always get, but it's been a great discussion.

I was feverishly taking down notes to

capture statements that were meaningful, and I have some from all of you, but there's a theme that permeates this when I look at capacity challenges, the statement if we fund it, they will come, that we have to have systems that are accountable as a business. We need to focus more on where we've been ignoring specialists' payments. Revenue at risk. What's come through to me from all of this is that we're not just providers, we're businesses, and these businesses have to succeed. The physician practice has to succeed, and so does the health system have to succeed. And our payment systems have to find a way to align business success drivers with population health needs, and right now that isn't occurring. And I guess my major question is should we instead of focusing on providers, have a focus on the provider businesses to create the payment solutions that will allow everybody to thrive?

DR. EMANUEL: Can you clarify that? I mean, I --

DR. KOSINSKI: Well, for instance -- for instance, I'm a gastroenterologist, so I've lived in the GI world my entire 40-year career.

And in my last 10 years, I've been involved in value-based care for patients with significant chronic GI diseases.

We can't get the attention of the providers because they'd rather be in the GI lab doing colonoscopies on healthy patients, because that's what's driving their revenue. And when we come in with a value-based care program that may give them a percent or two percent, the answer would be I'll just do another colonoscopy.

DR. EMANUEL: Well, let -- okay. Let me at least address that in particular. Because I -- and you know, we've been trying to work with some GI docs for and the same thing is the case. First, as I said, you're going to have to revalue those fee-for-service payments.

There's just no two ways about it. We overpay for lots of procedures. We know we underpay for E&M[39]. I mean, I think Mike gave an absolutely fantastic example about, you know, the initial visit being under -- grossly underpaid. Whereas for some other things, the initial visit is excessively paid. I believe ophthalmology is one of those cases.

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39 Evaluation and management

So I think, there's just no way of moving forward without revaluing that element. And you know, it's one of the reasons I suggest, you know, bundle payments for upper and lower GI scoping is going to be critical to doing that. So that's absolutely essential.

And I think -- this is where I think voluntariness -- I've been against voluntariness from day one. I lost out to many people inside because I don't think if we make it too voluntary, you know, then the people who are going to win, enter, and if they can leave, they'll leave if they're not succeeding.

And I think mandatory is very important going forward. So I think that is going to be the case. An individual -- the last thing I would say is, you know, one of the reasons I keep emphasizing the data and the financial modeling is you have to show doctors how they can succeed, and if you don't have that modeling, you can't. I also agree with you.

I think I've said it very explicitly, unless you make the bonuses really big, this is just not -- I mean with all due respect for professionalism, in the end if you can't make 30,

40, 50 percent more by doing a very good job, then, you know, you're not going to get people's attention. I don't think one or two or five percent does it.

And so I think those are the two things I would focus on, revaluing, and keep the AMA[40] out of it, and making sure the bonuses for really high quality are really big.

DR. KOSINSKI: Zeke, If I could just follow up one quick question on what you said earlier. You've said that primary care should be capitated, and procedural specialists should have episodes in bundles.

DR. EMANUEL: Yeah.

DR. KOSINSKI: What about the cognitive specialist?

DR. EMANUEL: Yeah. Look, I'm an oncologist, and I helped design the original OCM[41] model. I think it's way more difficult to do that right. I think there are ways of fixing that system to, at least of my specialty.

You've got adjuvant care, which is well defined, good standards for a lot of good

40 American Medical Association
41 Oncology Care Model

guidelines that you can base things off of. And then, I think you need some triggers for examining or limiting, you know, third line chemotherapy for metastatic disease is, you know, just not on, or you know, triggering a review at -- when the ECOG[42] status goes down. Then it really gets into the weeds.

I think it's just much, much harder there, you know. And I think a generalized solution is probably not likely, you're going to need some specialty specific stuff.

CO-CHAIR HARDIN: Michael, please go ahead.

DR. MCWILLIAMS: Just pulling on that thread a little bit more. So if we're thinking about large bonuses for quality, you know, we -- given that we can only put so much money on the table, and I think, Zeke emphasized this before, we're going to have to get pretty selective with the measures, right?

And then so that's sort of one thing we need to think about. And I'm -- trying to think through the best way to say this. But I, you know, going back to sort of thinking about

42 Eastern Cooperative Oncology Group

who should bear the risk and thinking about quality in particular, so that's a good example perhaps.

The bonuses could be quite significant. We probably still want them at a practice or organizational level, given that that aggregate sort of actor is going to be able to do more about the system's problems at play, right?

And so, I think in thinking about sort of management and professionalism, the real trick here is for an organization to be able to respond to a large bonus for a measure that we really care about, can measure well and do all the risk adjustment for, et cetera, in a way that changes clinician behavior without necessarily relying on passing through the incentive in full because of all the problems that -- that comes with that.

And I think that's where certainly, a lot of action, a lot of research, is being done in terms of nudges and sort of behavioral – you know, drawing from behavioral science. But I do think that's something that still does not get talked about as much, and we need to be working on more.

CO-CHAIR HARDIN: I'm going to go to

Jay next for the sake of time. Please go, Jay?

DR. FELDSTEIN: So I'm going to pile on, this has just been an incredible discussion. The only downside, it makes me feel old because we were having these same conversations at U.S. Healthcare 30 years ago. And it's a flash forward, capitated primary care physicians, bundling for specialists.

But see, if you triggered on -- on something which is my real question, is we always talk about getting rid of waste, you know, how do we pay differently. How do we address demand? What can we build in the system to reduce demand? Especially in the context of social determinants of health with fixed budgets.

Are we going to pay for housing costs? Are we going to pay for food as medicine, which is now being more prevalent in Medicare and Medicaid programs?

Or are we going to pay primary care physicians more and specialists less and hospitals less? How do we work that into the system?

DR. EMANUEL: Well, I -- well, that's a more general complicated question in the

following sense. Right. We have a food stamp program, a WIC[43] program, and a bunch of other food programs, we have a dysfunctional housing system.

And yet we know all of those things have a big impact on health spend, transportation added to it. I think, you know, and health care isn't great at its own administration and to ask it to administer food and to ask it to administer housing is probably a bad idea if we had functioning social systems.

So I'm not a big advocate of let's layer on everything onto the health care system. But I do think two things. I'll go back to what Tim said, which is, you know, the part of the strain on things like food stamps and housing, are a direct result of the increases in health care costs.

And if we could moderate those increases while the GDP grows, I think we'd create a, you know, some -- a left -- or some extra money that can be spent for various things that are super important.

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43 Special Supplemental Nutrition Program for Women, Infants, and Children

Until we can get to that kind of space, I think that there are -- my personal view is, there are two things we should substantially encourage the system, the health care system, to take over.

I do think nutritional food is exceedingly important. And health care either directly to work with provider -- to make sure people get enough food and to work with the schools for kids. The second thing I would say is, you know, this is part of long-term prevention strategy. And we don't invest enough.

And if I were God, the thing I would force us to invest more in is early childhood interventions. Because they are critical for, you know, developing kids, they're critical for their brains, they're critical for their nutrition and avoiding obesity and the subsequent hypertension which we're seeing a whole lot of in children, diabetes as well. So those are the two things I would make us pay for.

Now the latter, early childhood interventions do fall directly under health care. And I do think those are things we ought to mandate, sorry Alice, I'm going to say this,

every Medicaid program be responsible for -- I don't know whether it serves family partnerships, I'm not going to specify the exact kind of program, but early childhood interventions that take kids all the way through two-years-old.

But I do, you know, we have a dysfunctional social system on lots of levels which is why it's getting, all this stuff is getting layered on health care. Not that we're going to manage it so much better. But, you know, providing people food is critical to them recovering.

CO-CHAIR HARDIN: Let's to go Tim, then Michael, and then Alice. We've got about three minutes, just to give you context for your comments. I know we could talk a lot longer about this. But, Tim, please go ahead?

DR. FERRIS: Yes. I will go really quickly. So I just want to underscore everything Zeke said. I completely agree that the movement of moving more and more social care under health care, it just -- it is probably not the right way to do it, even though that the incentives are actually moving us to do that.

I'm going to say something, I think,

you know, helpfully controversial, and just say that it is not great incentives for the demand on health care if you or your employer pays an annual fee, no matter what happens.

I just want to emphasize that. We have designed a commercial insurance where you, as the person who is consuming health care and paying into that, gets no benefit from not utilizing those services, none.

It is like, think about that for a second. So what Zeke said about prevention, so prevention is a long-term thing. Why, if you spend an annual amount out of your paycheck, and your employer sends an annual amount, like 50 to 60 percent of all health care costs are a 100 percent predictable.

Do you -- so it's like, there is no insurance for a predictable cost, it is a predictable cost. So getting the consumers in the current design of commercial insurance is a strong incentive against the self-management of the use of health care services, and also prevention, because Medicare picks up the tab after age 65.

So that is a fundamental flaw in our

system that affects the demand side of care actually quite strongly.

CO-CHAIR HARDIN: Thank you. And, Michael?

DR. MCWILLIAMS: So 100 percent agree. Having dollars for social services flow through the health care system is just not efficient. And ideally, we would be doing in that in some other way.

I think an argument is that well, the dollars are in the health care system and so let's use them as efficiently as possible. And that is a reality, and so we should do that.

Even thinking in an ideal world, clearly, we want the health care system, to the extent that they interface with patients and their social problems, to be trying to help at the margin, at least insofar as it helps their health care, right?

So you can think about arranging transportation so that patients can get to important visits or waiving parking or giving tablets so that they can be -- they can have virtual care.

So you know, certainly there's some

very reasonable things to be doing. And one might ask, what is the role of payment reform in that, and I think that goes back to risk adjustment. If we have more generous payments for certain populations, that creates sort of like a surplus without a behavioral change.

As long as providers are competing for patients, then that should be passed through in the form of those things. And so, that's sort of like the major reason for trying to shift payment in a, you know, from between populations in ways that we think align with our social agendas.

CO-CHAIR HARDIN: Thank you. And Alice, I'm going to ask you to as part of your comments, if possible, add in what are you learning in California related to the waiver, and what did you learn in the uninsured populations you paid for?

DR. CHEN: Oh, that is not fair. Because I actually have a couple other comments--

CO-CHAIR HARDIN: So take us home.

DR. CHEN: Very briefly, like, agree like, probably 95 percent with my colleagues here. I would say demand reduction is absolutely a long-term play. Zeke, I have said exactly the

same thing as you. Like if you're going to invest in one place, it's early childhood development.

But it's not just like, continuous eligibility for kids, but it's also Head Start, and things that actually don't fall in the health care system.

And as an aside, I think the beauty of Medicaid is, MCOs[44] are fierce competitors as we're going for the RFP[45]. But many states after you get it, are like, you need to play together because this is actually a population health move.

Which actually circumvents a little bit of one of the problems with using the health care system for long-term demand reduction and prevention is, right now, 54 percent of Medicare goes through managed care, right, Medicare Advantage. Seventy-plus percent of Medicaid, a hundred percent of marketplace, ESI[46].

Churn is a huge issue. I've seen proposals saying like, oh, members have to stick with an MCO. And my colleagues will kill me, but

44 Managed care organizations
45 Request for proposal
46 Employer sponsored insurance

I do not think that's the answer, that is not patient or member centric.

But I do think we need ways to figure out how to create multi-payer alignment in a way that really circumvents some of these constraints.

Quickly on health-related social needs, and this does tag back to California and CalAIM, which is, I think if there are two things that we know from looking at international comparisons, it's like investment in primary care. Right?

Other states are 67 percent primary care, 30 percent specialists, we're inverted. Similarly, health-related social needs, if there is one thing take home, it's Betsy Bradley. If you haven't read Betsy Bradley's book, go read it, right? Because what she found is, we were looking for our keys under the lamp post.

On every graph, we are the highest spending country per capita by 50 percent. But when you widen the spend to health and social services, we are middle of the pack. We just spend it differently.

Other industrialized countries, for

every dollar on health care, it's two dollars on social services. For us, every dollar on health care is 55 or 60 cents on health-related social needs, social services.

And so what I would say in terms of the health care system is, I have also been saying, like, you know, everyone basically says there's 30 percent waste in the health care system. Although when you ask them where it is, they're like this. Right?

No one's going to -- no one's saying that it's like health care waste is over there, but it's 30 percent. You don't want to put all this other spend through it unless it's really surgical.

So I do think that evidence-based things are food as medicine for certain conditions, like post-discharge for CHF[47], or HIV, it's transportation for prenatal visits, it's supportive housing for people with SMI[48] and SUD[49].

So I think again, don't just throw everything in there. Because we know that that will just generate waste. But how can we be

47 Congestive heart failure
48 Serious mental illness
49 Substance use disorder

evidence-based about it and targeted in a way where given our short-term thinking constraints and health care in the U.S. political system at large, we can get some short-term gains to free up some of those resources for other important social goods, including primary care payments?

CO-CHAIR HARDIN: We want to thank each of you for this excellent dialogue. You know we could keep going all the way through lunch, but I don't think -- I think they're going to be very angry with me if I don't break for lunch.

So we want to thank you for your contributions. You've helped us cover a lot of ground today during this session. And you're welcome to stay and listen to the rest of the meetings as much as you can. At this time, we have a short break until 11:40 Eastern.

And please join us then for a panel discussion from CMS and CMMI leadership, who will discuss their vision to achieve the goal of having all beneficiaries in accountable care relationships by 2030. We'll take a 10-minute break now until 11:40. Thank you.

(Whereupon, the foregoing matter went

off the record at 11:34 a.m. and went back on the record at 11:42 a.m.)

*** CMS Panel Discussion**

CO-CHAIR SINOPOLI: So welcome back. At this time, I'm excited to welcome staff from the CMS Innovation Center, who will discuss their vision to achieve the goal of having all beneficiaries in accountable relationships by 2030.

First, we'd like to welcome back Dr. Liz Fowler, Deputy Administrator of the Centers for Medicare and Medicaid Services and Director of the Center for Medicare and Medicaid Innovation. Liz?

DR. FOWLER: Thank you, Dr. Sinopoli and Dr. Hardin. And just thanks for the PTAC for inviting us to be part of this meeting and dedicating a panel to this really important priority for us.

As I said in my opening remarks earlier this morning, the theme for this meeting is of great significance to us.

Promoting accountable care and providing the right opportunities for providers is central to meeting our 2030 goal of having

every Medicare beneficiary and the vast majority of Medicaid beneficiaries in an accountable care relationship for quality outcomes and costs.

The CMS accountable care goal is grounded in primary care because we believe that a strong primary care infrastructure is the cornerstone of a high-performing health system.

Health systems around the world that have invested in primary care, including prevention screening and reinforcing healthy behaviors, managing and coordinating care for patients with chronic conditions, spend less and do a better job keeping people healthy and out of the hospital.

But we also know that we need to include specialists in accountable care as well. So today to that end, you'll be hearing from our chief strategy officer, Dr. Purva Rawal, on our vision for primary care.

And she deserves a lot of credit, along with our Deputy Directors, Ellen Lukens and Arrah Tabe-Bedward, for crafting, honing, and advancing our overall strategic objectives and accountable care goals. She's also a prolific writer and has spent a lot of time thinking about

how to communicate with the provider community about our goals, progress, and signaling what comes next.

Pauline Lapin is not able to join us today, so instead you'll be hearing from Pablo Cardenas, from our Seamless Care models group. This group has launched, led, and currently houses all of our ACO models, like the Pioneer model, ACO Investment model, both of which are now a permanent part of the shared savings program, as well as the NextGen ACO model and currently ACO REACH.

You'll also hear from Sarah Fogler, Director of our Patient Center, Patient Care models group, which leads our advanced primary care models, Primary Care First and Making Care Primary are the current ones.

And her team also leads our specialty care strategy which includes current and past bundle payment models and the new team model that we'll launch in January 2026.

As part of her work on specialty care, she and her team have given a lot of thought working with Pauline and Purva into how we might engage more specialists in accountable care.

And then finally, Kate Davidson, who's sitting here today in person in D.C., is Director of our Learning and Diffusion group, which leads our multi-payer alignment efforts and works closely with the Health Care Payment Learning and Action Network, or the LAN.

Kate's remarks are going to focus on our multi-payer alignment efforts. But I think it's also worth noting that the LAN, which includes stakeholders from across the health care ecosystem, including patient and beneficiary organizations, recently launched the Accountable Care Action Collaborative, that's really an important partnership with us at the Innovation Center in promoting efforts to advance accountable care.

The collaborative also helps foster partnerships and spread learning and best practices. I really consider myself lucky to have the opportunity to work with all of these talented leaders and their teams.

Before closing, I'd be remiss if I didn't mention our work with other components within CMS. I've said in other settings how important it is for us to work with our

colleagues in CMS, the Center for Medicare, Center for Medicaid and CHIP Services, and the Center for Clinical Standards and Quality.

We do our best work when it's in collaboration with our colleagues, and you'll hear that in each presentation today. And particularly, we've worked closely with colleagues in the Center for Medicare who lead the Shared Savings Program to outline a shared Medicare-wide ACO vision.

And as we think about opportunities and options to scale or expand successful innovations in care delivery changes into something more permanent, this partnership is really critical.

And finally, the last thing I want to remind everyone is that the Innovation Center has been trying to be transparent as possible with our work.

We've made data for our models available for researchers. We have a proposed rule to make many of the terms of our participation agreements public.

And we've published articles and posted materials on our website to provide

hopefully a signal as we think about our primary care, accountable care, and specialty care strategy.

So look forward to your questions after our speakers and the conversation with all of you. And with that, I will turn it over to Dr. Purva Rawal.

DR. RAWAL: Thank you, Liz. Thanks for the opening and remarks. And I just also want to say thank you to the PTAC for having us here and our ASPE colleagues as well.

