Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

September 16, 2024
9:04 a.m. – 3:49 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

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

Lauran Hardin, MSN, FAAN, PTAC Co-Chair (Chief Integration Officer, HC^2 Strategies)
Angelo Sinopoli, MD, PTAC Co-Chair (Executive Vice President, Value-Based Care, Cone Health)
Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Lawrence R. Kosinski, MD, MBA (Independent Consultant)*
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
Terry L. Mills Jr., MD, MMM (Independent Consultant)
Soujanya R. Pulluru, MD (President, CP Advisory Services, and Co-Founder, My Precious Genes)
James Walton, DO, MBA (President, JWalton, LLC)
Jennifer L. Wiler, MD, MBA (Chief Quality Officer, UCHealth Denver Metro, and Professor of Emergency Medicine, University of Colorado School of Medicine)

PTAC Members in Partial Attendance

Joshua M. Liao, MD, MSc (Professor and Chief, Division of General Internal Medicine, Department of Medicine, The University of Texas Southwestern Medical Center)*

Department of Health and Human Services (HHS) Guest Speaker

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

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

Lisa Shats, PTAC Designated Federal Officer
Steven Sheingold, PhD

Via Zoom

List of Speakers and Handouts

1. **PCDT Presentation: Identifying a Pathway Toward Maximizing Participation in Population-Based Total Cost of Care (PB-TCOC) Models**
   Angelo Sinopoli, MD, Preliminary Comments Development Team (PCDT) Lead

   Handouts
   - Public Meeting Agenda
   - PCDT Presentation Slides
   - Environmental Scan on Identifying a Pathway Toward Maximizing Participation in Population-Based Total Cost of Care (PB-TCOC) Models

2. **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**
   J. Michael McWilliams, MD, PhD, Warren Alpert Foundation Professor of Health Care Policy, Professor of Medicine, Department of Health Care Policy, Harvard Medical School*
   Ezekiel J. Emanuel, MD, PhD, Vice Provost for Global Initiatives and Professor, Department of Medical Ethics and Health Policy, University of Pennsylvania*
   Timothy G. Ferris, MD, MPH, Founding Senior Vice President of Value Based Performance for Mass General Brigham, Inaugural Chief Transformation Officer for the National Health Service (England), Adjunct Professor of Medicine, Harvard Medical School*
   Alice Hm Chen, MD, MPH, Chief Health Officer, Centene*

   Handouts
   - Panel Discussion Day 1 Panelists' Biographies
   - Panel Discussion Day 1 Introduction Slides
   - Panel Discussion Day 1 Discussion Guide

3. **CMS Panel Discussion**

   Elizabeth (Liz) Fowler, JD, PhD, Deputy Administrator, Centers for Medicare & Medicaid Services (CMS) and Director, Center for Medicare and Medicaid Innovation (CMMI)
   Purva Rawal, PhD, Chief Strategy Officer, CMMI
   Pablo Cardenas, Value-Based Care Senior Advisor, CMMI (Mr. Cardenas participated on behalf of Pauline Lapin, MHS, Seamless Care Model Group Director, CMMI)
   Sarah Fogler, PhD, Patient Care Model Group Director, CMMI
   Kate Davidson, LCSW, Learning and Diffusion Group Director, CMMI

   Handouts

   - CMS Panel Discussion Day 1 Panelists' Biographies
   - CMS Panel Discussion Day 1 Introduction Slides

4. **Roundtable Panel Discussion: Stakeholder Perspectives on a Pathway Toward Developing PB-TCOC Models**
   Don Calcagno, Jr., MBA, Senior Vice President, Chief Population Health Officer, Advocate Health, and President, Advocate Physician Partners at Advocate Health*

Mark McClellan, MD, PhD, Director & Professor, Business, Medicine, and Policy, Duke-Margolis Institute for Health Policy, Duke University*
Palav Babaria, MD, MHS, Chief Quality Officer and Deputy Director of Quality and Population Health Management, California Department of Health Care Services*
Michael E. Chernew, PhD, Professor, Health Care Policy, Director, Healthcare Markets and Regulation (HMR) Lab, Department of Health Care Policy, Harvard Medical School*
Charlotte S. Yeh, MD, FACEP, Founder, Yeh Innovation and Former Chief Medical Officer, AARP Services, Inc.*

Handouts

- Roundtable Panel Discussion Day 1 Panelists' Biographies
- Roundtable Panel Discussion Day 1 Introduction Slides
- Roundtable Discussion Day 1 Discussion Guide

Via Zoom
[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available online:
https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee].

Also see copies of the presentation slides, other handouts, and a video recording of the public meeting.

Welcome and Co-Chair Update

Lauran Hardin, PTAC Co-Chair, welcomed the Committee and members of the public to the September 16–17 public meeting. Co-Chair Hardin explained that the Committee has been exploring themes that have emerged from proposals submitted to PTAC by the public. She also described previous public meeting topics, including addressing the needs of patients with complex chronic conditions or serious illnesses, developing and implementing performance measures, encouraging rural participation, improving the management of care transitions, and integrating specialty care in population-based total cost of care (PB-TCOC) models.

Co-Chair Hardin explained that the September public meeting will focus on identifying a pathway toward maximizing participation in PB-TCOC models. She noted that the topic is of interest to the Center for Medicare and Medicaid Innovation (CMMI; the Innovation Center) at the Centers for Medicare & Medicaid Services (CMS) and introduced Dr. Elizabeth (Liz) Fowler, the Director of CMMI.

Dr. Fowler explained that the September PTAC public meeting includes a CMS panel discussion examining the Innovation Center's work to advance accountable care strategies and support advanced primary care. She noted that the topic of the public meeting is of great importance to the Innovation Center. Dr. Fowler shared that CMS and CMMI have dedicated time toward discussing the pathway to reach CMS' 2030 goal of having all traditional Medicare beneficiaries in a care relationship with a provider who has accountability for quality, outcomes, and cost. She explained that value-based and accountable care delivers improved outcomes, better patient care experiences, and lower health care costs. Dr. Fowler shared that payment innovation and incentives can facilitate a shift away from Medicare fee-for-service (FFS) and allow providers to spend more time focusing on patients. She highlighted the Innovation Center's 2021 strategy, which focuses on 5 objectives to further the Innovation Center's vision of a health care system that achieves equitable outcomes through high-

quality, affordable, person-centered care. Dr. Fowler explained that CMS' 2030 goal is central to achieving the Innovation Center's vision and overall strategy. Dr. Fowler noted that more than half of Medicare beneficiaries today are in Medicare Advantage (MA). She emphasized that traditional Medicare would remain a viable option that provides high-quality, accountable care for beneficiaries who choose not to join MA but wish to retain a complete choice of providers. Dr. Fowler emphasized that meeting CMS' 2030 goal requires a multipronged approach and collaboration among health professionals.

Dr. Fowler indicated that the CMS panel discussion at today's PTAC meeting will focus on the Innovation Center's top priorities, including its vision for primary care, an update on its vision for accountable care, strategies for engaging specialists, and its work to align across payers. She mentioned that the Innovation Center plans to discuss accountable care at the 2024 Health Care Payment Learning & Action Network (HCPLAN) Summit in Baltimore, MD, this November. Dr. Fowler explained that CMS' definition of accountable care is focused on longitudinal care relationships with accountability for TCOC and quality. She noted that these care relationships are focused on providers addressing chronic health issues. Dr. Fowler concluded by stating that the September public meeting discussions will be useful to assess the work that has been completed and the work yet to be accomplished over the next 5 years.

Co-Chair Hardin invited Committee members to introduce themselves and describe their experience participating in PB-TCOC models. Following Committee member introductions, Co-Chair Hardin shared that 5 PTAC members served on the Preliminary Comments Development Team (PCDT): Angelo Sinopoli, PTAC Co-Chair (Lead), James Walton, Josh Liao, Lee Mills, and Chinni Pulluru. She introduced Co-Chair Sinopoli, who presented the PCDT's findings from the background materials.

Presentation: Identifying a Pathway Toward Maximizing Participation in Population-Based Total Cost of Care (PB-TCOC) Models

Co-Chair Sinopoli delivered the PCDT presentation. For additional details, please see the presentation slides, transcript, and meeting recording (00:16:14-00:45:16).

- Co-Chair Sinopoli described the objectives for the theme-based meeting, including the vision for future accountable care relationships and identifying pathways toward having all Medicare beneficiaries with Parts A and B in accountable care relationships by 2030; understanding the components for success in developing PB-TCOC models; discussing the organizational structure, payment, and financial incentives needed to support PB-TCOC models; and identifying approaches for addressing key issues and challenges such as performance measures, attribution, benchmarking, and risk adjustment related to facilitating accountable care relationships in PB-TCOC models.
- Co-Chair Sinopoli noted that PTAC received 35 proposals for physician-focused payment models (PFPMs), and nearly all the proposals addressed the potential impact on costs and quality. The Committee members found that 20 proposals met Criterion 2 ("Quality and Cost"), including 5 proposals that were determined to meet all 10 criteria established by the Secretary for PFPMs. At least 9 other proposals discussed TCOC measures in their payment methodology and performance reporting.
- Co-Chair Sinopoli provided PTAC's working definition of an accountable care relationship: a relationship between a provider and a patient (or group of patients) that establishes the provider as responsible for quality and TCOC, including the possibility of financial loss/risk for an individual patient or group of patients for a defined period (e.g., 365 days).

- Co-Chair Sinopoli also provided PTAC's working definition of PB-TCOC models: an Alternative Payment Model (APM) in which participating entities assume accountability for quality and TCOC and receive payments for all covered health care costs (excluding pharmacy-related) for a broadly defined population with varying health care needs over the course of a year (365 days). Within this context, a PB-TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be nested within a PB-TCOC model.
- Co-Chair Sinopoli reviewed the following questions for identifying pathways toward having all Medicare beneficiaries with Parts A and B in accountable care relationships:
    - Categorizing Medicare beneficiaries by the extent to which they are currently in care relationships with accountability for quality and TCOC.
    - Characterizing geographic areas by the extent to which their providers participate in value-based care.
    - Identifying model characteristics associated with success.
    - Developing approaches, models, target timeframes, and intermediary steps for increasing involvement in accountable care relationships for various categories of Medicare beneficiaries (e.g., dually eligible for Medicare and Medicaid).
    - Identifying and addressing gaps and challenges.
- Co-Chair Sinopoli noted that as of 2021, half of Medicare beneficiaries (51%) were in traditional Medicare FFS. Of those beneficiaries, half (50%) were in APMs.
- Co-Chair Sinopoli suggested that PTAC is interested in models within Categories 3B and 4 of the HCPLAN APM Framework. Category 3B includes models with shared savings and downside risk. Category 4 contains models with population-based payment.
- Co-Chair Sinopoli explained that in aggregate across payers in 2022, about 25% of payments to providers were from APMs with two-sided risk (Category 3B) and population-based payments (Category 4). Categories 3B and 4 accounted for 16.5% of payments to providers in commercial insurance; 18.7% in Medicaid; 38.9% in MA; and 30.2% in traditional Medicare.
- Co-Chair Sinopoli mentioned that the Committee members are interested in exploring CMS and CMMI population-based and advanced primary care models (APCM) from 2012 to the present. The models have provided critical insights into how value-based care can improve quality and reduce costs. An essential contribution of model testing has been the gradual shift toward assuming risk. Model evaluations have illustrated the importance of financial risk, care coordination, quality measurement, and flexibility to drive adoption and improve care outcomes.
- Co-Chair Sinopoli explained that the Medicare Shared Savings Program (MSSP) has grown since its establishment in 2012, when MSSP included 114 Accountable Care Organizations (ACOs) with 1.7 million beneficiaries. In 2024, the program included 480 ACOs with 10.8 million beneficiaries.
- Co-Chair Sinopoli noted changes in CMMI model design over time, including increasing financial accountability, accommodating providers less able to take on risk, reducing provider burden, increasing the duration of models, supporting low-revenue ACOs (e.g., small and rural practices), incorporating health equity, and incorporating specialists into the models.
- Co-Chair Sinopoli described provider organization factors that affect Medicare FFS beneficiary alignment with APMs, including provider types and providers' experience with value-based care infrastructure and processes. Community-level factors that affect Medicare FFS beneficiary alignment in APMs include primary care provider (PCP) capacity, provider market consolidation, and the presence of community-based organizations (CBOs) that can help practices address social determinants of health (SDOH). Broader geographic area factors that affect Medicare FFS beneficiary alignment in APMs include MA and MSSP penetration, socioeconomic status, and