This is kind of a foundational element of the Innovation Center's strategy, to get all of our beneficiaries in accountable care relationships. And so to have the chance to talk to you all about it today and take your questions, I think will be really helpful to us.

Liz already talked about the fact that there are -- that primary care and advanced primary care is the cornerstone of our strategy and our work. And so I'm going to just do a little bit of a deeper dive and talk about our work in the advanced primary care space across the portfolio.

It is the key kind of mechanism and

pathway for us to be able to achieve our 2030 goals. And then I'm going to, Liz also mentioned scaling and how the importance of being able to scale our successes in permanent ways.

And so we'll talk about some of the work that we're doing in ACO and advanced primary care space as well. I think it will tie nicely to the remarks that Pablo, Sarah, and Kate will be giving as well.

And I'll just say, when I'm talking about advanced primary care, a lot of that work is led by Sarah Fogler's team, who is -- and Sarah's going to be speaking later, so, you know, sharing all of this on behalf of lots of other leaders at the Innovation Center and members of our teams as well.

So what you see, this slide up here goes through three of the guiding principles that are informing all of our advanced primary care work across the portfolio.

So again, our ACOs, our state-based models we will talk about, and also our fourth-generation advanced primary care model. These were really informed by expert voices, the NASEM[50]

50 National Academies of Science, Engineering, and Medicine

2021 report, and our own learnings from over a decade of testing ACOs and advanced primary care models at the Innovation Center.

And what you'll see is, these are three guiding principles that we're carrying through all of our advanced primary care work. The first is financing.

It's not going to be a surprise to anybody that we have to change the way that we finance and pay for primary care in order to strengthen the primary care infrastructure in the country and achieve these accountable care goals.

And so we are moving , in all of those models, we are finding different ways of moving providers away from fee-for-service payments to hybrid or fully population-based payments that provide the flexibility for them to be able to tailor their care to the needs of beneficiaries and really focus and be compensated for those non-face-to-face activities as well, that we know are always going on in primary care and often not adequately compensated for.

The second is advancing health equity. If we want to achieve our accountable care goals and get all of our traditional Medicare

beneficiaries in an accountable care relationship, we have to reach all of our beneficiaries.

And so we know historically, we have not been able to serve a representative group of our beneficiaries through our models. And so we are very focused on and have a multi-pronged health equity initiative.

But in all of our primary care work, we're looking at payment adjustments, data collection, health equity plans, and a real focus on bringing safety net providers, in particular, into our primary care models. And I'll give you one example where I think we're starting to see a good response from the market.

But in Making Care Primary 41 percent of our practices that are starting -- organizations starting in that model, are actually Federally Qualified Health Centers. So we know that some of the ways that we're designing for health equity are attracting interest.

And now I think we have to, you know, get past enrollment to really understanding what their experience is and seeing how we are able to

support them in being successful in a value-based care construct.

And then the third is sustainability. And I think this will connect nicely to Kate's remarks that when practices and organizations are investing in transformation and care delivery change, we need to be thinking about the sustainability of those investments over time beyond our model tests.

So one way to do that is multi-payer alignment, which Kate will talk about. And then another way that Pablo will talk more about, is for us thinking about permanent pathways in the Medicare program.

So in our ACO work, for instance, we have our ACO Primary Care Flex model, we want to -- we are testing that within the Shared Savings Program to create that permanent pathway for sustainability. Next slide. Thank you.

And this, I'm not going to spend a ton of time here, but what you see here are all of the different advanced primary care models that we are operating at the Innovation Center right now from ACO REACH all the way through to ACO PC Flex, which is supposed to start January 1st,

2025.

The two that I'll zero in on a little bit are Making Care Primary, our fourth generation MCP model that Sarah Fogler and team are -- designed and are now implementing. It went live on July 1st.

One of the goals here was to, with MCP, was to build on our lessons learned from our previous models but really create a pathway for practices and organizations with varied levels of experience. In particular, we wanted to bring in safety net practices and independent and smaller providers.

And I could give you some, you know, some stats around the FQHCs to show, you know, we're already making progress in bringing new folks in. And then a second, I'll also talk just for a second about our head model, because that's a state-based total cost of care model, but there's an important primary care component there.

So not only is that model looking at hospital global budgets, but an increased investment in primary care in particular. Where CMS, these states have Medicaid and advanced

primary care Medicaid programs running, and we're bringing Medicare fee-for-service to amplify what those states are already doing.

So we know there's multiple pathways here, that we can also be working with states to support advanced primary care efforts.

And then the last, I won't spend a lot of time on because I think Pablo's going to cover our ACO Primary Care Flex model which is an ACO-based model.

So what you see here is kind of a diverse strategy, we're trying to meet practices where they are and make sure that they have a different -- that they have a range of options depending on where they are in that value-based care journey. Next slide.

And then the last thing I'll talk a little bit about, and Liz spoke about how important it is for us to be working with the other components and CMS.

We've been doing a lot of work at the Center for Medicare on a shared ACO visioning strategy which Pablo will talk about. We've also been doing more and more work again, led by Sarah Fogler and team, on the Medicare fee-for-service

side as well, to think about how do we create and use the traditional Medicare program to create advanced primary care options outside of ACOs as well.

This past year we worked with the Center for Medicare to propose a new set of advanced primary care management codes, or APCMs, in the fiscal year 2025 physician fee scheduled proposed rule.

Through that bundle, that proposed bundle, physicians and other practitioners who deliver advanced primary care could bill for these services on a monthly basis for as long as they are the beneficiaries' go-to point for health -- for the management of their health care.

Bundling those key services such as care management and communication-based technology codes into these APCM codes, we hope would help providers who want to provide these services but oftentimes are discouraged by complex and numerous codes that they have to bill.

Importantly, we -- CMS views this proposed bundle as the start of a multi-year

effort to inform a hybrid payment and coding option to deliver advanced primary care services in traditional Medicare.

And so we really view this as a first step along with that proposed APCM bundle, code bundle. There was a request for information that also went out to help inform this multi-year effort with our colleagues in the Center for Medicare. So I'm going to stop there and turn it over to Pablo.

MR. CARDENAS: All right. Thank you. The Innovation Center's vision is to drive a health care system that achieves equitable outcomes through high-quality, affordable, person-centered care.

And as part of the Innovation Center's 2021 strategic refresh, we identified five objectives to guide our work. One of which is to drive accountable care that results in the delivery of whole-person integrated care with accountability for outcomes and quality, as well as total costs.

Since 2022, CMS ACO initiatives have been guided by the objectives of alignment, growth, and equity to meet the 2030 accountable

care goals. In 2024, there were about 13.7 million people with traditional Medicare aligned to an ACO across the Shared Savings Program, our permanent ACO program, and the ACO REACH, and Kidney Care Choices models.

ACOs are now serving nearly half of the people with traditional Medicare. And as we look to the future, and increasing the number of beneficiaries in accountable care, it is important to look at what we have learned over the last decade from our model evaluations, as well as the Shared Savings Program.

Our ACO models have shown that ACOs can reduce spending and improve quality of care. Both Pioneer and AIM achieved savings and were included in the Shared Savings Program, with Pioneer as a high-risk option and AIM leading to advanced investment payments in the Shared Savings Program that started in 2024.

In addition, the current year physician fee schedule, in the current year, the health equity benchmark adjustment is being proposed in the Shared Savings Program informed by the ACO REACH experience, where we have seen this benchmark adjustment along with other health

equity focused features of ACO REACH have contributed to a doubling of safety net provider participation in the model from '22 to '23 and a 25 percent increase in 2024.

Bringing this innovative payment adjustment to the broader Medicare Shared Savings Program would provide greater resources to ACOs serving underserved beneficiaries.

Evaluations of other ACO models have not found savings and have shown that when ACOs have losses, they tend to drop out of models. Management companies play an important role providing infrastructure and support for care management and data analytics.

Cash flow mechanisms like population-based payments have been helpful for ACOs to make investments. And while they were underutilized in NextGen, we learned that those who did use them achieved greater savings.

We are continuing to test cash flow mechanisms in ACO REACH, along with additional flexibilities in the form of benefit enhancements, which waive Medicare payment rules to allow ACO providers to provide additional services and more care in the home, as well as

incentives to help ACOs better engage beneficiaries and address health-related social needs like transportation.

In previous models, ACOs have not leveraged the flexibilities we provided as much as we expected. And we are hoping to continue to learn more about which are of high value to ACOs, like the three-day SNF[51] waiver and parking cautioning support and what other flexibilities they would like in the future.

One other common theme from our models, as well as the Shared Savings Program, is that physician-led ACOs have been more successful at reducing spending than hospital ACOs. In the NextGen ACO model, we found that hospitals affiliated ACOs lower costs for ambulatory spending, while physician affiliated ACOs lowered costs for hospital spending.

CBO[52], in its evaluation, came to the same conclusions, that one, physician-led ACOs had strong incentives to reduce higher cost hospital care while hospital-led ACOs had conflicting incidents.

51 Skilled nursing facility
52 Congressional Budget Office

And two, hospitals have less direct control over their types of services provided to their patients. Physician groups were able to redirect patients away from low-value care more easily. Next slide.

CMS recently released a second evaluation report from the first two years of the GPDC[53] model. In the second year of GPDC, the model showed mixed results in growth spending, but consistent, significant increases in net spending relative to a comparison group of similar fee-for-service Medicare beneficiaries in their markets. Standard DCEs[54] improved multiple quality measures, but increased gross spending, particularly from acute care hospitals.

New entrants and high-needs DCEs reduced gross spending through improvements and utilization and minor improvements in quality. We found that standard DCEs affiliated with health systems drove most of the increase in gross spending among all the standard DCEs.

On the other hand, their peers led by primary care companies were associated with gross

53 Global and Professional Direct Contracting
54 Direct contracting entities

reductions in spending. However, when you factor in the Shared Savings payments, all DCE types increased net spending. The takeaway for us from these evaluations is two-fold.

First, we need to be able to better design for hospital-led ACOs to both do away with conflicting incentives and capture their ability to reduce other types of low-value care. And second, we need to get more physician-led ACOs into the program to drive higher savings overall.

The second point, along the NASEM's landmark primary care report and feedback from clinicians, ACOs, and beneficiary and consumer organizations, informed the design of the ACO Primary Care Flex model.

In its report, NASEM said primary care is a central component of ACOs, and organizations differ in the extent to which they emphasize, incorporate, pay for, and support it.

NASEM made two recommendations. First, primary care payments should shift from fee-for-service to hybrid or part fee-for-service part perspective. And two, sufficient resources and incentive should flow to primary care within ACOs to provide team-based care, to risk adjust

for medical and social complexity, and to support infrastructure, including digital health.

The ACO Primary Care Flex model will test a novel way of formulating monthly perspective primary care payments, or PPCPs, to ACOs. The PPCP is composed of two parts, a county base rate and payment enhancements.

Rather than basing the county base rate on each ACO's historical claims experience, as is done in ACO REACH, the county rate will be a common risk-adjusted capitated county rate for primary care.

The enhanced amount portion of the PPCP is based on characteristics of the ACO and its assigned patient population and is not at risk.

For most flex ACOs, we expect that the PPCP will increase primary care funding relative to ACOs historical expenditures. The ACO PC Flex model is a five-year voluntary model, with remote revenue ACOs on the Shared Savings Program, and it begins on January 1st, 2025. Next slide.

In addition to ACO PC Flex, we are thinking about what comes next after ACO REACH ends in 2026. We have heard a lot of feedback

from our participants, as well as ACO organizations and providers.

We also included an RFI in the PFS[55] asking for feedback on a higher-risk option in the Shared Savings Program, financial methodologies for high-risk ACOs, and future ACO models. Thank you to all who responded to the RFI.

When designing financial methodologies for models, we consider what participants value and what CMS must accomplish. For participants, it's prospectivity and predictability, and for CMS, accuracy and budget neutrality. Balancing these goals is challenging.

The dynamic that underpins most parameters of financial methodologies for models like ACO REACH, is a necessary tension between participant predictability and model accuracy.

We will draw on lessons learned from previous models, as well as feedback from interested parties as we consider where we go in the future to design ACO models that can inform and grow the Shared Savings Program.

These include changes to benchmarking

55 Physician Fee Schedule

to continue to make long-term participation sustainable and attract new ACOs, improve beneficiary attribution that can support meaningful specialty engagement and care, strengthen relationships between ACOs and community-based organizations to address health-related social needs, and assess the impact of voluntary participation in model tests on quality, access, and saving. I think now we're turning it to Sarah.

DR. FOGLER: Thank you much, Pablo. Hi everybody, great to see you. Sorry for not being there in person, but I think you will be pleased with our portion of the presentation today, which is really focused on how the specialty side is complementing the Center's vision for driving accountable care in the health care system.

So I don't have to reiterate, we have heard, and this group knows more than most, we are driving this accountable care infrastructure through our advanced primary care models and our accountable care organizations.

But I think we all recognize, and I would just point you to this quote in our 2021

strategic refresh materials, that team-based accountable care can't be accomplished with just primary care.

We have to recognize the important role that specialists play in our nation's health care system. Delivering person-centered care that's whole-person requires addressing the full range of patients' needs from primary and preventative care services to managing chronic conditions longitudinally and episodic care needs acutely. Much of this is provided by specialty care providers.

So in 2022, we developed and released a specialty care strategy that's really about enabling better communication, coordination, and integration between primary care and specialty care providers.

Each element, there are four elements of this multi-prong strategy, is consistent with the Center's broader accountable care goals. And in my opinion, I think the beauty of the specialty strategy is that it considers data and learnings from the previous decade worth of model testing, it capitalizes on existing model implementation, and it introduces new model

concepts and initiatives that fill gaps.

So let me take us to the next slide. We can go to the next one. So these are the four elements, and I expect this audience to be quite familiar, but I just want to briefly re-anchor us in them, because we have so many short- and long-term plans associated with these four elements, it can be kind of easy to get lost in the details or the independent milestones we're tracking to across all four of these elements.

The first element, and you know, I should say too, I called into the morning panels this morning, and I heard a lot of themes with Zeke and Michael and others on the panel, Tim, too, I think they were talking about making sure you have different incentives for primary specialty and procedural care, you know, the mandatory design of some models, the need for data sharing.

So all of these themes, I think, are woven throughout, I am happy to say, in the specialty care strategy that's really outlining our path for many years to come here.

So this slide just quickly summarizes those four elements. The first is really about

enhancing data transparency on specialty care performance, sharing data on specialists who provide high-quality care that is at potentially lower costs, can inform referral decisions, again, help primary care practitioners and ACOs identify good partner specialists, et cetera.

The second element really entails maintaining momentum. On more than a decade worth of work that we've embarked on with provider partners, on conditioned-based models like kidney, oncology, we have a new dementia care model, and episode-based payment models that I heard mentioned a bunch this morning as well.

The third element of our specialty strategy is really a nuanced idea here, although probably not an aha moment for many of us that have been at this for a while.

And it's really about, you know, continuing with the efforts that we have put into bolstering primary care in that infrastructure, but also really, you know, and we've done, I will say in the, as Purva would say, we just embarked on our fourth successor model here in the primary care space. So we've been at this awhile.

And I will say in the first three

models, we implicitly were encouraging specialist engagement and involvement through our primary care models. But we didn't really have levers to pull in specialists into those arrangements.

And with the new Making Care Primary, we have introduced those types of explicit levers to really do a better job through our primary care models, pulling specialists in through new types of incentives.

The other really neat part of this element, in my opinion, is that it's married up with plans that we have for ambulatory specialty care. And I will talk a little bit more about that in a couple minutes.

But the idea here is that we are pulling multiple levers. So we have work occurring in the primary care space, again, to bolster that infrastructure and resourcing for primary care practices.

But we're also making incentives available for specialists providing chronic condition management new tools and incentives to engage in value-based care.

The fourth and final element has flavors of the preceding three. It's really

about providing more data, it's really about providing tools and incentives for specialists to meaningfully engage with ACOs. There's some specific levers we're exploring here, but this is a longer-term feature of our specialty strategy.

So early thinking, kind of playing off Pablo's statements about kind of the next generation of the ACO work we'll be embarking on, we'll look specifically at our attribution methodologies, certain quality measures that we might contemplate to better engage specialists in the ACO framework, and then of course, some financial incentive opportunities to actively engage specialty care.

Let me take us to the next slide, which is really around the accomplishments in 2024. Oh, I'm sorry, we're not there yet. I got too excited to share our accomplishments.

What I wanted to point out on that next slide, though -- we can go there, on slide 4, is the Innovation Center's work in the specialty care space has really been -- you can see on this patient care journey map, in the acute medical event post-acute care space. CJR,

BPCIA[56], for example, we've really engaged proceduralists in those models.

But there was all this remaining space on the care continuum that we really didn't have explicit levers at play to engage specialists in value-based care.

So a lot of our work and it's oriented, these four elements and especially strategy along this continuum of a patient journey, because it helps us kind of organize those multiple models at play here and are really trying to address all points on a patient care journey and engage specialists in the value-based care along and in partnership with primary care physicians.

So let me now take us to our 2024 accomplishments, just so we can report out and hold ourselves accountable for some of the work that we have done in the past year. So some early successes here, we have started to release data to ACOs.

And this data is really constructed episodes, 34 episodes that are currently tested in BPCIA, we're now providing that information on

56 BPCI Advanced

attributed beneficiaries to ACOs.

I was just on a webinar last week with six representatives from different ACOs about their experiences with this data, and it's really -- the early feedback has been really positive.

Folks are really excited about the opportunities associated with this data, just to better understand the specialized services that their beneficiaries are receiving, which providers, you know, they might want to engage in conversation with about some of the data performance.

We also published an implementation update on our strategy blog in March, again, just trying to highlight how we're progressing along the elements, the strategic elements that we laid out.