rurality. Other enabling policies that affect Medicare FFS beneficiary alignment in APMs include the predictability of APMs, the availability of APMs for different types of providers, and the relationship between APMs and other options in the community.

- Co-Chair Sinopoli explained that ACO participation was less likely in rural areas, the West, and lower MA penetration markets.
- Co-Chair Sinopoli described data analysis conducted by ASPE on Medicare FFS beneficiary characteristics and the geographic distribution of APM participation. The sample included Medicare FFS beneficiaries from 2012-2022, attributed to 21 APMs. Key findings from the analysis included the following:
    - Of the 30 million Medicare FFS beneficiaries with Parts A and B in 2021, nearly half (49.7%) were in APMs. Of those beneficiaries in an APM, 41.6% were in a CMMI ACO or MSSP ACO, and 8.1% were in other CMMI models.
    - In 2021, beneficiaries in the MSSP, CMMI ACOs, and APCMs were more likely to be white, female, and living in metropolitan areas. Beneficiaries in chronic condition models were more likely to be Black, Hispanic, and male; have higher mortality; and have higher average Hierarchical Condition Category (HCC) risk scores.
    - Between 2012 and 2020, 38% of Medicare FFS beneficiaries had no history of APM attribution. These beneficiaries were more likely to be Black or Hispanic, and dual eligible; living in micropolitan or rural areas; and have lower risk scores.
    - APM penetration among Medicare beneficiaries increased between 2013 and 2022 but varied across counties in the United States. APM penetration has been slower on the West Coast, in rural areas, and in areas with high Area Deprivation Index (ADI) scores. An increase in APM participation was observed year-over-year in rural and metropolitan areas, although rates still lag in rural areas because of initially low participation rates. Opportunity exists to increase participation in these markets.
    - A relationship is evident between ADI rates and APM penetration rates; higher ADI rates correlate with lower participation in APM models. The highest APM penetration rates are on the East Coast and Midwest, with lower ADI rates.
    - Beneficiaries entering APMs have more diagnoses of cardiovascular risk factors, chronic kidney disease, and other types of chronic conditions within the first 2 years of participation.
- Co-Chair Sinopoli described potential factors for forming a vision for future PB-TCOC models, including implementing a comprehensive framework for PB-TCOC models encompassing population-based models and APCMs; developing multiple pathways with varying levels of risk for different types of organizations; aligning incentives across PB-TCOC models, other Medicare accountable care programs, and all payers; ensuring consistency and longevity in PB-TCOC models; involving primary and specialty care providers in accountable care relationships; and addressing disparities and health-related social needs (HRSNs) by incorporating health equity-related objectives.
- Co-Chair Sinopoli listed potential components for successful models, including facilitating the participation of a full range of providers in different geographic areas; integrating specialists with the multidisciplinary patient care team; maintaining patient choice; attributing each patient to an entity or provider who is accountable for their quality, outcomes, and TCOC; ensuring that providers have sufficient data to manage patient care; ensuring timely and usable data on organization, practice, and provider performance; providing clear incentives for value-based payment (VBP) paired with disincentives for Medicare FFS payment; aligning financial incentives across types of providers; and ensuring predictability and adequacy of payments that allow providers and practices to invest in longer-term care transformation activities.

- Co-Chair Sinopoli described multiple participation tracks with different risk-sharing options for various organizations. For example, no downside risk can provide an entry point into accountable care models for small, low-revenue PCP practices. In contrast, full downside risk can promote a shift to accountable care for high-revenue integrated delivery systems.
- Co-Chair Sinopoli noted potential milestones and components needed to achieve the accountable care relationship goal, including (1) providing care transformation support; (2) increasing predictability of PB-TCOC model elements; and (3) supporting widespread participation in PB-TCOC models.
- Co-Chair Sinopoli described components that can affect participation in PB-TCOC models, including provider/practice structure, performance measurement, financial methodology, data infrastructure, patient attribution, health equity, and payer alignment.
- Co-Chair Sinopoli listed factors that can challenge participation in PB-TCOC models, including the complexity of the number and types of APMs; the duration of APMs; administrative and infrastructure burden; the profitability of traditional Medicare FFS; a lack of risk-bearing in traditional Medicare FFS; a lack of health equity incorporated as a central component in model design; and challenges with expertise, technology, and cost associated with participating in APMs. These challenges are particularly acute for small, low-revenue, and rural practices.
- Co-Chair Sinopoli described potential barriers to provider participation in ACOs, including the size of the practice and patient population, costs associated with ACO participation, and ACO participation decisions being made primarily by organizations and not individual providers.
- Co-Chair Sinopoli concluded the presentation by reviewing the topics that would be discussed during the public meeting: perspectives on developing a pathway toward the 2030 goal of having all beneficiaries in care relationships with accountability for quality, outcomes, and TCOC; stakeholder perspectives on a pathway toward developing PB-TCOC models; organizational structure, payment, and financial incentives for supporting accountable care relationships; creating a balanced portfolio of performance measures for PB-TCOC models; and addressing challenges regarding data, benchmarking, and risk adjustment.

Co-Chair Hardin invited Committee members to ask questions about the PCDT presentation. Committee members discussed the following topics. For more details on the discussion, see the transcript and meeting recording (00:45:26-00:51:03).

- Committee members emphasized considering the transition to participating in PB-TCOC in context. Model participation does not exist in a silo; participation exists in the context of MA, social vulnerability, and other provider-based factors.
- Committee members were encouraged to learn that APM participation is related to identifying more chronic diseases. This finding may indicate that the models successfully find chronic illness in older adults and individuals dually eligible for Medicare and Medicaid (dual eligibles).
- Committee members noted that the heat maps showing regional differences in APM participation may help identify areas needing support. The negative correlation between ADI rates and APM participation could indicate a relationship between high ADI and social needs determinants. Providers in these areas may have less capacity to treat challenging patients, which could lead to frustration and the decision not to participate in APMs. Committee members suggested that there may be opportunities to understand nonmedical determinants of health within communities with high ADI rates and identify how these factors influence APM participation.

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

Subject Matter Experts (SMEs)

- J. Michael McWilliams, MD, PhD, Warren Alpert Foundation Professor of Health Care Policy, Professor of Medicine, Department of Health Care Policy, Harvard Medical School
- Ezekiel J. Emanuel, MD, PhD, Vice Provost for Global Initiatives and Professor, Department of Medical Ethics and Health Policy, University of Pennsylvania
- Timothy G. Ferris, MD, MPH, Founding Senior Vice President of Value Based Performance for Mass General Brigham, Inaugural Chief Transformation Officer for the National Health Service (England), Adjunct Professor of Medicine, Harvard Medical School
- Alice Hm Chen, MD, MPH, Chief Health Officer, Centene

Co-Chair Hardin moderated the panel discussion with 4 subject matter experts (SMEs), who offered their perspectives on developing a pathway toward the 2030 goal of having all beneficiaries in care relationships with accountability for quality, outcomes, and TCOC. For additional details, please see the transcript and meeting recording (00:00:09-01:32:54).

Panelists introduced themselves and provided background on their respective organizations. Full biographies and panelist introduction slides are available.

- J. Michael McWilliams introduced himself as a Professor of Health Care Policy and Medicine at Harvard Medical School. Dr. McWilliams shared the goal of designing payment models so providers succeed and benefit. A clear, long-term vision for the health care payment system is needed to guide payment system reform. The focus should be to simplify and harmonize a smaller set of models. Design flaws in existing APMs lead to modest savings and selective participation. Efforts should focus on improving design elements such as savings rates, benchmarks, risk adjustment, and ways to share savings with patients to boost participation. Primary care population-based payment should be better integrated with TCOC systems. The ACO Primary Care Flex Model shows promise. For additional details on Dr. McWilliams' background and organization, see the panelist introduction slides (slides 2-4).
- Ezekiel J. Emanuel is a breast oncologist, Vice Provost for Global Initiatives, and Professor and Co-Director of the University of Pennsylvania's Healthcare Transformation Institute. He previously served as a special advisor on health policy to the Director of the Office of Management and Budget (OMB) and National Economic Council, where he worked on developing the Affordable Care Act (ACA). Transitioning to VBP is problematic because it requires significant changes to providers' financial and operational management. Timely, accurate, accessible, and actionable financial data are needed for more practices to adopt VBP. CMS should promote low-cost, open-source solutions to inform providers about their performance. To achieve standardization, the same platforms and processed data should be provided across all the programs (e.g., MA, the Marketplace). Fewer and better-designed programs are needed in collaboration with frontline physicians. See the panelist introduction slides (slides 5-7) for additional details on Dr. Emanuel's background and organization.
- Timothy G. Ferris introduced himself as a former PTAC member. He is the founding Senior Vice President of Value Based Performance for Massachusetts General Brigham and the Inaugural Chief Transformation Officer for the National Health Service in England. The increasingly older U.S. population is the most significant risk to value-based care initiatives. Technological advancements and transitioning from a one-to-one to a one-to-many health care delivery model

are needed to address this challenge. Quality metrics should be aggregated at the practice or health system level since this is the relevant delivery unit. Despite the shift toward VBP, the underlying FFS system still creates misalignments between the payment rates and actual service delivery costs. For additional details on Dr. Ferris' background and organization, see the panelist introduction slides (slides 8-11).