Folks may be familiar with the new TEAM model, Transforming Episode Accountability model, and this is a successor, a little bit of a Frankenstein version of some of our CJR activities and our BPCIA episodes, but really focused narrowly on five surgical episodes in our model we did finalize, a mandatory episode base

payment model that will launch January 1, 2026.

And we'll be working with the mandatorily assigned hospitals for that model over the 2025 calendar year to prepare them. We also released and just received comment on September 9th, an ambulatory specialty care RFI in the calendar year 2025 Physician B schedule.

So we are actively combing through comments. But what I just wanted to highlight was again, Element 3 of our specialty strategy where we had explicit features of our new primary care model, and we're trying to marry those up with some specific incentive structures for the ambulatory care specialty practices, so that we're working from both sides of the equation here. So excited to see how people received and thought about that.

We also are launching data dashboards and are making sure primary care participants are able to see within their market, specialist performance across their -- or, I'm sorry, their primary care attributed lives, but also just all Medicare beneficiaries in a given market.

So if they haven't identified a specialty program in the past, they may decide

they want to by combing through this data. And also just wanted to put a plug in for our condition-based models here.

We did launch GUIDE[57], which is a dementia-specific model July 1st, so we'll be kind of watching how that unfolds, along with the Making Care Primary model. And for an oncology model, we've just -- or are just, I think we're right on the cusp of closing a second application period for that model.

So lots of what feels like disparate work here, but there's a method to the madness that all of this is tied to one or more of the four elements of the specialty care strategy. So let's move to the next slide, and I'll tell you where we're headed.

And this is really again, a lot of these milestones are going to take us for way beyond just the next two years here. But for what we're focused on for 2025 and 2026, here's a list of six things that come front and center for me.

All of the specialty strategy work that we have published has really been fed by

57 Guiding an Improved Dementia Experience

engagement with stakeholders, so beneficiaries, physicians, non-physician practitioners that are working in the specialty care space, health policy experts, so we plan to continue that.

We're working a lot with specialty societies at the moment. Talking about measures, for example, we've had a number of RFIs. So that continued robust engagement will hopefully be maintained in the coming years just so we can right the ship if we get sideways.

But also be, you know, staying ahead of trends in a way that makes the elements of the specialty society successful over time. We also plan to expend -- extend, I'm sorry, and expand on our data sharing offerings, so we, I mentioned, are sharing episode data.

We plan to, soon, in 2025, share episode-based cost measure data, so more on the chronic condition specialty care services and costs. And so that again, will go out initially to ACOs and then we'll be expanding that data sharing offering over time.

I mentioned combing through comments that we're getting on a potential new concept in the ambulatory specialty care space. Also

supporting hospitals that will be mandatorily required to participate in the new TEAM model. We have data sharing plans for that, we have webinars on the docket to help them prepare.

I also mentioned our condition-based models continuing to support those. And the final one on here, a kind of late breaking, and I just want to share with this group, I won't go into depth here, but we are planning to publicly release implementation performance metrics specific to the specialty care strategy.

So everyone may remember that the strategic refresh a year or two thereafter was followed by what metrics the Innovation Center would be holding themselves accountable for to drive these accountable care goals and the other strategic objectives.

We're going to do a similar process for the specialty care strategy, so in 2025, look for a handful of metrics that we will be publicly reporting on at some frequency to demonstrate our progress towards better engaging specialists, better meeting beneficiaries' specialized needs. All of what we just talked through in the preceding slides. So let me stop there. And

hand it, I think back, maybe to the moderators.

MS. DAVIDSON: I think I'm up, Sarah. Thank you.

DR. FOGLER: Sorry, Kate. And now Kate Davidson, with no further ado.

MS. DAVIDSON: It's good to be there with you all day. I think that you heard across the board today all of us mention, the goal that we've set at CMMI to try to ensure that 100 percent of Medicare beneficiaries and the vast majority of Medicaid enrollees are in an accountable relationship by 2030.

And as we set out to make progress against that goal, it was really important for us to understand what the barriers were to be able to achieve that, and also what some of the potential solutions would be.

We know that one of the real reasons why providers are not adopting APMs or moving into value-based care, is because of the administrative burden that comes along with participating in some of our models, as well as in value-based care arrangements across other payers in the landscape.

And so we've heard very clearly from

providers that some of the challenges that they've experienced are related to reporting and collecting data, as well as to -- as well as analyzing their data and aggregating that.

So for this reason, the Innovation Center set a goal within our strategic refresh to include a multi-payer alignment strategy across 100 percent of the new models where applicable. I was really glad to hear this morning that a number of the presenters also focused and talked about multi-payer alignment in their remarks as well.

So there's a real, I think, focus on this across the industry. But in addition to setting a goal to include payers in our models, we've also shifted our approach to partnering with payers.

In the past we've asked payers to largely adopt the models that CMMI has developed. But we know that just like us, our payer partners have also learned a lot over the 12 -- over the last 10-plus years that they've been testing APMs.

They've invested in operational changes within their own organizations, and they

are also serving different patient populations with different needs across their lines of business. So we're testing a new approach to alignment that is predicated on payer partnership.

You can see here on this slide, how we are approaching this work across the life cycle of our models, working to create industry buy-in and align priorities early at the concept or ideation phase, actively recruiting payers through individual and group conversations to participate in our models, understanding what their priorities are, and what the value proposition is for them to align with us, increasing the number of lives that are covered across lines of business through the implementation of our models, and continuing to adopt the learning store models across our portfolio and into successor models to sustain industry changes, which is like what Purva talked about earlier in her remarks.

In addition to all of this, and as Liz mentioned, we're actively working across all of our partnerships in CMS, across the lines of business in Medicare, Medicaid, and the

Marketplace, to pursue all the potential policy levers that we have in order to support alignment efforts. Next slide, please?

The graphic on this slide was taken from a policy report and framework recently published by the Duke-Margolis Institute for Health Policy.

The Health Care Payment Learning and Action Network, or the LAN, adopted this framework and are leveraging its approach as we align efforts across payers and other industry parties to reduce provider burden.

We're also using a similar directional alignment approach across the Innovation Center's model portfolio. You can see on this graphic on the left, the functional areas of directional alignment, performance measurement and reporting, health equity initiatives, which I know that Alice Chen mentioned earlier today, technical model components that Michael McWilliams really mentioned in his remarks earlier, data sharing and aggregation, and technical assistance.

And the idea is that we are leveraging shared goals across lines of business to promote alignment in these key areas. And we know that

you can't just turn alignment on like a switch. It takes time, effort, and resourcing for payers to align.

So on the right hand side, you can see a graphic that shows the process for which we are aligning as payers over time, assessing needs and gaps, engaging stakeholders, developing concrete action plan, leveraging existing trusted local and national conveners, such as the LAN, and implementing and continuing to iterate and refine over time. Next slide, please.

And finally, I want to share an example of this alignment work in action through one of our newest models that Purva mentioned earlier, Making Care Primary or MCP.

We're so pleased with the initial response that we've received from our payer partners in MCP. We received over 50 letters of interest from national and regional payers interested in the setting of shared vision and goals for primary care across the eight states where we are testing MCP.

In MCP, we worked with the payers prior to the model launch to identify shared vision for goals and primary care, completed an

environmental scan of the most common measures used across payers, and identified a parsimonious set of quality measures that we are testing in the model, that is also aligned with the universal foundation set.

We also developed a data sharing strategy with the goal of having a shared all-payer data aggregation approach for providers so that we are supporting them to look across their entire panel rather than a slice of their population covered by any one specific payer.

We worked with the state Medicaid agencies before the announcement and launch of the model to support a deeper understanding of the policy and care delivery context specific to their states.

And finally, we developed a hyper-local approach. The Innovation Center is resourcing local infrastructure in recognizing the need for flexibility with our payer partners to include additional design elements based on their local priorities.

This is a ten-and-a-half-year model in primary care. So this is just the beginning of our partnership and alignment efforts. We see

this as an iterative process and an opportunity to refine the design elements within our models over time as we work together with those partners at a local level.

And with that, I would like to thank the PTAC, as well as ASPE for bringing all of us here together and for having me here today.

CO-CHAIR SINOPOLI: Thank you all. And we really appreciated all your comments, there is some great insights. And now, if the Committee members have questions for our guests, if you will flip your name tent up, and we will recognize you to ask questions.

So I have one question. I think early on, you mentioned support for team-based care and bundling that payment for team-based care. I would like to understand a little bit more what you mean by that and how you're defining the team. And when you say bundling that for payment, is that putting the teams at some kind of risk or is that -- what does that mean exactly?

DR. FOWLER: I think this might be for Sarah?

DR. FOGLER: I'm happy to take this.

Yeah. So thanks for asking that question. I think that we have some proposals in the, again, this calendar year 2025 physician fee schedule that were about this advanced primary care management bundle.

And so, you know, we're tracking to the annual cycle of the physician fee schedule rule that any clinician enrolled in Medicare is able to bill for services. But there's really a grander plan, and we asked some questions and accompaniment with those proposals around this APCM code.

And it was really asking about a future state scenario where we might be able to introduce hybrid prospective payment into primary care through the physician fee schedule.

So we're just asking a lot of questions but starting out of the gate with a very small bundle of care management codes that we've historically seen as being underutilized, but also being like, just really hard to bill because there's lots of documentation associated.

I would say this year's proposal is really a toe dip in the water of trying to pay differently for team-based primary care. But it

would be a multi-year effort.

So there's not really specificity yet around how to construct the team. For example, the level of detail that you would see in terms of eligibility requirements in an advanced primary care model in the Innovation Center we're not to that point yet in the physician fee schedule. But the idea here is to translate learning, as Purva was describing, the same way that we translated ACO learning into the permanent Medicare Shared Savings Program and taking some of those learnings from our Advanced Primary Care model and translating them into permanent pathways in traditional Medicare.

And so, again, APCM proposals are really around small bundling of care management codes to reduce administrative burden in the initial years of implementation.

But we do have a vision for trying to drive team-based care and payment through the physician fee schedule in future years, which is why we have an RFI accompany those proposals in this cycle. I hope that's helpful.

DR. FOWLER: And we would welcome your input once we get the responses to the RFI, we

have a chance to review them, we can share those and really talk about what those next steps are. So happy to involve you in that future conversation.

CO-CHAIR SINOPOLI: Thank you. I appreciate those comments, and I think it is very important to address that topic, so thank you. Lauran?

CO-CHAIR HARDIN: So as you're looking across lines of business and across -- and towards an all-payer model, I'm curious what themes are emerging as universal practices that you might consider to address health equity and also health-related social needs? That's the first level of question.

MS. DAVIDSON: Sure. I'll start and then I'm sure Purva, who is leading our health equity efforts, will have a lot to say on this front. I think first, and foremost, there's a lot of focus on data collection around REaL[58] and SOGI[59] data.

I think folks are really interested in getting that right. There's a lot of technical

58 Race, Equity, and Language
59 Sexual Orientation and Gender Identity

aspects of that and a lot of things are changing and evolving with the -- with a lot of the data infrastructure across the country.

I think that we want to get to a place where there's alignment in collection efforts, as well as some of the technical aspects of how we're defining REaL and SOGI data across our payers, so we don't get to a place where there's so much fragmentation, much like we are in the quality space right now.

So that's one major area focus, and we've been doing a lot of thinking along with our payer partners around just that. And then also thinking about how we can pull in some of our other stakeholders across the work across the field and in implementation. So that's one piece.

I think the next piece is also around screening and referral. There is so many efforts that are happening across providers, across payers, and really happening in the local context of referring to -- or for screening for social needs.

But then there's that connectivity piece about how do we ensure that then we are

finding them services that are very hyper-local and in the community. So we've been, you know, working across all of our models and to have a strategic way of understanding best practices for that.

And then thinking about how we scale that. So you'll see that the LAN is getting a lot of work through the Health Equity Advisory Team, as well as the ACAC that was mentioned, the Accountable Care Action Collaborative, to understand just those best practices that we're seeing emerging across the field.

And then paying that into the work that we're doing around multi-payer alignment, so that we're actually able to scale and implement.

DR. RAWAL: I think you did a pretty good job of covering it. I will just take us back a little bit to, you know, how we were able to get to a point where we can have health-related social needs screening and referral in all of our models is really the work that the Accountable Health Communities model did.

Where we were able to demonstrate through that model that you can screen for HRSNs[60]

60 Health-related social needs

at scale in different geographies, regions, and different settings. Unfortunately, we identified a high level of need when the screening was occurring.

But that we can also successfully -- people were very willing to also take navigation services. And I think that's the picture that Kate is painting as well.

That we set a baseline for screening, and now what we're really trying to do is find ways through, some of like, for instance, our health equity payment adjustments that we're making in all of our models to make sure that we're resourcing those providers that are caring for more complex populations, underserved populations, to get beyond being able to screen to refer, work with like, local community-based organizations.

And our learning system has been doing some really great work in highlighting some of those best practices. For instance, an ACO REACH model really understanding what some of the ACOs are doing around building partnerships and longer-term connections to ACO -- to community-based organizations.

Because we know that, you know, across a patient's journey, those health-related social needs are often shifting and changing. So you might resolve one, you might have another one, you know, down the road. And so those long-term connections are really meaningful.

CO-CHAIR SINOPOLI: Thank you. Larry?

DR. KOSINSKI: Just a quick question, probably for Sarah. Do you see any roles for APCM codes for cognitive specialty work?

DR. FOGLER: It's a great, great question. And I think, was it the last meeting that PTAC had, someone had shared a slide, I don't know who constructed it, but it talked about all the various ways primary and specialty care coordinate over time and in some, it's more intense, in some it's less intense. And when is the specialist being the quarterback versus the primary care physician?

I think the honest answer to that, Larry, is we're still sorting through what our intentions would be in the long-term for cognitive specialists to bill APCM regularly for chronic condition management.

So I think in the short-term, there's

no limitation on other than the eligibility requirement as proposed in the rule to bill an APCM code. I think the longer-term vision, you know, we're still coordinating with input from all of the experts here about how do you really drive accountability when you have multiple players at play?

And I think this is the question that always comes back and resurfaces. And in these meetings, but in all sorts of meetings, we've talked about weighted attribution, or just primary care attribution, or shared specialist/primary care attribution, or just pure specialist in the case of oncology and kidney.

So I think, again, the honest answer to those questions, I think we're still debating and batting around. But at this time, as proposed, any physician or non-physician practitioner billing the physician fee schedule would be eligible to bill such care management-oriented bundles.

Dr. Fowler: I think we're also watching what happens in the GUIDE model, where we do have a lot of, obviously, because the patients are with dementia and all stages of

dementia, so we'll be watching very closely to see what happens in that model and some of the patterns and behaviors and what's working and what's not.

CO-CHAIR SINOPOLI: Perfect. Thank you. And Jim?

DR. WALTON: Thank you. Great presentations. Thank you. I was going to pick up on the comment you made about the health-related social needs. And I, you know, I've been doing some work in rural Oklahoma, and what I was finding in a high ADI region where there's low participation, where I didn't find low participation.

The capacity to address health-related social needs is the rate limiter. And I was curious whether or not there was a model in your mind's eye around capacity development through the safety net infrastructure because that's within the purview of HHS.

And I asked -- I posed this question to some of the FQHCs, and it was with mixed result, you know, because of it's out of scope, oftentimes, you know, it would be way out of scope.

But it -- there is some levers -- there are some levers there, I think, we might think about pulling to some models. So I'm just curious, is that something that's already been talked about and discarded, or where is that at?

DR. RAWAL: Yeah. And Liz and others should jump in. I don't think that, you know, we're looking at a single model to address health-related social needs. But I hear you that the -- you know that there are some limiting factors in terms of the actual infrastructure and the social safety net.

One of the ways that we are trying to at least resource the providers, we have yet to reach these and others in our models, is through these health equity payment adjustments.

So whether it's our ACO models or others, we are adjusting benchmarks in PMPM[61] payments. Usually using a blend of, you know, a geographic level index and individual local factors that were at least driving more dollars to the providers.

The other thing I will say is because you mentioned this was in rural Oklahoma, and a

61 Per-member-per-month

lot of folks -- one of the things that Keith Davidson and team just did was a series of rural hackathons in Montana, Texas, and North Carolina. And where we're trying to understand again, some of those local needs, but also source innovative and novel ideas.

And we did hear a lot about ideas around health-related social needs and the need to link communities to organizations, a lot of them are under-resourced and overwhelmed as well. And we can't really resolve those health-related social needs without better partnerships across providers in the CBOs[62].

But we're also really open to ideas there as well, so you know, in your discussions with FQHCs, Jim, if there's anything you can share with us, I think we'd really welcome that.

DR. WALTON: Yeah. Just my, just one comment here is that -- is that, you know, the indexing around health equity oftentimes feels like it's indexed to screen and maybe refer.

But if there's no place to send the patients -- and so the question would be somewhat, could it be indexed for places that we

62 Community-based organizations

know that in fact there's a problem with any capacity and say we would love for you to develop this, you know, adjacent to the health center somehow, you know.

Make it be marketed if we can, if we can find someone to do that, to come in, like aggregators that does with primary care aggregation, could do the same thing in other areas if there were funds available through the PMPM.

DR. RAWAL: Yeah. I think we'd be open to hearing more and hearing about some of those ideas.

CO-CHAIR SINOPOLI: Thank you. I think Chinni is next?

DR. PULLURU: This is a question for Sarah and Kate.

As you think about specialty spend and integration, has there been any thought put to sort of downstream product such as pharmaceuticals, Part B, immunologics, you know, the spend variation that happens there between specialties?

And also as far as end-of-life care, you know, productizing downstream to compensating

for hospice utilization or palliative care utilization?

DR. FOGLER: I can start. And others may have thoughts on this, too. But Kate and I can maybe take a stab. I think the first, I guess what I want to answer your question is I think the first step in that -- in that process is really about providing the data and information to shine a light on where there is differential patterns of services or as you were describing, you know, downstream products or services costs.