- Alice Hm Chen introduced herself as the Chief Health Officer of Centene, a leading provider of government-sponsored health care. She began her journey as a primary care internist at a safety net clinical practice, serving in several health policy positions, and is now working for a payer. Measure alignment and clarity are crucial to making value-based and accountable care more feasible. Centene tracks 170 measures, and only 4 are common across all programs. See the panelist introduction slides (slides 12-15) for additional details on Dr. Chen's background and organization.

Panelists discussed their visions for ensuring that every Medicare beneficiary with Parts A and B coverage is in an accountable care relationship. The following are highlights of some of the statements made by panelists.

- The first objective of multi-payer alignment is improving coordination among Medicaid, the Marketplace, and Medicare. Lowering health care costs requires a more efficient and flexible system, and payment reform could reduce system waste.
- Establishing effective benchmark rates requires many technical considerations. The "ratchet effect," where decreased spending lowers the benchmark, discourages provider participation. Setting fixed administrative benchmark trends, introducing permanent bonuses, or enhancing capitation payments for ACO participants could help address this issue. A long-term vision for setting benchmarks is needed.
- A suggestion was made that health care benchmarks should be tied to general inflation because health care expenses have risen at twice the inflation rate over the past 50 years. Clinicians should not be directly incentivized based on TCOC. Health care organizations should have incentives linked to total costs, which should be transformed into quality and outcome measures for clinicians.
- Panelists stated that in health care reform, multiple factors should be addressed simultaneously rather than focusing solely on payment issues. PCPs should be capitated consistently across different groups, and capitation should include bonuses for quality. CMS should leverage its influence to establish standardized quality metrics across payers, as there are currently different and excessive quality measures implemented across organizations. Flaws in the current FFS system must be addressed, including reevaluating the top several hundred billing codes accounting for most claims. Improvements to risk adjustments are also needed, as current methods using HCC scores are outdated and create problematic incentives. Machine learning can significantly enhance HCC scores using simple Medicare data. Proper risk adjustment also will require a reinsurance program for the top 5% of high-cost patients, which would alleviate pressure on doctors and health systems. Standardized bundled payments for specific procedures, such as hip and knee surgeries, are necessary to reduce costs and improve care among specialists.
- Clinicians should not face direct incentives related to TCOC, as many providers lack the necessary size and sophistication to manage these pressures effectively. Whether intermediaries add value to individual practices and the health care system is unclear. Quality metrics should be aggregated at the practice level, as care occurs primarily in the provider space and community. By distinguishing the roles of purchasers, payers, and providers regarding data collection, waste

in the system can be reduced. Payers may selectively contract with those scoring the highest when using risk adjustment. This can create challenges for safety net providers who may struggle to achieve the same quality levels.
- A salary model is preferable for incentives, as exposing physicians to purely FFS incentives can create undesirable outcomes. Alternatively, organizations can pool risk and achieve collective goals that individual physicians alone cannot.

Panelists discussed barriers to participation in TCOC models and ways to help alleviate these barriers.
- Health care providers need accessible and affordable data and financial models to guide their decision-making about their participation in VBP. Providers would be better equipped to understand the economic implications of changing their clinical practices if Medicare could offer data and models at a lower price—such as $10,000 to $20,000 instead of hundreds of thousands. However, providing raw data is insufficient; providers need processed information and precise models. High costs associated with financial intermediaries can also deter providers from engaging. In contrast to specialists already well-compensated, it is essential to establish financial benchmarks that allow primary care providers to earn more. PCPs should be incentivized to provide high-quality care through significant bonuses (e.g., a 50% increase in income). Opportunities for minor increases in income (e.g., a 10% increase) are inadequate to encourage the necessary changes to transform processes of care.
- There is significant tension between payers and providers in the U.S. health care system, and more collaborative relationships are needed. Exhaustion among PCPs is also a substantial barrier in health care delivery, as many PCPs are overwhelmed with existing patients and struggle to engage with new ones. Primary care redesign and better access are needed. Technology, particularly telehealth, is a potential solution to address supply-demand mismatches in care. However, technology could exacerbate disparities without careful attention, leading to wealthier patients receiving timely, in-person care while poorer patients receiving only virtual care.
- Traditional benchmarks based on an organization's historical spending can discourage providers serving historically disadvantaged populations from participating in payment models, as they may be locked into low spending patterns. Risk adjustment would ideally ensure that spending aligns with different populations rather than just focusing on predictive accuracy. Also, because ACO programs often use coding to determine risk adjustments and payments, providers not adept at coding may choose to hold on participating until they have the resources to improve their coding capabilities.
- Large language models (LLMs) should be used for risk assessment and adjustment. A study from Denmark involving 15 million people found that actuarial methods were correct 8% of the time, statistical methods 23%, while LLMs achieved an accuracy of 43%. This significant difference in performance suggests that LLMs should be used for risk assessment and adjustment as much as possible. Also, electronic consultations between health care providers (e-consults) are the future of health care. Dr. Chen published a study on e-consults, which Dr. Ferris felt encouraged to implement immediately at Massachusetts General Hospital.
- Massachusetts General Hospital pioneered e-consults, as initially only safety net settings showed interest in this approach.
- Adopting new predictive techniques for risk adjustment is necessary, as traditional methods such as ordinary least squares regression may soon become outdated. Increased predictiveness is not always better because the inputs can be manipulated through excessive coding. Specifically, when using HCC scores, providers who submit more claims and diagnoses receive

higher payments, undermining population-based payment models' goals. Beyond predictive accuracy and coding integrity, equity must also be considered when developing risk-adjustment methods.

Panelists discussed goals for Medicare payment system reform rather than general participation.