So I would say the specialty strategy right now is really trying to arm model participants, providers, and organizational entities with more information so they can garner insights specific to their network. So that's what we're focused on right now.

I think on the question about palliative and care for the serious ill population, I think we have spent a lot of time at the Innovation Center thinking about how to best build a value-based care models for those individuals.

And there's flexibilities for example,

that we've introduced into a number of our models to promote and encourage better care delivery and more team-based care for those individuals.

I think others may be able to speak to that better than I can, like what they have seen in terms of outcomes of those additional waiver authorities, for example, to care for those populations.

But the biggest parallel I can draw is the work in GUIDE, which is not the same thing as caring for a serious ill population or end-of-life care and hospice, but there's some overlaps there.

And that model has specifically incorporated design parameters that really are around building partnerships both with multiple different provider types, specialty types, but also community-based organizations.

And I was just reviewing data the other day that came in for the applications for the GUIDE participants  The number of partners, those, you know, Medicare provider types but also community-based partnerships, it's just mind-blowing, really, how communities have constructed their participants and the theme-based care that

they're going to provide to individuals with dementia and their caregivers.

So I would just -- that may be a long-winded, slightly tangential answer to your question. But I just wanted to point out like, one, I think the data sharing is a big way to get at those downstream, what's kind of happening on the ground.

But also just expanding the participant view so that we're promoting these partnerships and we're bringing in different types of providers. You mentioned pharmacy, we certainly have those as a named participant or provider partner in our Making Care Primary model as well.

So the more we can promote different types of providers and different types of, you know, community-based organizations in the construction of these models, I think we are interested in doing that and have demonstrated that in several of our model opportunities right now.

CO-CHAIR SINOPOLI: Thank you, Sarah. And I think our last question will be from Jennifer?

DR. WILER: I think on behalf of all of us, I just want to echo the thanks for spending your time with us. We find these sessions so valuable. I have a quick comment and then a question.

My first comment is as a co-creator of what I believe were the first care coordination codes that went before CPT[63], that went down in flames and were not approved, I'm so happy to see the APCM codes being put forward.

And would just comment that I hope that in the future that there's an opportunity to expand those defined services also for specialty care providers to participate meaningfully in value-based care coordination.

My question is around pivoting from just data sharing to insights through analytics. We heard a lot about that this morning. And I'm just curious, there's an important first step that you all have described around data sharing, which is fundamental.

But I'm curious how you all are thinking about insights? And whose responsibility is it to deliver that, and specifically from the

63 Current Procedural Terminology

Innovation Center's perspective?

DR. FOWLER: Sarah and Kate, probably, do you want to take that, one of you?

DR. FOGLER: You should definitely start, and then I can pick up.

MS. DAVIDSON: Yeah, I think there is so much evolving in this space right now, which is really exciting. I think that we -- there's a real recognition that data and both reporting, but also through the collection and through the aggregation process is really important in order to enable a population health approach to the work.

We are watching and collaborating very, very closely with our partners across HHS to think about what are some of the policy changes and shifts, and the opportunities that are coming along with bulk FHIR[64] and APIs[65].

And how our models can support and accelerate the adoption of some of that technology and infrastructure. You know, I think that from our perspective, we -- number one, we want to see this kind of arc of a change and

64 Fast Healthcare Interoperability Resources
65 Application Programming Interface

shift.

Right now, I think CMS is really taking the perspective that we need to make sure that all of the providers that are engaged in our models have the data in order to be able to understand how they are -- how they are performing within our models.

And so Sarah talked a little bit around the data that's coming out of our specialty care models. But we also have data feedback tools that are across all of our primary care models as well. We really think about what the infrastructure is and what the providers need in order to be successful in the models themselves.

So all of that is to say, I think that will shift over time as some of the data and technology shifts as well. So we would love for providers to be able to make decisions themselves about who those aggregators are that they're engaging with, whether that is, you know, an enabler that is supporting their work within an ACO, or whether that's an HIE that is supporting the aggregation.

And in the meantime, CMS is ensuring

that we're providing those reports and the information that those providers need to be successful within our models as well.

CO-CHAIR SINOPOLI: Thank you.

DR. FOWLER: Maybe I want to add one thing, is we just published an article in Health Affairs, August 21st, talking about our data sharing strategy. So I might refer folks to that.

And if you wanted to have a further conversation, Dr. Will Gordon, another of our medical officers, is also a clinical informaticist by training and leading a lot of these efforts in conjunction with our leaders here that you heard from today.

CO-CHAIR SINOPOLI: Perfect. And I will echo again, statements have been made about how much we appreciate you all's participation with us and just enjoy talking to you and hearing from you. So that's very much appreciated. So thank you all, you know.

Right now we're going to take a break until 1:40 p.m. Eastern time. And join us back then. We'll have another great lineup of experts for our roundtable panel discussions, which

focuses on stakeholder perspectives on a pathway towards TCOC models. Thank you.

(Whereupon, the foregoing matter went off the record at 12:43 p.m. and went back on the record at 1:41 p.m.)

*** Roundtable Panel Discussion: Stakeholder Perspectives on a Pathway Toward Developing PB-TCOC Models**

DR. MILLS: Welcome back and good afternoon. I'm Lee Mills, one of the PTAC Committee members. At this time, we're excited to welcome five amazing experts for our next roundtable panel discussion, who will share their stakeholder perspective about a pathway towards developing population-based total cost of care models.

You can find their full biographies and slides posted on the ASPE PTAC website. At this time, I will ask the panelists to go ahead and turn on their videos if you haven't already. I will briefly introduce each of our guests and give them a few minutes to give some introductory comments.

And after all five introductions and comments, we'll have plenty of time then to ask

questions, engage in what we hope will be a robust discussion, both within the panel and with PTAC.

First, we have Dr. Don Calcagno, Senior Vice President and Chief Population Health Officer, as well as the President of Advocate Physician Partners at Advocate Health. Welcome, Don.

MR. CALCAGNO: Great. Good afternoon, and thanks for having me. I am not a clinician, just to be clear. But I do want to thank everybody for your time today. I appreciate the opportunity to be here and really to talk about this timely, important topic.

By way of background, I'm the chief pop health officer for Advocate Health, which is a large non-for-profit IDN[66] that covers six different states. If you see the slide here, we are privileged to serve about 2.4 million patients in over 110 value-based contracts.

So we have any type of contract from upside only, downside, professional cap, or global cap across Medicare, Medicaid, commercial, or ACA lines. And the way we do this is across

66 Integrated delivery network

15 different networks that are consisting of both employed and independent physicians.

Five of those networks are MSSP or REACH, and if you break those down further, three are MSSPs, two are an enhanced with significant downside risk, one is Track C, and then we have two REACH programs.

One is primary care capitation, and one is total cost of care capitation. Collectively, these five networks serve about 250,000 beneficiaries, 77 percent of which are in some significant form of downside risk, meaning greater than 40, 50 percent.

Collectively, if you look at this, our MSSP and REACH organizations have saved about three-quarters of a billion dollars since about 2015.

Our experiences, as you see at the bottom of the slide, tell us there's three key success factors. Number one, the adaptability to policy change. And what we mean by this is, you have to be willing to participate early in any of the CMMI Medicare waivers or even commercial ACO risks.

One of the things I like to say

though, is you need to do it with a purpose. It can't be a side hustle or something some department's doing independently of itself.

The second part of adaptability that I want to be clear with is, sometimes these programs change. And so that stroke of a pen can immediately change the dynamics, for the better or for the worse, such as in the BPCIA or REACH changes. So adaptability is key to success number one.

Number two, size, scale, multi-disciplinary clinical integration across the continuum is key. As you talk to people across the country, some point fingers at specific stakeholders in the value chain, thinking that the cost is a particular person's problem or person's provider type problem.

We actually firmly believe that inclusion of primary care, specialty, hospitalist, post-acute, are the only way you're going to succeed in true total cost of care models.

And one of the things we point out as an example, is Advocate Physician Partners, where I'm president of currently, is a 4,500-physician

clinic-integrated network. It includes employed and independent doctors, primary care specialists, post-acute networks hospitals.

And we've been clinically integrating for the better of part two decades. And the results are clear across all forms of lines of business of our success. So we firmly believe that's a key success factor.

And then the last success factor I threw out is the sophisticated pop health platform. You may think of it as infrastructure cost, but to succeed, you do need advanced analytics and risk modeling.

And all that starts with just capturing and organizing the data, which is not easy, nor is it cheap. But it also requires equal parts of folks on prevention, as well as managing acute episodes, and often through team-based care, such as pharmacists doing that form of dosing.

And then lastly, we'd say evidence-based protocols that are tied to learning health system are absolutely key. You can go to the next slide. So if you take those three success factors, we really see them manifesting

themselves across the domains PTAC's interested in today, as you see in this chart.

I'll just call out two areas. At the basic level, and I consider this table stakes, is the willingness to participate. There's several areas you can focus on.

But the general theme comes down to this: one, there's a cost to participate, either very currently financial or secondly as an opportunity to cost.

And two, you have to consider the opportunity to improve care and be financially beneficial, not a deficit for you. So we think that's what causes people to decide to participate or not participate. Once you move on to the advanced level, however, the thing gets a little different.

And here we think to be advanced, you do recognize the role of the hospital specialist or primary care that you have to manage across the continuum. Now, you'll see at the top there, we do believe that are a need for different degrees of flexibility in the models.

The way I engage a specialist might be different than how I engage a primary care

doctor. And then lastly, we would say think about risk adjustment differently. It's not about HCCs, it's factors like frailty, SDOH[67], polychronic conditions, et cetera.

So the current model that we are in today, or the current environment, as you see at the bottom of my slide, there's a lot of competing CMS or CMMI programs. And we firmly believe this leads to fragmentation.

Give you an example, when the Oncology Care Model came out in 2015, our integrated oncologists joined the OCM model, and it impacted the network by allowing the oncologists to put costs into MSSP while capturing more money themselves.

Today we see the same thing happening with Comprehensive Kidney Care Contracting, CKCC versus MSSP. And it's even the little things like identifying participating providers. MSSP does it the TIN[68] level, REACH does it at the 10 NPI[69] level.

So Advocate alone had to spend over $100,000 creating a separate TIN to be able to

67 Social determinants of health
68 Tax Identification Number
69 National Provider Identifier

participate in REACH. So thank you. I look forward to the discussion today.

DR. MILLS: Thank you so much, Don. Next, we're excited to welcome back Dr. Mark McClellan, Director and Professor of Business, Medicine, and Policy at the Duke-Margolis Institute for Health Policy at Duke University. Welcome back, Mark.

DR. MCCLELLAN: Thanks, very much. It's great to be back with PTAC and great to follow Don and be on such a terrific panel. Go to the next slide, just a few comments I want to make to start.

First off, some disclosure that people might view as relevant. Next slide. One of the things on that list is that I am one of the co-chairs for the Health Care Payment Learning and Action Network which reference the background materials for this meeting, which is showing that while we have made some important progress towards a whole-person or person-first care, with some direct intentional link to total costs and important outcomes for the population treated, we still have a long way to go. This varies across programs.

What I would note is two things. One is that CMS, under both the current administration and previous administration have been consistently committed to this goal. And if you ask private payers or for that matter, most other stakeholders, most of them believe that these shifts in payment and shifts in care models that those payment shifts support, are part of the future.

So even though this has been slow progress, a long way to go, not a sense that there's a better solution out there, so that's why this meeting is so important. Yeah, next slide.

But say on just a 40,000-foot level, made considerable progress in getting these kinds of models adopted into primary care. I think that's a great place to start.

Without advanced primary care, as many of these models have shown, it needs more resources, more reach, throughout the care continuum.

It's very hard to build up a coordinated longitudinal sustainable care model for Medicare beneficiaries, as well as across

other payers.

But we still have a ways to go, and these other key circles as I mention here, specialized care, integrating social services and support, integrating technology, drugs, are still paid for pretty much on a fee-for-service basis as all of these shifts are happening.

And even within primary care, still some more work to do. So I'm going to focus on this next slide for the remainder of my time. Some ways to accelerate progress towards the 2030 goals that CMS has put out or referenced in these materials, 100 percent, you know, or about 25 percent overall, larger in primary care, less when saying specialty care, and our overall health care system, so quite a ways to go.

And this is something that the other panels had mentioned, too. Getting to predictability around a long-term outlook for these models, CMMI and adoption in CM[70] have shown, and an option in Medicare Advantage, and now Medicaid managed care more have shown that a shift away from fee-for-service into more person-based payments for primary care

70 Center for Medicare

supplemented perhaps with fee-for-service payments for additional kinds of services, is a fundamental approach that seems to work.

I'm not sure that CMMI needs to keep setting up additional models separately on five-year tracks to add into that. Probably more important to have predictability that while the details may continue to evolve as Don mentioned, there will be different levels of moving away from fee-for-service that will be sort of a high end, direct contracting or REACH type option that goes beyond the two or three years left in any particular one of those models.

An overall framework that, I think there's a growing amount of consensus to support, and it should be a continuing area of focus for further development.

Related to that, multi-payer alignment is key. There have been a number of studies, including a few more, just in the last month showing that even primary care groups that are pretty far along are facing 200 or more performance measures that are covering a lot of the same things.

And we just don't have that on the

fee-for-service side, where there's a standard CMS developed and backed set of CPT, ICD[71], DRG[72] type codes.

There's a lot of effort under way, and I mention it in my appendix slides in the Health Care Payment Learning and Action Network to support multi-payer alignment at the state level.

And with national health care payers and purchasers, people can't realign their contracts on a dime. So asking people to join the CMS program in the short-term is tough.

But again, with those predictable signals about where we're going, there's a lot of interest in getting on a pathway towards increasing directional alignment, not just on measures, but on everything else that matters, benchmarks, data sharing, et cetera.

Third, we have a lot more work to do on specialty care. Some good models like Don mentioned for kidney care, where the nephrologist kind of coordinate all of care, for oncology care that can plug into these comprehensive models.

CMS is moving forward with their TEAM

71 International Classification of Diseases
72 Diagnosis-related group

model, a mandatory version for short-term common episodes and procedures that are hospital-based.

The big missing area that is on the CMS strategic priority list, is longitudinal primary specialty coordination where there are a ton of good ideas out there that are being taken up in advanced Medicare Advantage plans with sub-capitative primary care and specialists that are in the same network moving further away from fee-for-service care, and some employer plans and Medicaid plans.

Finding ways to build these nested models, you know, again, you need that primary care, whole-person base for these models to work, but supporting them.

For example, by giving specialists who are participating in these models more flexibility to bill on a person basis, to support those longitudinal care coordination steps instead of just getting paid for the procedures and admission under fee-for-service, that's an important area for further steps as well.

Next on the list is making sure that our payment models are really based on person-focused longitudinal care, not fee-for-service.

At some point, we'll know we've kind of gotten there when these models are no longer called Alternative Payment Models, but they're kind of the base.

This is an example of how this is still playing out. When we set up the Medicare Advantage program, I just had the privilege of being there at CMS. We were looking for a way to do risk adjustment to make this accountable person level care work.

This was in 2004,2005, best available data of course was fee-for-service claims at that point. If you were designing risk adjustment today, getting to Don's earlier comment, I don't think you'd be using fee-for-service claims.

I think you'd be using data that can now be captured accurately and reliably through multiple modalities incorporated in the clinical dashboards and care supports that clinicians think really matters.

Things like frailty, things like functional status, multi-morbidity, social -- social risk factors, et cetera. Those are all doable today, just very hard to do in this traditional model.

And it's leading to some growing challenges in applying a fee-for-service reported data which is often missing for some of the biggest chronic disease risks based on fee-for-service practices, which are not representative of these emerging successful models.

So transitioning to more modern data can be less burdensome and can get a better basis for aligning care reforms with the performance measures that we're using in these now hundreds of billions of dollar programs and getting bigger.

Also with this evolution in making the alternative models more the norm, person-based care the norm, is recognizing that if we have a good core structure to build on, shifting from five-year evaluations, some more rapid learning approaches, where more contained steps can be tested.

Things like ways of sharing data more effectively, between primary care and specialty providers, things like making those adjustments and the models that are inevitable as learning -- as evidence improves and technology improves,

they can be more predictable in ways in which can be piloted with participants and with CMS, maybe with other payers.

Rapid learning is an area where can complement these five-year big long-term evaluations. Got a lot to say about engaging beneficiaries too, but we've got some other panelists who have also some excellent ideas on that. So I'll stop there and thank you for the opportunity to join.

DR. MILLS: Thank you, so much, Dr. McClellan. We're happy to welcome back as well, Dr. Palav Babaria, Chief Quality Officer and Deputy Director of Quality and Population Health Management at the California Department of Health Care Services. Welcome, Palav.

DR. BABARIA: Thank you so much for having me back. And I think as many of you probably know from last time, I serve as our department's Chief Quality and Medical Officer.

And in that capacity, responsible for all of our value-based payment initiatives across the California Department of Health Care Services, which is our state Medicaid agency here in California.

So a few just grounding facts and figures. In California, we currently cover more than 14 million individuals, so on average about one in three Californians are enrolled in Medi-Cal, depending on what part of our state you are in. Sometimes that proportion goes up to close to 50 percent or more and in other places it is a little bit lower.

More than 65 percent of our enrollees identify as people of color, and we also have an outsized coverage of children. So we cover about 40 percent of all births in California, and about two-thirds of the children who are enrolled in Medi-Cal identify as Black and Latino.

Like many other states, we also really bear the majority of care and payment for individuals with complex needs and unmet care. So more than two-thirds of all of our long-term care facility days are covered by Medi-Cal.

And then we currently also have a number of justice involved initiatives that are ongoing, where about 80 percent of individuals cycling through our correctional system are also eligible or enrolled in Medi-Cal.