- It is essential to evaluate whether models encourage widespread participation and meet broader goals, such as reducing wasteful health care spending and focusing on high-value care.
- The primary goal should be to keep health care costs rising at the rate of general inflation. This would help alleviate concerns about the impact of rising health care spending on the U.S. budget.
- A successful health care system must ensure the financial viability of providers, ideally 85% to 90%. In the mid-1990s, when managed care led to lower payments, many practices went out of business. Given the current shortage of PCPs, designing the system to support providers' financial success is crucial, as this is directly linked to overall participation in APMs. Another goal should be delivering high-quality care for a core set of 5-6 easily measurable metrics, particularly for common chronic conditions such as hypertension and diabetes.
- Other goals should focus on increasing the financial risk that organizations assume and improving health care outcomes. Many providers may claim high participation in value-based arrangements, but if the revenue at risk is minimal, it does not lead to substantial improvements in cost or clinical outcomes. The goal should be to ensure that value-based care evolves into a system that improves patient outcomes and reduces the TCOC rather than just meeting participation thresholds.

Panelists discussed whether TCOC model incentives should be provided to clinicians.

- When all payers—commercial, Medicare, and Medicaid—moved to risk contracts, there was a need for coordinated metrics tailored to primary care, specialty care, and procedural care. Massachusetts General Hospital developed an internal performance framework to align incentives across different types of care (e.g., primary care, specialty care). Under this framework, clinicians had incentives. Although hospital administrators were initially skeptical about incentivizing clinicians, focusing on better patient outcomes and efficient care delivery ultimately led to success.
- The role of clinical leadership is to translate and convey information to providers effectively. It is essential to understand the motivations of health care providers; payers prefer to contract with providers who prioritize patient care over insurance details. The challenge lies in aligning incentives from purchasers and government entities with those of providers in a way that is both meaningful for providers and can lead to overall success.
- Transferring financial risk to individual physicians can have negative consequences, such as demoralization and conflicts of interest at the point of care. While monetary incentives may not significantly impact physicians' finances, they can still influence behavior. Management science and behavioral insights should be carefully considered when determining how much risk should be passed on to clinicians.

Panelists discussed aligning population health needs with the financial viability and success of physician practices and health systems.

- Panelists emphasized the need for revaluing FFS payment, as specific procedures are overpaid while others, such as initial visits, are underpaid. Bundled payments for specialty procedures are needed, as generalized solutions are typically ineffective for specialty care (e.g., oncology). Participation in payment models should be mandatory rather than voluntary because it will

ensure broader engagement and prevent providers from opting out when failing. Providing doctors with transparent financial modeling is essential to demonstrate how they can succeed in these systems. Significant bonuses for providing high-quality care—potentially 30-50% increases—are vital for motivating providers.
- Considering budget constraints, quality bonuses should be tied to a select set of measures. Such bonuses should be structured at the practice or organizational level rather than passing incentives in full directly to individual clinicians. More work is needed on effective strategies for motivating and changing clinician behavior, including research drawing from behavioral science approaches.

Panelists discussed whether social services, such as food and housing, should be included under government-sponsored health programs.

- Integrating social supports such as food and housing into health care is challenging, as the health care system is strained. While the health care system should not be responsible for all social support, involvement in a few key areas is necessary. It should ensure nutritional support for individuals and invest in early childhood interventions, which are vital for long-term health and development. Specifically, Medicaid programs should be mandated to include early childhood initiatives.
- Integrating more social care into the health care system may not be the best approach despite current initiatives pushing this shift. Existing insurance models fail to incentivize individuals to manage their health care usage effectively because consumers pay a fixed annual fee without benefit for not utilizing health care services. Also, because Medicare covers costs after age 65, individuals are further disincentivized to practice prevention and manage their long-term health.
- Channeling funding for social services through the health care system is inefficient. Health care systems should assist with patients' social issues impacting health care access, such as providing transportation to medical appointments or access to virtual care. Payment reform and risk adjustment can help align health care with broader social objectives by providing more generous payments for specific populations.
- Investing in early childhood development (e.g., programs such as Head Start) is crucial to reduce long-term health care demand. While the U.S. spends significantly on health care, it lags in spending on social services compared with other industrialized countries. There is a need for targeted, evidence-based approaches—such as nutrition, transportation for medical appointments, and supported housing—to effectively utilize health care resources without adding unnecessary costs. Social services should be strategically integrated to align with health care goals rather than indiscriminately expanding health care's role in social services, which could lead to waste.

CMS Panel Discussion

SMEs

- Elizabeth (Liz) Fowler, JD, PhD, Deputy Administrator, Centers for Medicare & Medicaid Services (CMS) and Director, Center for Medicare and Medicaid Innovation (CMMI)
- Purva Rawal, PhD, Chief Strategy Officer, CMMI
- Pablo Cardenas, Value-Based Care Senior Advisor, CMMI (Mr. Cardenas participated on behalf of Pauline Lapin, MHS, Seamless Care Model Group Director, CMMI)
- Sarah Fogler, PhD, MA, Patient Care Model Group Director, CMMI
- Kate Davidson, LCSW, Learning and Diffusion Group Director, CMMI

Co-Chair Angelo Sinopoli moderated the panel discussion with 5 SMEs, offering their perspectives on the CMMI vision to have all Medicare and most Medicaid beneficiaries in an accountable care relationship for quality, outcomes, and cost by 2030. For additional details, please see the transcript and meeting recording (00:00:02-01:01:05).

Panelists introduced themselves and presented their slides. Full biographies and panelist introduction slides are available.