So I give those backgrounds, you know,

as you heard from some of the previous folks on the panel, multi-payer alignment is critical. And in California it is hard to find practices that are caring for Medicare Advantage or Medicare fee-for-service patients who don't also have a significant footprint in the Medi-Cal space, just given how big our program is in California. You can go to the next slide.

So I tried to keep it really simple and focused for our feedback for this Committee. I think the multi-payer alignment is critical. We, as a state Medicaid agency, have definitely been on a journey to improve Alternative Payment Models and improving and supporting total cost of care models for all of the reasons that this is also being explored in the Medicare program.

We recognize that as we approach our, you know, managed care plans, because about 99 percent of our 14 million individuals are enrolled through a managed care plan, and then there are downstream providers.

Doing this and having broadscale uptake is really contingent upon how simple we can make it for practices. For some of our practices, they are working with five different

Medi-Cal managed care plans in their geographic region.

They then have additional Medicare plans that they are working with, commercial lines of business Covered California, and it does definitely, you know, lead to exponentially worsening sort of burden to do all the reporting to track the quality measures.

So we started several years ago and were part of the HCPLAN state transformation collaborative to really bring together at least the public purchasers in California.

So DHCS covers about 14 million people. Covered California is our state health exchange, covers an additional over 1 million individuals. And then CalPERS is our state retiree, sort of pension public purchaser, who I think is the second largest purchaser behind the federal government of health care insurance.

And so collectively we cover almost about half the state. And so we have aligned across those three purchasers. So that link that's in the slides here is our contract language that all three of us, it is almost identical, inserted for our managed care plans

about what our expectations are for downstream Alternative Payment Models and primary care spending that we are requiring consistently across our three organizations.

We now have a state entity called The Office of Healthcare Affordability that did not exist when this multi-payer alignment contract language was issued a few years ago.

That state department and office is now issuing further guidelines statewide for how we're going to achieve total cost of care targets, how we're going to move into establishing benchmarks and requirements for both primary care spend, as well as Alternative Payment Models.

And so we are updating our sort of prior multi-payer alignment to now align with that statewide effort, but we have gotten great feedback that I think that has, you know, at least brought more of the public purchasers to the table.

And definitely, I think, as was mentioned before, figuring out, you know, how do we do that across Medicare and Medicaid, especially in states where Medicaid is a

significant payer is going to be critical.

And exploring, you know, how can some of these same efforts be spread across the Medicaid program nationally would help with that alignment for providers that really serve both populations.

The second bullet here is really around strengthening and centering primary care. As, you know, Mark McClellan and others pointed out, there is no future where we can really achieve total cost of care targets that does not involve improving and changing how primary care is practiced in America today.

And I say that as still a practicing primary care clinician who sees patients every week that exactly that fragmentation, lack of care coordination, is, you know, we all know resulting in completely unnecessary and burdensome and costly utilization.

And so we also have very specific targets around what we expect of primary care and have aligned those expectations and targets across those same public purchasers in California.

And then the last bullet is really,

you know, we recognize as you saw on that slide right before this that states are very different.

We all have very different demographics within Medi-Cal. Who we cover, you know, is different than who my other public purchasers are covering, who mostly are covering older individuals, retirees, fewer children, fewer pregnancies.

And really thinking about how do we take a quality measurement approach that can span the totality of all of the populations, but then be sort of, you know, create subcomponents that individual practices can adhere to, even if they don't cover all of those lives, is really critical.

And when we have explored, you know, greater participation in some of the federal models as a state, that has often come up as a barrier that the model is really, you know, designed for Medicare and does not exactly translate to the Medicaid world.

And if we are going to actually get to this multi-payer alignment, thinking about that upfront and figuring out how do you do measurement on a full population basis and think

about some of those sub-populations will be really critical. Thank you.

DR. MILLS: Outstanding. Thank you, Dr. Babaria. Next, we're excited to have back, Dr. Mike Chernew, Professor of Health Care Policy and Director of Healthcare Markets and Regulation Lab in the Department of Health Care Policy at the Harvard Medical School. Welcome back, Mike.

DR. CHERNEW: Thank you so much. It's great to be here. A perfect panel, I've enjoyed the comments that have been made so far. And hopefully mine will be somewhat synergistic. I'm looking forward to discussion.

So first a disclaimer, what I say today is going to represent my personal views and don't necessarily reflect the views of organizations I'm affiliated with and that is just an easy way of saying, I'm speaking as me, not MedPAC. So anyway.

CO-CHAIR HARDIN: Michael, you're muted, so after, if you could start at the beginning of this slide, you're still muted.

DR. CHERNEW: How about now?

CO-CHAIR HARDIN: Now you're good. So all we heard was MedPAC and then you were muted.

DR. CHERNEW: Yeah. I'm speaking as me not MedPAC. But we'll go on. Let me -- I just -- I only have two slides, so I'll give you main thoughts.

The first one is, I'm not a fan in general, or at least not a big fan, of the test and diffuse paradigm that was put in place. And I think this is going to be consistent with what a lot of folks have said, and I think we're kind of moving past it which is the performance of any given model is going to depend on other available models.

One thing that I thought was really a shame, Don said was how many models did they have at Advocate, so issues around which groups you put in which models.

And remember everyone is trying to decide which models to be in and if you're -- it creates a lot of, I think, confusion, some burden, and maybe some challenges in getting all of the benchmarks and everything right when you're juggling a whole bunch of different models.

So I don't have a problem with different models, but I think you have to be very

careful when there's too many models and you're launching them all similarly.

There's a separate concern that happens, I think, between episodes and population-based payments, there has been a lot of discussion on population-based payments, which is the models can end up siphoning off savings.

So for example, if you avoid a post-acute stay, which is an important thing to do, and you have patients that could be in one model or a population model.

If you run the models at the same time, the savings can get siphoned towards say the episode model, not the population-based model.

So it's hard to get the population-based model to work, and so you have to think through how these models are going to work when you have multiple people claiming that they're the folks getting rid of the waste. I tend to be a fan of population-based models.

I think that's the only way that you're broadly speaking going to get the system-wide reform and allow organizations within their own context, so in this case, say advocates, to

build episodes they need internally to try and engage with specialists in a whole bunch of ways. So that would be my view of how to build those models.

I also think there's a big concern with some sunsetting models, which I think is very much in the spirit of what Mark said in terms of getting a long-term vision of where you're going. If a model's a few year trend, you've got to make a lot of investment to make them work.

It's one thing, Don, when you said there's a cost here, and you have to think about how to manage the cost, you tweak it. But when the whole model might go away, your real ability to commit and invest becomes actually quite challenging.

And so I think we just really need to think of this as we're transforming the way that payment is done, more so than we are testing a bunch of things and now we're going to launch a bunch of new models, because that's what we do, we launch models.

So the MedPAC recommendation is basically to create a portfolio, synergistic

models built around a foundation of population models and add episodes, and this part's important, where the episodes are synergistic with the underlying population-based model.

So where you think you can really add to savings synergistically as opposed to, well, we needed a model for this group, or we needed a model for that group.

Or even worse, we didn't have enough models, so we put some more models in. I think you really have to worry about that sort of mindset of building more, diffusing more. I think the key point is to improve and execute on the models that you have.

So I'm not saying the models should be written in stone and never changed, I used the word tweaked. But I think – you're going to have to learn and tweak things.

But I don't think it's going to be successful to continually redesign, you know, sunset models, redesign models, and then re-launch new models but different program parameters in a whole range of ways.

The amount of effort it's going to take organizations to figure out is this model

good, how does the benchmark working, you know, I think it's just way too much to get real system transformation. So next slide. I should have said last slide.

So here's my top few four-ish design and polish issues. Number one, avoid the ratchet. You can't have organizations that succeed get paid less in the future. There's a number of ways to deal with that. They have a prior savings adjustment that deals with part of it.

There's regional benchmarks that deal with part of it when they blend it in. I'm a fan of something called administrative benchmarks. Administrative benchmarks is closer to what they do here in Europe. I happen to be in Amsterdam.

Not exactly what they do, but they have a sense of a budget, and then you have to live in the budget, and you have rules for how the budgets go up and down, and you're not ratcheting it based on your performance or the performance of everyone else in the market so everybody's chasing everybody down. And eventually that model's going to lose.

So you're going to get to a point where you're not going to be able to save more

money. So I think we need to think through, whether you agree with me or not, it would be a wonderful discussion, but we really need to think through how to avoid the ratchet of being a victim of the organizations that are successful. You want those successful organizations to really be able to succeed long run, not just in the short run.

Second thing is you have to improve the ability to detect stinting. Mark said a little bit about quality. I broadly agree. I won't go into my ideas about how to do that, but I think there's one view, which is reward everybody and try and make sure that, you know, everybody is getting paid more for doing better.

And I don't know how the, you know, philosophical opposition to that, but I think it's much more important than these models that you worry that they're under-delivering care because that's what their incentives are.

You need better measures to make sure when that's going on. And those measures and the systems around those measures might not be the same measures as you would come up in a quality measurement program like many of the ones we have

now.

Third point, I think the key thing here is don't micromanage ACO activities. So a lot of people think well, we believe that they need to set contracts, not just at the ACO level as population-based, but they need to push the population-based down to the clinician level, or they need to engage specialists with this type of contract in a whole bunch of ways.

My general view is success is context dependent. And what they do at Advocate is not going to be what they do at MGH[73] or wherever in California, you're going to do things differently.

You have to allow the organization's flexibility to do that and not expect that you can build a contract that says even if it worked on average, it's the way every organization should manage their internal incentives and reward systems and payment models.

And so again, I think that matters. Sometimes you have salary, sometimes you need bonuses for productivity. Organizations have to be able to do that.

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73 Massachusetts General Hospital

The key point I'm trying to make is ACO success requires flexibility of the organizations to build the programs that they need to build to be successful in their context, and you shouldn't have limitations based on the regulations where they're making decisions about what they're doing because of the regulatory requirements as opposed to what they think is efficient for delivery and care.

Last point is, there's a lot of stuff going on on the Hill and a lot of discussions about how to support primary care. There's an Alternative Payment Model bonus.

I have some ideas about the design of that we can talk about later. But there's also primary care capitation policies. There's a physician piece -- physician pay bill, for example, that's got a primary care capitate – sub-cap primary care.

And then there's a bunch of global service and care management codes, largely, I typically call them the G-codes and had a bunch, they've changed a bunch.

They all have this sort of flavor providing some level of sub-capitation,

particularly for primary care in the case of ACOs, maybe for total capitation. Those things all inter-relate. So they create incentives for what programs you want to be in.

And I don't know who, Don, you can send me an email about the person's name, but someone's got to be running an analysis to see what works best for Advocate Health given if there's all these new programs running around.

And will we actually be better if we went back to MIPS[74] and took the partial cap through the G-code as opposed -- you know, with less risk, as opposed to the total cost of care model which a ratchet that's moving us forward in a ratchet way.

And these -- these sort of complexity of decisioning when I listen to myself talk, I realize how complex it is. The complexity -- you know, the decision is such that I think the core thing to do here is to slow down and try and build something that's more synergistic that works together, and not continually launch new things to try and get at the same basic goal of creating payment models that allow and incent

74 Merit-based Incentive Payment System

efficiencies.

So I think that's my last slide, so I think we're going to go on to Charlotte, but I'm glad I didn't -- if I had another slide, I was going to be surprised. So, you're up Charlotte.

DR. MILLS: Very good. Thanks so much.

DR. CHERNEW: And you're going to get introduced and everything.

DR. MILLS: We're thrilled to have Dr. Charlotte Yeh join us again, founder of Yeh Innovation, Chief Experience Officer of Cherish Health and former Chief Medical Officer of AARP. Welcome, Charlotte.

DR. YEH: Thank you very much. So I just want to be clear that I'm going to be bringing in a number of perspectives. I've been an emergency physician for over 20 years, and that is really highlights the underbelly of the health care delivery system and the shortfalls in the community and social support.

But I've also been a policy and regulator as the CMS Regional Administrator. But most importantly, for the last 16 years, I've been part of AARP as their Chief Medical Officer

in the business community doing a deep dive into the consumer engagement within the private health care sector.

And finally, the beautiful part is I'm free of organizational constraints, you're going to hear my personal insights, since I am now free, and I am an advisor now for AgeTech, for Innovation for Healthy Aging, and bringing together all of these experiences. So next slide.

So what I'd like to say is kudos to PTAC and the staff, and I love our panelists. I would say ditto to everything that they've said. But I believe that there are two major omissions that we have in these alternative payment and total cost of care models, that if are not addressed, these programs will not succeed.

First and foremost, I really haven't heard anyone short of Mark saying beneficiary engagement, anything about meeting the needs, wants, expectation for the beneficiary.

You can build the most beautiful program that then invites every provider and specialist and primary care to participate. You can build it, but the beneficiary won't come.

And we'll dive into that.

If we do not create the kinds of incentives, infrastructure, and support structure to be meaningful to the beneficiary, why would they sign up?

And the second is, we -- the second major omission is we talk about fee-for-service, and we talk about the payers in fee-for-service as they're all uniform and they're like every other payer in the system. And the answer is they're not.

About 21 percent of Medicare beneficiaries actually pay out-of-pocket for Medicare supplemental plan. And that is 41 percent of people who are in Medicare fee-for-service. That is -- and there are another 18 percent that have retiree benefit supplemental plan, another 10 percent that are dual eligibles. These payer sources are very, very different.

And Medicare's supplemental plan is extraordinarily different, because if we improve the ACOs and they're billing for more Part B and physician office visits and physician services, which overall saves money, you're actually

hurting a Medicare supplemental plan, because they don't achieve the savings because they pay it out in Part B.

And the Part A savings reduce hospitalization, ED[75] visits, et cetera, actually go to Medicare. And then secondly, the Medicare supplemental plans have the real opportunity to dive deep into the consumer. So I'll talk a little bit more about that in a minute.

First, back to the beneficiary. I think where we have forgotten is what's meaningful for the beneficiary. So to try and keep this simple, to understand, I call them my five Cs.

The first is cost. We talk about total cost of care. But how many of you are actually measuring the total cost of care to the beneficiary, their family, and their caregivers?

Right now, caregivers provide about $600 billion annually on out-of-pocket expenses that are unpaid and unreimbursed. About 21 percent of the cost, and it's about $7,000 on average by a caregiver, about 21 percent of that is on home renovations.

75 Emergency department

So that if you want somebody not to fall, you've got to build in safety bars, you've got to have safety maneuvers, you've got to have monitoring systems, you have to have wide enough doorways, you've got to accommodate wheelchairs, walkers, et cetera.

So 21 percent of the expenditure are home renovations. Seventeen percent are medical costs. Six out of 10 caregivers say that they are actually being asked to do medical services and procedures that they've not been trained to do.

And it's not just in the out-of-pocket expenses, but it's also time. There was one study out there that says right now, your average Medicare beneficiary spends about three weeks going to and from in medical visits. That’s 20.7 contact days, and about 11 percent of Medicare beneficiaries spend 50 days or more in contact with health care.

So what are you doing to make the time efficient? Because what happens is anywhere from 12 to 30 percent of caregivers are either cutting back on work or leaving their jobs in order to provide that care. Where are you in the ACO and

in the beneficiary services thinking about the time and money?

And finally, it's resources. About 28 percent of Medicare beneficiaries are solo agers. So the amount of services you need for a solo ager are very different than the ones I have just described who are paying out-of-pocket as a caregiver.

But what about hearing loss? Did you know that about two-thirds of all people 70 and older actually have significant hearing loss, and yet it's not paid for by Medicare?

But more importantly, 49 percent of people who have a lot of trouble hearing, do not have a primary source of care. How are you going to engage someone if they don't know how to communicate?

How many of you are bringing into your virtual visits, captioning, speech to text? How many of you are using speech to text in the office so you make it convenient, and you make it easy for someone to communicate?

Then that second C is convenience. I just told you how many hours it takes. Right now, on average, a Medicare beneficiary has to

wait an hour -- a month, in order to get an appointment. One out of six Medicare beneficiaries is told to go to an urgent care center because they can't get an appointment.

If you're going to bring in all this technology, are you going to do it as a single platform, turnkey operation? We know that through AARP studies, about two-thirds of Medicare older adults in, you know, that are 65 and older, say that technology and all the services you are providing are not designed for them.

We know that in ACOs and health care systems, they're designed around the workflow, the physician. Where are you designed around the workflow of the patient?

Think about the capacity and capability, not only of the primary care, but the capacity and capability of the patient and their family.

The third C is for choice. I think this is way undervalued in this whole picture. Why do you think 21 percent of people stay in Medicare supplemental in fee-for-service Medicare of the total Medicare beneficiaries?

Because they want the freedom of choice. They want a doctor they trust. They want a doctor who looks like me, not necessarily that's assigned. They want a specialist that will meet their specific needs.

And how about the ones that spend some time in their home, that they go visit their children, you know, are you taking into account that maybe they are going to be getting care from multiple sources? And don't underestimate how important that choice is connected to having trust.

The fourth is coordination effort, you know, it's been recognized. I'm going to dive into that a little bit deeper when I talk about opportunity for success.

But think about the coordination, not only of medical care services, but that caregivers are spending about 13 hours a month just managing insurance, appointments, just the administrative cost of trying to take care of themselves.

What are you doing to reduce that time? And you bring those values, the beneficiaries will come.

And finally, lastly, compassion. If you don't build in time for touch, time to hold someone's hand, time to help them through crises in life, there's a study out there that AARP has identified one in two older adult -- I mean, in the last two years, one in two older adults have gone through a significant transition, whether it's health issues, retirement, issues with children moving out, loss of a spouse.

If you don't take these pieces into account, you will not allow your primary care and your specialist to do their best job.

So and then finally, and you know, that may sound daunting, and we can't possibly think about the beneficiary, but this is where can we work with our Medicare supplemental plans for example?

So in -- at my time at AARP, we worked very closely with our Medicare supplemental plan and did care coordination for the high-risk and most complicated patients.

We found that disease management didn't really work, but if you did whole-person care as Mark alluded to, we had a reduction of hospitalization, reduction of ED visits,

reduction of falls.

And we have a positive ROI[76] that could range anywhere from two to one, to three to one, and then the most complex patients as high as seven to nine to one positive ROI.

So that opportunity exists, but you have to understand how to do consumer engagement. And what was really unique is it didn't matter who their physician was, this was a direct to consumer, to coordinate their care so that they could operate with a physician.

So if we did a fall prevention program about 40 percent of all of the -- I'm sorry, about 40 percent of the people we called about opportunities to prevent falls called their doctors, and about 6 percent actually had their medications changed.

If they were on a high-risk medication, 60 percent called their physician and 15 percent actually had their medications changed.

So let's not forget about the lever of use to the beneficiary, and let's not forget about using existing models like Medicare

76 Return on investment

supplemental plans which are 40 percent of fee-for-service as an opportunity to help align the payment, the payment structure, and the outcomes that you want.

DR. MILLS: Thank you so much, Dr. Yeh. I appreciate all those great introductory comments from each of you. In interest of ensuring balance across different perspectives and questions, we'll encourage panelists to keep each response to just a few minutes. We've prepared some questions we think will kind of crystallize all the rich strains of input we've heard.

Question one is, what would you say are the most important factors that affect participation in an accountable care relationship at the provider level or in different kinds of geographic areas?

And a follow-up to that is, what are the most important strategies to increase that participation?

We'll start with Dr. Calcagno and then Chernew and then Babaria.

MR. CALCAGNO: Great, thanks. To me I simplify it this way, change is hard. Right? If

you look up behavioral economics, status quo bias, people don't like change. So I really boil it down to, are providers willing to participate, are thinking, am I going to be better off tomorrow than I am today?

And then the question really is, well what's that mean, is it financially better off, is it my work flows easier, do I have more administrative burden, or probably most importantly, can I actually care for my patient the way I want to?

So when you boil it all down and start talking to clinicians, from our experience you can really say it falls in a couple categories which I have touched on before, right?

There is limited resources and lack of infrastructure in small practices, small provider groups.

The work we all talked about and do is not easy, it does require a significant infrastructure, so how do we support that?

Two, independent physicians are entrepreneurs and by definition they are looking to balance risk and reward. Now it may be different for employed positions, but the

independent physician is definitely trying to balance that equation.

And three, as I've alluded to, risk models don't really do a great job capturing real risk, frailty, access, social economic, et cetera.

I firmly believe that you can overcome this through better clinical integration. As I mentioned Advocate Physician Partners, 4,500 docs. But what I didn't say is about a third of our practices are less than three physicians. Several are solo practitioners. But yet they participate in these programs because we provide them the infrastructure, we provide them the financial backing, et cetera.

Two, I think you have to be flexible in your model design by being across six states and different markets. South side of Chicago, very different issues than downtown Charlotte. And so being able to approach physicians there, or a rural doctor, et cetera, you need to be able to approach them where it makes sense to them.

Again, I already mentioned the application risk adjustment, not just the financials but even some of the quality metrics.

We internally do some quality metric risk adjustments as well.

And then again, I know I've said it multiple times, but don't change the rules mid-participation, right? I think Michael spoke about that as well. That drives my clinicians crazy. Hey, what you're doing, you did well, we're not going to do it that way anymore.

And then from a beneficiary perspective, I'm glad to hear you talk about that Charlotte, I really there is a huge opportunity for beneficiary engagement. Enhanced benefits be it access, be it reducing their out-of-pocket costs, be it helping them navigate their disease states, et cetera.

There is a lack of awareness, there's a lack of education. So helping them understand why these are good for them. And then taking a playbook out of some other models out there, there is no reason we can't tailor some of these plans to high-risk patients. To get them excited and engaged to what they're doing.

And then lastly, I'll just add, if you think about what the other payers do, they require primary care selection. They have a very

much more defined network, which I know is not always popular for people to say micro or narrow network, et cetera, but it improves coordination.

And then they do offer supplemental benefits. Our MA plans, the number one thing that drives them in the Chicago market is if there's a rich dental plan.

So I do think there are ways to incent beneficiaries. Thank you.

DR. MILLS: Dr. Chernew?

DR. CHERNEW: Great, thank you. I'm going to talk about five quick things, but I'm not going to say much about them. One I said I in my remarks, benchmarks have to be set well so you're not going to lose when you model this long-term.

Two, Don mentioned this, so I'll just say it, risk, how much downside risk you are imposing is a big deal for organizations. I actually think the evidence suggests you can succeed without downside risk, and so I would be very wary of imposing a lot of downside risk because you believe it's necessary for success. I actually don't think it is.

I think I said a version of this in

remarks as well, it needs to be simple. It needs to be simple in two ways. It needs to be administratively simple. I think admin will kill a lot of groups, it's just, who wants to spend their time doing admin to participate. You really have to simplify that part.

And then simplifying the choice. Now remember, people are not choosing, I want to be, and I want to be out. There's one thing. It's like sending someone to the grocery store with 5,000 different versions of ketchup and saying which ketchup do you want. It is a really hard choice to participate if there's so many things you have to weigh off and know what they are. So you really need to simplify the set of models to get people in.

And then the last thing about participation that I'm going to say is, and no one said this so it might be out of scope is, you need a certain scale to succeed. And if Medicare Advantage becomes 90 percent of the market, you're not going to get a lot of people in. So, you really need to think about how this plays with the Medicare Advantage world. And if that's out of scope, sorry.

Last thing I'll say about beneficiary engagement and benefits and stuff, and I'm glad an ocean away from Charlotte when I say this, I'm a fan of aspects of beneficiary engagement, but I think it's often said, without understanding the full environment, I'm not saying Charlotte didn't understand the full environment of what's going on, people have a bunch of supplement benefits that are, say for example, in the fee-for-service world. You need to figure out how you're going to coordinate different groups of people doing different types of things in different ways.

And I worry that our desire to let the ACO manage this is actually admirable, but it is actually much more complex than you think because now you're coordinating with what the benefit, supplemental benefits are. And remember, the main thing was, just make it simple to join, right? Beneficiaries do need all the things Charlotte spoke about, but they don't need everybody to give it to them, right?

And so you need to figure out how you're going to do that because the coordination across these groups, and I feel the same way about multi-payer coordination. If you want, Mark

mentioned Medicare Advantage plans doing this underneath, which I think is a good idea, but the Medicare Advantage plans, if they're using prior auth and prior auth is saving money and that money is then captured as a bonus to the groups that they're sub-capitating, it becomes quite complicated to figure out how it works.

So someone else on the call can explain to me how to coordinate that.

I would simply end by saying, keep it simple. Don't take the money away if they succeed. Don't give them too much risk and then you'll do okay. And be humble at what you can accomplish. I'm done with my rant.

(Laughter.)

DR. MILLS: Excellent. Dr. McClellan and Dr. Yeh, any brief comments on participation?

DR. YEH: Mark, do you want to go ahead or, okay. So, first of all, Michael, you said it correctly, simplicity, it can be done. I'd also like to say, stop playing everything and laying it on the providers, that there are ways to engage the beneficiary directly.

Thirdly, we have not at all talked about the opportunity with Medicare supplemental

plans that people choose so that they can see any provider that they want. There's real opportunity, but here's the problem, with Medicare supplemental plans, if we do all these quality improvement programs, if we do care coordination, they are actually counted as administrative expense and not medical expense.

So there isn't the incentive to bring in where 40 percent of Medicare beneficiaries purchase the Medicare supplemental plan, you can't bring that payer in because all of these efforts to improve quality and outcome and coordination of care counts as an administrative expense.

That's just one example of where we could align. And let's understand who this lever is that we have yet to use. And I can say, we made it simple. We had over 30,000 beneficiaries that we could demonstrate the longer they were in the program, the fewer hospitalization, the fewer ED visits, the fewer falls. But those were all savings to Part A and not to the Medicare supplemental plan.

So what can we do to bring that payer in to work with the ACOs, to work with the

clinicians, and to work with the beneficiaries because it can succeed? We modeled it in markets, we scaled it across two states, we converted it to telephonic, and we continued to have the same results, including 44 percent less likelihood to move out of the home into a long-term facility. We're not tapping into this.

DR. MCCLELLAN: And quickly, Charlotte and I in one way or another have been working for, I don't know, a decade or so on how to get you Medigap better integrated with traditional Medicare and the shift to whole-person care arrangements. That was an important issue.

Now as you see, like, you know, the majority may be headed toward the vast majority of beneficiaries being in Medicare Advantage because they can get more generous benefits and more coordinate, more generous benefits going along with those networks, which traditional Medicare doesn't do, at least not in the same way. And that's the kind of choices, as Charlotte said, that people want.

If people are left on traditional Medicare at this point, generally are people who have these supplemental coverage plans, or are

there for some other special reason. And that is a key part of the future now. It's no longer something you can just think about down the road.

And also on getting these additional benefits and affordability to work, we need to give ACOs, and these accountable providers, more help across the whole spectrum of benefits. You're seeing this play out over the next couple of months in the Part D benefit redesign that's happening, which is making the benefit much more generous, which is great, but it means that the prescribers, and the Part D plans, are bearing a lot more risk than they used to.

That is so much easier to do in a MA plan where you got transparency and visibility into the whole beneficiary's care experience. You can take stuff, like while using drugs it might be costly, to get costs down, downstream. You can have a more ability to influence what would be an otherwise more generous benefit.

And that's showing up in the bids that CMS got this year in the need for this special demo. So that's something that may not be easy, but I think can be addressed, and maybe even go further.

And think about drug payment models, to Mike's point, that aren't just, well let's just assume that any new drug coming on the market is going to face a lot of prior auth, is going to have to set a high price since the volume is not going to be very big. It will be 10 years before we get the volume way up and the price way down. Can't get there faster if you're implementing all of these alternative payment approaches.

So very important steps for getting beneficiary engagement, starting with affordability in the traditional Medicare program from here on out.

DR. BABARIA: I think I got –

CO-CHAIR HARDIN: Yes, go ahead, Dr. Babaria.

DR. BABARIA: -- skipped over.

CO-CHAIR HARDIN: I was just going to say I think you were prepared to comment.

DR. BABARIA: No problem. So one, I know this is out of scope, but to piggyback off of Michael.

You know, in addition to really thinking about what's, how is this carried

through MA I do think, you know, Medicaid is that other piece. Because at some point if we want this to be the norm for all health care payment, and not an alternative model, we can get there so much further if we figure out the Medicaid piece and then commercial can follow, right?

You hit a tipping point across most markets and most states if you can figure out a way to do that. So thinking about where the synergies are at the federal level would be really helpful.

And then I think some of our practical implementation experience at the state level is really, even if the models are different, you know, there is a lot you can really simplify and standardize when it comes to which quality measures, what the reporting looks like across different models. And we have a lot of self-imposed wounds that we had inflicted because we have a lot of directed payment programs that flow about $5 billion annually to mostly large health systems and hospital systems.

And we had designed those in the silo, and they were actually sort of adding administrative burden. The measures were similar

but not exactly the same as all of the value-based payment work happening in managed care, and in our ACOs.

And so we, over the last three years, have done tremendous cleanup. And have almost 99 percent alignment now over measures at least. And have tried to simplify the administration as much as possible. And we're really seeing the dividends of that payoff where even if people are participating in different programs, different models, those synergies are very clear.

DR. MILLS: Wonderful, thank you for that. We're going to turn now to incentives. And the question is, what factors do you think are most powerfully affecting primary care and specialty, and/or specialty providers incentives to participate in ACOs or other types of APMs?

And what would you think would be the most important model desire priorities for given that insight to what incentives are working and impacting what would be the design priorities to try to increase participation of different kinds of providers in total cost care models over the next five and a half years?

Sorry, let's start with Dr. McClellan,

then Calcagno, then Chernew, then you and Babaria.

DR. MCCLELLAN: Great, well thanks very much. I do think this is one of the big challenges ahead. And I want to congratulate CMS and PTAC for some focused increasing attention to these issues in recent years.

CMMI has a whole strategy on steps for this. And I know it's been a focus for all of our interactions with PTAC. So hopefully some real synergy opportunities for action there.

As I mentioned briefly in my remarks, and reflected in a lot of our work, specialty care is complex. And I do think you want to keep it simple, to Mike's point, but we haven't, we've kept it kind of too simple from the standpoint of really getting specialists engaged in these models.

One way that I think more help is needed is in providing some models. Not necessarily requirements, but just make it easier. Especially for the smaller practices. The physician-led ACOs to engage specialists more effectively.

It's true that there is no one-size-

fits-all on how you want to compensate specialists who are working with primary care providers, but it's also true that if you're a primary care ACO and you're not Don's size, and I'm going to come back to the big ones in a second, you have a pretty tough time engaging with specialists. You're not a big enough share of the market to get the specialists to pay attention to actually engaging in a, forming a contract with you that works out those shared savings and new steps for collaboration. And you also don't have the bandwidth to come up with what those terms might look like.

CMS has done some interesting things recently with their shadow bundles and stuff like that to try to provide at least some templates that can be used. Now give California some credit on this. We're looking at what California has done around specialty engagement and some of the work that we're doing in the North Carolina state transformation collaborative.

So some models that make this easier, and this would be a great area for a rapid learning test within an overall model. So, you know, four providers who are in ACOs and want to

work more with specialists, if there is a critical enough mass in the market of specialists.

And there are a growing number of specialists that are doing this in MA and see Larry Kosinski there too. Sonar is a great example of a model that is, you know, GI collaboration on chronic management of conditions that can't be sustained under current, easily under current specialty payment mechanisms for colonoscopies and doing procedures.

So there are some models that can work. I think they can be piloted and implemented more widely. I think collaboration between groups like AGS[77] have been working on this. ACC[78], orthopedic groups, AAOS[79]. There is some good models out there.

And MA needs this too. The network models there have implemented things like sub-capitation arrangements and the like. But they're still hurting, I think, for meaningful performance measures. You know, getting to, for example, standard functional status measures for

77 American Geriatrics Society
78 American College of Cardiology
79 American Academy of Orthopaedic Surgeons

people with back pain or lower extremity disease or standard measures of outcomes and quality of life for patients with inflammatory bowel disease. These are not that hard to do now, they're good standards out there, they just haven't been built into the models.

For the hospital base and larger systems, I really appreciate what Don is doing, but got to say, there are a lot of hospital-based systems out there that aren't yet fully on board or engaged. They may have MSSP programs running to help manage their medical patients, but not necessarily fully engaging their specialty groups, which are still accountable for turning over procedures and getting those beds cleared and used as rapidly as possible while getting by in the shared savings model. There I think you may need some more steps in the mandatory way.

You know, CMS is moving towards mandatory bundles for the short-term episodes. If you really want to get more of the payments linked to coordination, not just for the primary care doctors but for the specialists, and link to things like tracking functional status over time, I'm not sure voluntary is enough for these larger

integrated systems.

And by the way, there are a lot of large systems that are not integrated like Don's but are more consolidated. And I do think there's some good ways to support more independent primary care practices and specialist practices to get that infrastructure. You don't have to have ownership, necessarily, in order to achieve these goals.

And conversely, what we have seen is a lot of evidence that these larger systems don't do as well in the ACO models and do have higher prices.

DR. MILLS: Great. Dr. Calcagno.

MR. CALCAGNO: So, you know, a lot of what I want to talk about is really what we've already touched on. So a couple key things.

I think Michael said it, a portfolio synergistic models. I think if you really want participants, that's where you have to start. I can go through a litany of examples where these models competing with each other have actually caused fragmentation across the work we're doing. So I'd start there.

I'll end on what Mark talked about on

predictability and certainty. Again, most of our independent physicians are entrepreneurs. They basically want to be able to balance risk and reward. And if a stroke of a pen can change the model significantly, that's not going to be exciting for them to participate.

And I know I've mentioned it multiple times, but real risk adjusts I'll call it. A lot of clinicians on the call today. And I know when I talk to my physicians, both employed and independent, they don't just see a hypertensive patient, right? They see a polychronic patient because that same patient has diabetes and also has CKD[80], et cetera.

It doesn't speak to their SDOH factors, their health disparity, their lack of access, their frailty, et cetera. So real risk adjustment that makes sense to the clinician.

And that goes, I think to the theme, I think Michael started it, but several people have said it, simplify. A lot of these programs are way over engineered. And as a result, it's not that doctors couldn't make sense of them, the doctors aren't going to spend the time to make

80 Chronic kidney disease

sense of them. Something that should just naturally make sense to the clinician would be very helpful.

And I might add two other things that I haven't heard spoken about a lot. One, I'll call it eliminating the burden. When you look at, again, I'll use my network, so again, 15 networks who looked across all our contracts, we have 107 different quality measures. And even if I looked at one single network, it's a very, very large number.

One of the ones that really matter, how can we standardize, how can we simplify. Clinicians don't want to just check a box to say, hey, they thought about this or did that. What are the real things that they're are going to improve our participation.

And then again, it's been said several times, but don't punish success. When we're successful in BPCIA, we're successful in REACH, next thing we know the rules have changed.

You saw a massive exodus from BPCIA when the rules changed. So we can't do that because that goes back to the certainty principle. And you also can't continue to reduce

targets when you've had continued success, so how do you get around that ratcheting effect.

So bottom line I think at the end of the day is, how do you balance all these things? I think embedded bundles would make a lot of sense. Again, that idea of synergistic models in a portfolio. But then you also have to balance that with what support and resources are you providing?

You know, we are fortunate, as Mark pointed out being a large system, we are able to capture some economies of scale and whatnot. But we still sometimes turn to Medicare Journey and others that have access to data and have applied bundles and things like that. Is there a way to make that more accessible for folks that really are smaller practices, smaller networks, et cetera? Thank you.