- Elizabeth (Liz) Fowler, CMS Deputy Administrator and Director of the CMS Innovation Center, provided opening remarks for this session. Dr. Fowler noted the importance of a robust primary care infrastructure to support the overall CMS strategic objectives for accountable care. Health systems worldwide that have invested in primary care, including focusing on prevention, screening, and reinforcing health behaviors, have achieved success while also spending less on health care than the U.S. Specialists should also be integrated into accountable care. Dr. Fowler shared that CMMI is working as transparently as possible by making model data available for researchers, proposing a rule to make participation agreement details public, and publishing articles on CMMI's strategy for primary and specialty care integration. Dr. Fowler introduced the other 4 CMMI panelists.
- Purva Rawal, CMMI's Chief Strategy Officer, shared that primary care and advanced primary care is the key mechanism to achieving the 2030 goals. Improving financing, a guiding principle informing all CMMI's advanced primary care work, includes strategies to strengthen the primary care infrastructure , including moving from FFS to hybrid or fully population-based payments. Advancing health equity is another guiding principle, aiming to reach all beneficiaries and bring safety net providers into primary care models. Within the Making Care Primary (MCP) model, 41% of organizations are Federally Qualified Health Centers (FQHCs). Sustainability, the final guiding principle, is focused on maintaining organizational investment over time through multi-payer alignment and establishing permanent pathways into the Medicare program. The MCP model was built on prior lessons learned and created a path for organizations with varied experience levels to join, such as safety net hospitals and FQHCs. States Advancing All-Payer Health Equity Approaches and Development (AHEAD) is a state-based TCOC model increasing investment in primary care. For additional details on Dr. Rawal's presentation, please see the panelist introduction slides (slides 3-6).
- Pablo Cardenas, a CMMI Value-Based Care Senior Advisor, shared that in 2024, approximately 13.7 million traditional Medicare beneficiaries aligned to several ACO models, including MSSP, ACO Realizing Equity, Access, and Community Health (REACH), and Kidney Care Choices (KCC). Evaluations of ACO models have shown that they reduce spending and improve the quality of care. For example, Pioneer ACOs and the ACO Investment Model (AIM) achieved savings and were incorporated int the Shared Savings Program. Additionally, in the current physician fee schedule a health equity benchmark adjustment is being proposed in the Shared Savings Program, informed by the ACO REACH experience. In ACO REACH, a health equity adjusted benchmark and other health equity-focused features contributed to a doubling of safety net provider participation in the model. Other ACO evaluations have not found that providers produced savings and showed that providers stopped participating when financial losses were reported. ACOs using population-based payments, however, achieved more significant savings. Physician-led ACOs tended to receive incentives that led to reduced spending and greater

control over patient care. In contrast, hospital-based ACOs experienced conflicting incentives and had less direct control over services provided. The Global and Professional Direct Contracting (GPDC) model evaluation from performance year 2022 suggested designing hospital ACO models to remove conflicting incentives and increase a hospital's ability to reduce low-value care. Lastly, physician-led ACOs are needed to drive higher savings. For additional details on Mr. Cardenas' presentation, please see the panelist introduction slides (slides 7-10).[1]

- Sarah Fogler, the CMMI Patient Care Model Group Director, described the importance of specialty care in chronic condition management and acute episodic care in CMMI's strategy for value-based care. CMMI's strategy also includes enhancing data transparency on specialty care performance, maintaining the momentum on a decade's worth of work on condition-based models (e.g., kidney and oncology), bolstering primary care and associated infrastructure, and providing tools and incentives for specialists to engage with ACOs. A recent achievement was the release of constructed episode-based data attributed to beneficiaries in ACOs. In 2025 and 2026, the CMS specialty care strategy will focus on continued robust stakeholder engagement, expanding on data sharing offerings (e.g., episode-based cost measure data), considering a new ambulatory specialty care model, supporting hospitals with implementation of the Transforming Episode Accountability Model (TEAM), continuing to support condition-based models, and publicly releasing implementation performance metrics. For additional details on Dr. Fogler's presentation, please see the panelist introduction slides (slides 11-19).
- Kate Davidson, the CMMI Learning and Diffusion Group Director, leads multi-payer alignment efforts in collaboration with HCPLAN. Barriers to achieving all providers and payers in accountable care by 2030 include administrative burdens and collecting and analyzing data. The multi-payer alignment strategy outlines how CMMI partners with public and private payers who have invested in infrastructure and have extensive experience serving diverse care populations. For example, MCP participants will collect and report to MCP payers on the same identified quality measures. MCP uses a hyper-local approach with local infrastructure resources and allows additional design elements that fit with specific populations and priorities. For additional details on Ms. Davidson's presentation, please see the panelist introduction slides (slides 20-23).

Panelists discussed how team-based care is defined and how payment will be bundled.

- The 2025 Physician Fee Schedule (PFS) proposed rule starts with a small bundle of care management codes that are historically underutilized resources available for physicians, although they require substantial documentation for billing. There is no roadmap for constructing team-based care or defining eligibility requirements in APCM. The testing and implementation will be a multi-year effort. The goal is to translate learnings from these models to permanent pathways in traditional Medicare and to drive team-based care and payment in future years through the PFS.
- Dr. Fowler welcomed the Committee members to provide input on responses received to the Request for Information to the 2025 PFS proposed rule, once received, specifically related to bundling team-based and primary care payments.

Panelists discussed emerging universal practices addressing health equity and HRSNs across all-payer models.