DR. MILLS: Excellent. Thank you for that, Don. Dr. Chernew.

DR. CHERNEW: So first I think we can all probably agree that mandatory will really help you with participation. So I won't dwell on that.

My other piece of advice would be that

just design good models, and don't design so many of the models that people are confused about which ones to participate in. I'm less worried about small practice, because I think if you design good models you will get conveners and other organizations that will enable small practices to participate in ways that will allow them to leverage things that being small they wouldn't otherwise be able to do.

And then my third point, and I did have a third point, was beware of episodes. So I like episodes, I understand, but you really need to think through what money is it, what do you want to have happen where you're going to save money and approve quality?

So one thing is, you want there just to be fewer types of episodes. You want a population health in a way that you don't need as many hospital admissions, or whatever that is. I completely understand.

And that money I think we're going to agree, in many cases goes to the primary care doctor. Some chronic conditions, you know, you might want to go to a specialist who's managing a patient, you know, nephrologist, or someone like

that. And I can understand that.

But a lot of the money from the ACO savings, or the savings overall, is coming from post-acute care. And so you need to be careful if, who is going to get the money if you keep someone out of a nursing home or you do some other type of more efficient post-acute care. Is that money go to a specialist because you have now put in an episode where the specialist controls that saving, or is that savings going to go to the primary care doctor?

And if you put in a lot of episodes, or you're not careful about what episodes you put in, you will be giving all that money, you know, my view is post-acute care is the ATM for ACOs. And if you give that money to the specialist, because you built a lot of episodes, you're giving a lot of the money that I think the population-based, primary care-based systems would have been counting on to make their savings, and they would be syphoned away to some potential specialist who now controls it because of the design of the episode.

So while again I'm not anti-episode, I actually think there is a number of ways you can

like, in fact, I like the TEAM model because they have really scaled back and thought about that, I think a bit more you can debate TEAMS separately. But I don't think trying to find a model that fits everybody to engage them is going to be helpful if those models span savings that otherwise go to the organizations that are bearing population risk.

DR. MILLS: Great. Okay, Dr. Babaria, Dr. Yeh, last comments on that topic?

DR. BABARIA: I definitely ditto the keeping it simple and really supporting stability because that is really needed on the risk stratification front. In our state Medicare program for similar reasons, existing risk stratification models and risk predictive models are very utilization and cost-based and weren't meeting our needs, especially around social drivers of health and underutilization, so we are building our own state-wide transparent algorithm to do that predictive risk modeling that is more clinically informed. So happy to follow-up or provide info if that is helpful to anyone.

DR. YEH: And then I just want to add in, because I haven't heard it spoken of, is a

lot of what we've describe tend to be elective in planned care. But remember, about two-thirds of care happens after hours, it's not Monday to Friday.

So if really want to get participation from the primary care and specialist we have to be including the emergency departments, the urgent care, et cetera, that provide that safety net after hours which is good for the beneficiaries and may help reduce the burden of care on your clinician participants.

And with geriatric emergency departments now growing, that can improve both the outcomes, sorry Michael, but may reduce some of the post-acute care needs in actually keeping people into the home, and that kind of follow-up care. I don't think we're tapping into that lever as well to help the ACOs be more successful.

DR. MILLS: Outstanding. Thank you for that. We're going to stay on the theme of incentives, but actually turn our attention to beneficiaries.

And what kinds of incentive do you think are most important encouraging beneficiary

participation of different, in the different kinds of fee-for-service beneficiaries who are not currently in the countable care relationship?

And I suppose as you've highlighted, as we've got both MA and Med Supp and standard fee-for-service, how do we align beneficiary incentives to try to get the best outcome there?

We'll start with Dr. Yeh and Dr. Barbaria and Dr. Calcagno.

DR. YEH: Well I guess I would start with, we're not measuring the beneficiary experience, if you will. One is, are we actually measuring the total cost of care that the beneficiary is spending on their out-of-pocket expenses? If we really want them to participate, it's just like if supplemental benefits and MA, we should be allowing those kinds of supplemental benefits to reduce their total cost of care.

Number two, time is money. And if you can demonstrate that you are reducing and coordinating and making the time convenient for the beneficiary, their families, and their caregivers, people will appreciate that. Make it simple for them as well and think about the workflow of their life, not just the workflow of

the practice, of the practitioners, they're important.

Thirdly is to, what we found more important than anything else that brought people in was creating that coordination of care, making it easy to navigate all the fragmentation. And can you bring in the services that beneficiaries care about? I haven't heard us talk about DME[81], supplies. You know, all this out-of-pocket expense where you've got to buy your own dressings, you got to buy, you know, your own supplies, your own walkers, et cetera. Not everything is covered. And what are we doing to make it easy so that you can live every day simply at home?

And finally, creating the kind of technology that is easy, turnkey, platform based. Right now what beneficiaries face is you have a different app for your blood pressure, one for your pulse ox, one for your respiratory rate, one for your temperature, one for your activity tracker. So the more we can make it convenient and simple for the beneficiaries, they will come.

That's why they buy their Apple

81 Durable medical equipment

devices. It's why they use their smartphone. Because they want it to work in their lives.

DR. MILLS: Dr. Barbaria.

DR. BABARIA: Yes. So over as a part of our transformation to Medicaid, we have actually set up a number of Medicaid member listening sessions. But the state level that meets directly with our executive team on a quarterly basis, as well as at the regional level via all of our managed care plans, and I think this goes back to, what's in it for the member.

And the refrain we consistently hear, right, members don't care, you know, am I in a ACO, am I in a MA plan? In fact, I would say I think general perception is being in those things limits choice and limits access and not the converse.

And what they really care about is, can I get an appointment when I need it, do I have long wait times? Is my provider someone that relates to me, speaks my language, that I trust, and have that relationship with? And are my health care needs and preferences being honored and met?

And we have very, you know, we have

lots of members who are in ACO and manage care plans who are having those needs met, and others who are equally not having those needs met. And I think really looking at what will incentivize and drive them in is, essentially at the end of the day how well those needs are being met, along with the education and sort of word of mouth, you know, for those entities that have been able to achieve those goals.

DR. YEH: But we're not measuring that on a consistent basis. So you cannot improve it if you're not measuring and tracking.

DR. BABARIA: Yeah. And we, you know, we have our sort of CAHPS surveys that are very poorly responded to. We collect them in English and Spanish which leaves out about, I think 17 threshold languages in the State of California and are inadequate. But the more we can march towards patient-reported outcome measures and universal member experience, the closer we will get there.

DR. MILLS: Agreed. Dr. Chernew and then doctor, sorry, Dr. Calcagno first and then brief comments from Dr. Chernew and Dr. McClellan.

MR. CALCAGNO: I think it's as simple as this, beneficiaries, A, don't understand what an ACO is, B, quite honestly, they don't really care until the point that they need it, and then C, all the coordination we do is really behind the scenes so it's transparent.

And my proof point on this is, my father was recently diagnosed with cancer, and he didn't care, he's on Med Supp, didn't really care until all this happened, right. And now he has an oncology nurse navigator. She is essentially coordinating everything he needs upfront. He is super excited about that. Right? He loves that.

So think about that as a model for the ACO. How do we make sure that coordination is front and centered for those that need it, and then how do they understand it? Right?

There is a whole bunch of health care literacy. You know, there is, particularly in my father's case, 80-year-old, not exactly cognitively all there, right, so there's challenges that you have to deal with. But I think it all comes down to, are they seeing the value of it.

They don't necessarily have to

understand the stuff all the experts on this call understand, but do they see the value, and can the design make that value transparent to them?

DR. MCCLELLAN: And just to add maybe a way to think about additional benefits and traditional Medicare, you know, yeah in ACO, Don and others could come up with some additional hearing assistance or other benefits they could just offer, but most the ways that additional benefits get delivered in traditional Medicare is through there's a billing code for it and, you know, accounting for the copay and so forth, it's something else that could be covered.

And CMS is trying to move in that direction. You've seen some additional billing codes for things like care coordination. Don, I'm not sure how helpful the additional billing codes are going to be for you all for that. Telehealth, expanded services, remote monitoring. Charlotte, digital technologies. That structure helps.

I think what CM, the Center for Medicare has not quite figured out yet is, well, you know, we want to allow for more of this billing to help organizations move in this

direction, but how do we combine that with the overall big picture of simply put, we want to help organizations get to, not just some additional fee-for-service billing, but more comprehensive total cost of care and beneficiary management.

One way to do this, and this may sound a little bit more complex, but it seems like we're almost at the point with so much alternative payment approaches and traditional Medicare, they almost need two tiers for these additional efforts.

So the kinds of concerns that people have raised about telehealth, about covering digital and so forth, mainly apply in the unmanaged fee-for-service setting where a concern is that there would be more billing. It's not, there is nobody who is overall accountable for those costs or is making sure that it's being used in a way that makes sense.

So if Don wants to, if Don's plans that are in substantial risk find these additional coordination billing codes for primary care docs, for that matter, specialty docs useful, if they want to do more billing for

digital health, great, they're on the hook for those services translating into better outcomes and lower cost.

It'd be a nice clear signal that I think is confusing some providers today is, well, you know, I could take these little steps towards care coordination but, you know, I'm not really sure what the long-term models are going to be so maybe I'll just stick here for a while. This would more clearly reinforce that the goal is to facilitate the fact that you can deliver more flexible services and better benefits, maybe even some copay forgiveness if the ACO wants to do it, if we make it easier for plans and, sorry, for providers to set up these models.

DR. MILLS: Wonderful. Last word, Dr. Chernew.

DR. CHERNEW: So I'm largely where Don is on that. I don't think you want to overwhelm beneficiaries with joining an ACO or not joining an ACO, a bunch of things that would be really confusing for them.

The beneficiaries can choose their doctors. If the doctor is in ACO, the doctor, I think, will have an incentive to provide a good

job. I think you want to measure to make sure they're not providing a bad job. I said something about stenting.

I think that's the core thing that you should worry about. And you should just not spend as much time trying to figure out new ways of engaging coordination and a whole bunch of other things. Just make sure that the ACO has the right incentives and they're doing the right things in terms of costs and outcomes. And that includes patient experiences in a whole bunch of ways, I think that's the key thing.

I agree with Mark in the sense that for services that are not going to be covered by Med Supp, having a package that allows ACOs if they want to offer those services I think is valuable, but understand, a lot of the Medicare Advantage benefits are financed with a pretty generous Medicare Advantage payment model.

So don't think that you're paying Medicare Advantage and ACOs the same amount, and then you're going to get the same level of benefits because they're financed on a very, very, very, I don't know how much more time we have, very different frame. And so, you really

need to think through how all of that will really work and practice because you're not going to get the same ACOs competing with Medicare Advantage plans given the vast differences and the mechanisms for how they're paid.

And I would just try and be a little more cautious about what you think you can accomplish by trying to build in a lot of programs to try and get particular types of care coordination and/or beneficiary engagement. Just pay them a flexible amount, measure the amount of beneficiary satisfaction, give them the opportunity to provide things that they otherwise might not be able to provide and call it a day without worrying about complex codes in a bunch of ways. And Mark and I will have to have a beer over what to do with telehealth codes.

DR. MILLS: Outstanding. I'm going to turn to our last question. We have about 10, actually nine minutes left.

I want to turn to other markets, perhaps inside the United States, perhaps outside United States. What kinds of lessons can be learned from other markets, and are there examples of effective approaches you've seen in

other markets used to address challenges and barriers affecting provider participation and value-based care that might be relevant here?

So that's a wide open, tell us what you'd like us to know type of question starting with Dr. Barbaria, Dr. Chernew, and Dr. McClellan.

DR. BABARIA: I'm going to pass it on my esteem colleagues on this panel, I don't have much to add to this question.

DR. CHERNEW: So if I'm esteemed, then I'm not sure that I qualify, but assuming I do, I'm going to answer because I think I was supposed to be next.

So I'm here in Amsterdam. I was talking to the Dutch health authority about what they do, but understand a lot of their things are mandatory, they have a very different system in a range of ways.

It's not like they had a fee-for-service system they decided to put in value-based models and then try to solve the problem we're trying to solve. They built systems that are just fundamentally different for how they work. They mandate insurance.

Here in the Netherlands, everybody chooses their doctor. I think Don or someone said that. So the attribution issues aren't there. They don't quite impose the same amount of risk in the same way. There is some version of risk, they have the different insurance system.

So this is a much longer question than I'm prepared to answer, but it is not a question like, maybe there is other places that do this, but I think you would find the U.K. as well, they have a completely different system in the NHS[82]. They didn't build a lot of models and then try to get people into models the way we're thinking about getting into models. They did do certain similar things, but I don't think we have time to get into the specifics, at least where I'm in, so maybe someone else will know examples that are more analogous to what we're trying to do.

DR. MCCLELLAN: Yes, I think the main thing is, because this is hard, and don't worry, we're not the Netherlands for better or worse, I guess. What I have seen really starting to help is this recognition that while there are

82 National Health Service

differences across payers, there are common themes.

A big one is, we started with this stronger primary care. So I don't know any segment of the U.S. health insurance market where there aren't efforts underway to try to increase advanced primary care, team-based care capabilities and link those to some accountability for coordinating care and managing total cost. Yes, the specific areas that Medicaid is going to focus on for that with moms and kids are going to be different than Medicare and polychronic patients can be different than commercial where it's more dealing with discrete issues, and maybe more behavioral health and other things like that.

But having these state transformation collaboratives that CMMI has started to support is a good way to help get people on the same page. I wish it could go faster. And, you know, I think here maybe it's a structural issue with CMS and CMS finding ways to work together better across programs.

We've talked about how CMMI models go into Center for Medicare programs. Well, if we

got a good core structure in the Center for Medicare, maybe what's needed is helping CM, telling CMMI, hey, we need to refine this model, it's not working very well, can we do a more rapid evaluation within our existing programs.

And to Don’s earlier point, you know, I wish it were so, but unfortunately having been there, CMS doesn’t perfectly get everything right. Right in the beginning. The models have to change. That’s the way you learn more about how benchmarks actually work and participation, if it's a voluntary model.

But you can make that process more expected and have processes built in to pilot changes and engage around them. And that can be extended to multi-payers too.

And just to, back to comments about what they’re doing in California. It’s just kind of a reminder that CMMI and CMCS, you know, the state part of the Medicare program really needed to be building some stronger ties.

So the state transformation collaboratives are not an exception, or kind of a rule, as states are thinking about their waiver

renewals and SPAs[83] and other steps that should be, and the states are interesting in aligning, they just have somewhat different populations and priorities. But I think some real opportunities for more synergies.

MR. CALCAGNO: And then I would just add, if you think about just the Medicare Advantage Market, the ACA, et cetera, they require network adequacy, right? So again, I know it's not high on folks' list to narrow networks, but the more, when you look at our other payers that are doing MA ACA plans, you have to define the network upfront. And because it's defined, you're able to better coordinate across that network.

And I do, again, include hospitals, primary care specialists and post-acute all have to be in that network. There is definitely a selection bias if you're a primary care-led ACO, if you're a hospital-led ACO.

And just having everybody on the same page, again, going back to that simplified portfolio where we don't have competing models, we don't have competing providers in the network,

83 State Plan Amendment

we have one network that can actually coordinate together, that would be the big takeaway that I'd have.

DR. MILLS: And Dr. Yeh.

DR. YEH: Thanks. So I just want to add three things. One, I really want to underscore when Don was talking about care coordination, we found when we were using the Medicare supplement and we signed a care manager to these individuals, high-risk, high-cost.

We could reduce hospitalization, ED visits, et cetera, because we had a trusted relationship of someone who could navigate the insurance, navigate the appointments, navigate the medications, navigate the activities and behavior changes that would have to come. And they don't have to exist only in health care system. There are continuing care organizations, assisted living types of approaches that provide that care coordination.

And what's valuable, and to know how important it is, when they do a good job for the parents, the children then sign up for those programs. So that it can bring you back not only cost savings and better outcomes, but it can help

also with the engagement side.

The second is, I want to underscore what Michael and Don and Mark have said about not making these changes. These care coordination programs, at least in our experience and fee-for-service Medicare, you don't begin to see those returns until at least 12 months.

If we're looking for short-term gains, you're not going to get it, you have to be in this for the long haul and over time. Which is really important. So I just wanted to share that piece as well.

DR. MILLS: Okay, outstanding.

CO-CHAIR HARDIN: Palav, if you had a comment?

DR. BABARIA: Yes, it was mostly covered it, but I recognize we're coming up at time. You know, I think what one of my esteem colleagues on this panel said earlier is, you know, reframing the question to be less about how do we design a model and more about, how are we going to make this the norm, right?

And I think everything that you have heard from the panelist so far is really, when that is the problem you're solving for you make

different decisions. And it really is about scalability, bringing in those other payers, connecting the dots with sort of non-Medicare coverage to get to that tipping point. And so really keeping that at the foundation of the design I think will really help.

DR. MILLS: Excellent. Thank you for that fantastic final word. It encapsulated it all. Thank you so much for the five of you joining us this afternoon. You're welcome to stay and listen to the rest of the meeting.

On behalf of the Committee and the wider audience, I'd like to thank each of you for your time and your insights and your lifetime of learning that you provided for us. There were outstanding conversations. We do appreciate your time.

At this point we're going to take a short 10-minute break. And the Committee will return at 3:20 Eastern, where we will reflect on the day and start discussing potential comments and recommendations for the report to the Secretary. Thank you. We are in recess.

(Whereupon, the above-entitled matter went off the record at 3:09 p.m. and resumed at

3:22 p.m.)

*** Committee Discussion**

CO-CHAIR HARDIN: Welcome back. As you know, PTAC will issue a report to the Secretary of HHS that will describe our key findings from this public meeting on identifying a pathway towards maximizing participation in population-based total cost of care models.

We now have time for the Committee to reflect on what we have learned from our sessions today. We will hear from more experts tomorrow but want to take the time to gather our thoughts now before adjourning for the day.

Committee members, I'm going to ask you to find the potential topics for deliberation document. It's tucked in the left front pocket of your binder. To indicate that you have a comment, please flip your name tent or raise your hand in Zoom.

I also just want to alert you, as we have in the past, I'm going to go around the circle to have everyone add in what were your key takeaways from today that we for sure want to capture for the report to the Secretary, or remaining questions that you're hoping that we

get to tomorrow.

So would anyone like to start? Who would like to start?

CO-CHAIR SINOPOLI: I'll start.

CO-CHAIR HARDIN: Angelo, please go ahead.

CO-CHAIR SINOPOLI: First of all, I thought it was a fantastic day. All of the groups and the panels were just amazing. And clearly had a lot of expertise and a lot of experience.

Today was kind of a culmination of things I think we've heard over the last couple of years as we've talked about various things, but it was nice to see it packaged in a particular way that kind of drove where we think we need to go.

Some major areas of focus that I heard about, are again, are things that we've talked about but just heard it in a different way. One was data. And not just raw data, and maybe having access to that raw data, but being given that data in the way that actually provides the information to the practices so that they understand how to manage their patients, and also

understand how well they're doing.

The other thing that was talked about today was measures. Simplifying measures, developing fewer measures, and creating standard definitions across Medicare, but also all payers.

Developing fewer models. Now there are too many opportunities to participate and too many different models and is there a way to rationalize those models to fewer models? Heard some comments around being aware of, being wary of downside risk directly to physicians. And although we've talked about that a lot, I think there was some good cases made today about not maybe giving direct positive rewards but not moving the downside risk directly to the docks.

Also, paying attention to the beneficiary needs. And are we measuring that, and how are we incentivizing activities for the beneficiaries to participate?

Heard again today some comments about team-based care from several people and how important that was and how maybe in the future we could create a model that helps pay for team-based care. And then also heard a lot of discussion around benchmarking. And particularly

comments about avoid ratcheting. Which obviously occurs today.

So those weren't all inclusive, but those were things that quickly came to my mind at the end of the day today, and so I thought those were important things that needed to be highlighted, so.

CO-CHAIR HARDIN: Thank you, Angelo. I'd like to go to Larry and Josh next so we make sure that we don't miss you since you're virtual. Who would like to go first? Larry, you're off mute. Please go ahead.

DR. KOSINSKI: All right, I'll go. I was making my notes, but since you pushed up earlier, I'll do it.

What I heard, we don't all hear the same things I guess, but what I heard was we need to coordinate the business success drivers with the population health needs. And that applies to the health system, it applies to the practice. And it also applies to the beneficiary.

And we need to use simple methods with actionable data to help us accomplish that. That was my major, my major takeaway.

The second one is, we still have a

problem with the specialists. We can do bundles and episodes, but we still have these big issues lurking out there, what do we do with the cognitive care model for specialists? And they're the ones that are taking care of the most complex costly patients that we have out there.

I jot down a lot of good sayings. I love what Michael said it, you know, post-acute care is the ATM for ACOs. I love that one. I may make a slide out of that.

But, you know, we heard over and over again, it's got to be actionable, it's got to be simple, it's got to be implementable. And we're in an era of hybrid models as well, and we've got to utilize existing structures to try to help the specialists become part of the solution.

I'm sure, I haven't had the chance to go through my notes I have more, but that what I've got right now.

CO-CHAIR HARDIN: That was great, Larry, thanks. Josh, please go ahead.

DR. LIAO: Yes, thanks. I, a couple key takeaways and a couple tension points that I'd love to, you know, look forward to teasing out maybe tomorrow or in future meetings.

The first is kind of predictability and certainty. This sense of, you know, when it's not predictable or you do everything right and the outcome is unpredictable. I think that being problematic, that was something that shone through for me.

And the second, maybe more importantly, was kind of this idea of rewarding success generously. And I can see three kind of subcomponents of that. One is model design. So you heard ratchet, like one every 2.5 speakers. So ratchet is a model design issue.

But there is another issue which is just the size of incentive. I think Zeke said it the most kind of directly, you know, one or two, three percent versus 10, 20, 30 percent.

And then kind of like the impedance on whatever side. Meaning, if you rely on conveners, they play a very important role, but they suck up a lot of that incentive, right? So even if you increase the size, you only get that slice, right?

So there is some model design. There is just the money you pump in, and then there is like the ways in which you make most of the

transmit to the clinicians and the groups that are delivering care.

And there are a lot of ways to think about. I think democratizing and flattening data being one. Creating financial buffers. There is a lot of things we can talk about more, but that idea of rewarding success generously, to say simply to put an incentive on people for participating I think is relevant.

The third thing, I know a few of our SMEs[84] tried to stay away from this very thoughtfully, but, you know, I think Mike Chernew's point is the right one which is that no choice is made in a vacuum. You make a choice about a APM or a population-based TCO model alongside any other model out there.

And so, everything I just said about predictability, certainty, the generosity with which we reward success to me has to be taken alongside those other things. Even if we're thinking about models directly, you can't ignore the environment there, we ignore it at our peril. So I think that would be those three comments I have.

84 Subject matter expert

A couple tensions I don't know what to do with, it's just me kind of putting it out there for the Committee is, you know, I heard kind of themes around, you know, we want simplicity, we want fewer, we want rationale, and yet I heard kind of ripples of another, what I would call side of it, which is, but we need it to be tailored, it needs to be like relevant, and we need to give people a choice. And I find those are sometimes not always directly aligned.

You know, you can create a clinical integrated network. It can be large, it can cover everybody, and then you will not have as many options, right? So do you want simple, streamline, rational, or do you want more options that are smaller.

One more example than I'll stop. You know, we talk about not having too many models. And I tend to agree with having fewer rational models, and yet I don't know which edge of the blade we're on.

If you give more groups more types of models with different parameters, does that increase their participation?

And if you decide to cone it down to

two or three very large models, are we sure that's going to increase participation, decrease it, I don't know, it's an open question that I don't know if anybody can answer. So we just need to balance a few of those things that I heard, I think.

CO-CHAIR HARDIN: So key, thank you, Josh. Jay, please go ahead.

DR. FELDSTEIN: So in the theme of keeping it simple, we hear over and over and over again in every meeting, and for my tenure here, we've got to pay primary care physicians and providers more. Period. End of story.

All we're going to debate is how to get them the money, and how much. And I think we heard today it needs to be consequential. It can't be a small bonus, it's not going to change behavior, so we need to focus on that.

And then an area that I find very interesting, and I will disagree with some of our esteemed experts that we had this morning is, how do we handle social determinants of health?

The panel this morning seem to feel, well, if we really take care of health care costs, we'll have more money to spend on social

determinants of health or spend it better. I'm kind of on the other side of the chicken, egg here, that I think if we spend more and figure out how to pay more for social determinants of health, we'll have less health care expenditures.

CO-CHAIR HARDIN: Excellent. Thank you. Chinni, please go ahead.

DR. PULLURU: Fantastic day I thought. Just lots of diverse opinions. And some surprising ones.

So first I'd like to start with something that threaded through the entire day and that was democratizing and standardizing data. Nothing new to us. We've heard this now for years.

However, I think the thing that is really important is that the, to ask that CMS take the lead in that, and having data, the ability to standardize and syndicate data not be expensive. Because one person, two person, or rural practices just can't afford that. And so I think that just an important point.

The other thing that I found somewhat surprising is they asked that incentives not necessarily be passed down at the provider level.

And measurement, like quality measurement, be done at the clinic level.

I'm not sure I agree with that entirely, but I do appreciate that it's nuanced. And that when you do translate incentives down to the provider level, you have to be very careful. And I think to ask for flexibility in the ACO to do that is important.

So the last thing that was said in the day, and I'll kind of, was simplicity, flexibility. And things that enable the provider, and not to forget the beneficiary. I thought that was a really important point that came out towards the end of the day, that beneficiary adoption is important.

So let's look at the cost of the beneficiary, let's look at what they're looking at as well. Not leave them out of this sort of realignment.

And then the last thing that, you know, I found to be somewhat really important that surfaced up is just the reminder that MA and ACO are not comparable because they're funded very differently.

And we often look at MA and say, gosh,

they're getting to all these things and look at all their benefits, I wish we were able to just do that. And I think that it's important to remember, and be reminded of, consistently, that the funding mechanism is different. So if we can't fix the funding mechanism, then we have to be cautious in comparing the two.

CO-CHAIR HARDIN: So helpful. Thank you, Chinni. Jim, would you like to go next?

DR. WALTON: I'm going to just focus on one part that has not been said, I think. And I wanted to just amplify something that Larry said. The physician provider enterprise must succeed to match capacity to the population health needs.

And there was a comment by one of our speakers around the mismatch over the next 20 years, I suppose, between the capacity of the provider community and the population demands – needs, right, and also then, and also demand. And then there was a discussion around the idea that if we overpay and underpay at our own peril.

And so from a charting of our, let's say the recommendations to the Secretary, it seems to me that that might really be a part of

the front end of everything we're going to talk about.

All the things we want to say is about that because we, as the provider, representatives of the provider community, are that particular, that's our opportunity to have a voice into the public conversation about the policy, prioritization so that capacity doesn't, we don't find ourselves 20 years from now, when I'm 87, that we don't have enough capacity. And I've chosen to live at a particular geography where the capacity to get specialty care is now, is limited to a telehealth visit because the migration to the urban area.

You know, it is significant. And so I thought I'd just elevate that and get that into the discussion.

CO-CHAIR HARDIN: Thank you, Jim. Lee, would you like to go next?

DR. MILLS: Love to. Similar to Jim, I'm just going to focus on, I got so many pages of notes it would take me hours to try to draw pearls out of that.

But some key points that I certainly heard. Of course data, ever present topic. I

did hear something almost even a little bit more events we've heard is we need not just a data utility infrastructure where the data is the lifeblood moving through the system, but that the models and the payer sponsoring value-based care, the ACOs, the enabled companies, need to be more proactive, more aggressive in doing analytics, serving it to the doctors as actionable intelligence.

Right now models typically say, we make our data available, do with it what you will. We're hearing, and I've experienced this over 50 years, that is neither, it's not even close to sufficient, right? That alone is a barrier that would make most non-huge high-revenue groups just pass.

Secondly, I think I heard, as clearly as I had ever heard before, that complexity is just out of control and out of hand. And that is reflected multiple different ways. But essentially, I heard from these experts, essentially a please, stop releasing more models, pick one, it will tweak, it will evolve, it will adapt. It will get better. It will not be perfect when you start, but just pick a couple of

horses and let's ride them, stop with the models. Which I thought was interesting.

And then I appreciated the focus on beneficiaries a little bit differently than what we've had. And I heard two different things.

One was, I appreciated the attention, the highlighting that we also, we often focus on the fee-for-service versus MA dichotomy. You know, when it's just flat Medicare, you pay your 20 percent, you see whoever you want, you don't get any coordination, it's just open, open range. And MA brings all these benefits and coordinates it, and there is financing mechanisms to fix.

But this tweak in the middle that's 40 percent of fee-for-service have a Med Supp. That they're paying much more out of pocket, but actually they're not getting any of the additional benefits, the coordination.

Those companies that want to coordinate, if the fee-for-service beneficiary has a Med Supp and they're in an ACO that provides care management, that goes to cost base, it's not medical cost. That was a really interesting tweak I think is pretty important that seems amenable to some policy changes.

And then lastly, I heard, and I'm not sure how I feel about it yet, but I mean, I heard somebody at the end say essentially that focusing on beneficiary choice or beneficiary incentives was the wrong question because beneficiaries choose their physician. And if you build a system that physicians are successful in and lets them take better care of their patients, the beneficiaries get what they want. They get the access, they get the communication, they get the coordination, and it all works out fine. And that was interesting.

CO-CHAIR HARDIN: Thank you, Lee. And Lindsay.

DR. BOTSFORD: Well I guess this goes to, you can hear the same thing and take away different things. So I think what I heard in the conversation around beneficiaries is certainly a call that we should look from the lens of the beneficiary as we think about payment models and where we need to be.

I heard conflicting things today as to whether incentives makes sense and whether it truly is sufficient to just get the doctor that they want. So I think there is questions to be

answered around, how can savings be shared with beneficiaries, what is it that beneficiaries want and need. And probably some of those result in why beneficiaries are making choices to get a supp or go to MA or other choices being made.

So I know this is a conversation we're already thinking about as a Committee, and hearing multiple different panels touch on it today I think just confirms we need to probe more.

CO-CHAIR HARDIN: So helpful. Walter.

DR. LIN: Great day. Learned a lot. And I look forward to another exciting day tomorrow.

You know, just taking a step back, right? So the theme of this two-day public meeting is around, essentially identifying a glide path toward the goal of achieving a hundred percent beneficiary in accountable relationship by 2023. And I think the very first panelists of our very first panel called that, I guess big dot goal into question, right?

So my big dot takeaway from this, today's meeting was, perhaps there should be some other definitions of success along this journey

to value-based care besides just a hundred percent participation. But regardless though, I think that's going to be one element. There might be other elements that hopefully will come out in our continued discussions. And even perhaps tomorrow.

Along this journey though I thought the panelists raised a lot of great points in terms of what might be hindering some beneficiaries and providers from participating in total cost of care models. And just to kind of highlight some of the things that have been already mentioned.

Risk adjustment is one big issue, right? I think one of our panelists put it very bluntly and said, HCC is broken. And if we were to redesign a risk adjustment system today, it would not be using old fee-for-service claims data. And there would be a much smarter way to do that.

Looking at, for example, frailty. And I heard that mentioned a couple of times. And perhaps I'm sensitive to that because of our June meeting, which a lot of our subject matter experts talked about frailty and functional

status and cognitive status in helping with risk adjustment.

But the other kind of similar thought along those lines was, there is no way of moving forward along this glide path without reevaluating some fee-for-service codes. I thought that was great to hear because that's kind of been my own experience as well at bedside and working with other clinicians who bill these codes.

You know, I think Tim Ferris mentioned that, gave the example that initial visit is 10 times the work of a follow-up visit, and yet it pays just a little bit more. And there is some other kind of examples on the way.

I'm glad to see CMS, CMMI moving in that direction with codes like the advanced primary care code that was discussed during the CMS panel discussion. But I think that's going to, those kinds of codes are going to help lubricate some of these friction points that have slowed glide path.

CO-CHAIR HARDIN: Thank you, Walter. And Jen.

DR. WILER: So many wonderful points.

And really excellent day. I think the only other comments I would add in is going back to the phenomenal analysis that my colleagues in NORC did reframing for us who are the population of patients that we're talking about and what has been the impact to date. And again, really, I think rich data that's going to have a lot of impact from the health policy and care delivery perspective.

And I continue to be struck by the fact that nearly 50 percent of all Medicare beneficiaries are in Medicare Advantage plans which as, juxtapose to those who are in traditional Medicare, and yet there is only 30 percent or less of provider payments that are being made in this APM space.

So back to the points made around a goal of 100 percent accountable care relationships by 2023, thinking about reframing the goal may be important. And I like Dr. Ferris' question around, who is responsible for creating, or who's accountable for creating capacity?

And the simple math that if a unit cost is more than payment and participation is

voluntary, then we have a supply and demand mismatch. So who is responsible for fixing that, and for which population, regardless of, ultimately then payment?

And I thought it was interesting that Dr. Chen said as painful, I think I wrote this down quite correctly as a quote. "As painful as it was, it was good that CJR was mandatory." Again, back to the comments that we've made previously around voluntary versus involuntary being a big dot mover.

And then two other subpoints that I would make is this comment around a consideration that risk adjustment benchmark goals should consider some rate that is commensurate with inflation in thinking about, you know, what is total cost when we think at the 100,000-foot view, what does success look like?

And then I also heard a comment around maybe future risk adjustment methodologies being more sophisticated using LLMs. And that sounded to me like a real opportunity for industry innovation for us to think better about how to leverage big data to be more meaningful to create benchmarks.

CO-CHAIR HARDIN: Thank you, Jen. And I will ask, add just a couple of quick comments.

So as we look at all-payer models and integration and heading towards total cost of care, there were a couple of themes that stood out to me. So one is a universal need to address health equity in looking at payment rates, and also upfront investments for building an infrastructure to address the complexity on the table.

The second is health-related social needs and how universally amongst payment models it's important to have a flow of how that's addressed. And three key themes that are emerging as part of that, one is nutrition, the second is transportation, and the third is housing.

And then the other key theme, as much as we definitely have universal desire to have primary care that we trust, the other theme of longitudinal care management and that relationship and the opportunity to engage beneficiaries in a partnership to really participate in their care and that importance of having an integrator to bring everything

together.

*** Closing Remarks**

So we've had a fantastic day. I want to acknowledge the PCDT group for the excellent presentation that they began this meeting with, as well as the research and articulation from ASPE and NORC. And all of our panelists. We've had excellent dialogue today.

I want to thank everyone for participating. And also for all of you who are listening in. We will be back tomorrow at 9:00 a.m. Eastern time.

Our two-day agenda will feature three amazing listening sessions. Our first listening session will focus on organizational structure, payment, and financial incentives for supporting accountable care relationships.

The second listening session will focus on developing a balance portfolio of performance measures for population-based total cost of care models.

And the third listening session will address challenges regarding data, benchmarking, and risk adjustment. There will also be an opportunity for public comment tomorrow afternoon

before the meeting is concluded with Committee discussion.

We hope you will join us then. Thank you. And the meeting is adjourned for the day.

*** Adjourn**

(Whereupon, the above-entitled matter went off the record at 3:49 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: 09-16-24

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

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Court Reporter