[1] Pablo Cardenas delivered this presentation on behalf of Pauline Lapin

- CMMI is focused on aligning data collection efforts on race, ethnicity, language, sexual orientation, and gender identity. Many ongoing efforts are underway to support social needs screening and referrals to services provided by the local community. The Health Care Payment Learning & Action Network's (HCPLAN's) Health Equity Advisory Team (HEAT) and Accountable Care Collaborative have helped to identify best practices.
- The Accountable Health Communities (AHC) Model successfully screened HRSNs across geographies and settings at scale. Beneficiaries were eager to use navigation services, which helped providers serve complex populations.

Panelists discussed the role of APCM codes for specialty work in cognitive health.

- CMMI is discussing the long-term vision for cognitive specialists to regularly bill APCM codes for chronic conditions. Specialists are able to bill APCM codes without limitation in the short term as long as appropriate eligibility requirements are met. CMMI is considering how to drive accountability with multiple players (e.g., weighted, shared, or just primary or specialty attribution) to inform the long-term vision.
- The Guiding an Improved Dementia Experience (GUIDE) Model evaluations will inform future steps.

Panelists discussed whether there are any models related to increasing the capacity for addressing HRSNs through the safety net infrastructure.

- CMMI is not looking at developing a single model to address HRSNs.
- Health equity payment adjustments are one method that CMMI has been using to increase resources for safety net providers, including providers in rural areas.
- Jim Walton noted that indexing around health equity tends to focus on screening and referral, which can be problematic if the support services are not available in the local community. There may be opportunities to consider how the per-member-per-month (PMPM) payment could be used to help address those capacity issues.

Panelists discussed specialty spending variations of pharmaceuticals and producing downstream compensation for end-of-life care, including hospice and palliative care utilization.

- Providing data and information can illuminate where there are differential patterns of services and spending. Related to end-of-life care, CMMI has invested considerable time in building value-based care models for palliative care beneficiaries. Flexibilities and waiver authorities were built into these models to promote better care delivery. The GUIDE Model has design parameters about partnerships and CBOs that could inform the design of future palliative and hospice care models. Data sharing can facilitate partnerships with pharmacies and CBOs.

Panelists discussed who would be responsible for delivering data analytic insights.

- Data collection, reporting, and aggregation are essential to the population-level approach. CMMI is working closely with partners across HHS on policy changes and opportunities with Fast Healthcare Interoperability Resources (FHIR), application programming interfaces (APIs), and models that can support adopting this technology and infrastructure.
- CMS wants to make sure that all providers participating in models, have the data in order to understand their own performance.

- CMMI has data feedback tools across the primary care models.
- A discussion of CMMI's data sharing strategy was published in Health Affairs on August 21, 2024. Dr. Will Gordon, a clinical data informaticist at CMS, could provide further insights.

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

SMEs

- Don Calcagno, Jr., MBA, Senior Vice President, Chief Population Health Officer, Advocate Health, and President, Advocate Physician Partners at Advocate Health
- Mark McClellan, MD, PhD, Director & Professor, Business, Medicine, and Policy, Duke-Margolis Institute for Health Policy, Duke University
- Palav Babaria, MD, MHS, Chief Quality Officer and Deputy Director of Quality and Population Health Management, California Department of Health Care Services
- Michael E. Chernew, PhD, Professor, Health Care Policy, Director, Healthcare Markets and Regulation (HMR) Lab, Department of Health Care Policy, Harvard Medical School
- Charlotte S. Yeh, MD, FACEP, Founder, Yeh Innovation and Former Chief Medical Officer, AARP Services, Inc.

Lee Mills moderated the panel discussion, which featured 5 SMEs offering their perspectives on a pathway toward developing PB-TCOC models. For additional details, please see the transcript and meeting recording (00:00:01-01:27:54).

Panelists introduced themselves and provided background on their respective organizations. Full biographies and panelist introduction slides are available.

- Don Calcagno introduced himself as the Chief Population Health Officer for Advocate Health, a large, nonprofit organization serving 2.4 million patients across 6 states holding 110 value-based contracts. Success factors for value-based contracts include adaptability to policy change, a willingness to participate early, multidisciplinary clinical integration, and a sophisticated population health platform with advanced analytics and risk modeling. Mr. Calcagno introduced 2 paths, basic and advanced, for organizations to participate in TCOC models. Two key factors to consider when participating at the basic level are first, the costs to participate (both financial and opportunity costs), and second, whether the opportunity to improve care is financially beneficial. Factors to consider for participation at the advanced level include recognizing the differing roles that hospitals, specialists, and PCPs have, and managing across the care continuum. Risk-adjustment methods must incorporate factors such as frailty, SDOH, and polychronic conditions. The value-based environment is fragmented with competing CMS or CMMI programs, such as Comprehensive Kidney Care Contracting (CKCC) versus MSSP. Mr. Calcagno also provided an example of differing methods of provider identification--Tax Identification Number (TIN) in MSSP versus TIN-National Provider Identifier (NPI) in ACO REACH, for which Advocate Health spent $100,000 to comply with the TIN requirements for both models. For additional details on Mr. Calcagno's background and organization, see the panelist introduction slides (slides 2-12).

- Mark McClellan is Director & Professor of Business, Medicine, and Policy at the Duke-Margolis Institute for Health Policy at Duke University.
    - Dr. McClellan noted that he is one of the Co-Chairs of HCPLAN and referred to the HCPLAN report results shared as part of the PCDT presentation by Co-Chair Sinopoli earlier in the day. He shared that progress has been made toward whole-person care linked to total costs and outcomes; however, more work needs to be done to continue moving toward TCOC. Under both current and past administrations, CMS has committed to the goal of having all beneficiaries in an accountable care relationship. Most stakeholders also believe that shifts in payments and payer models are part of the future. There has been considerable progress with adopting models in the primary care space, which is a solid starting point to gain resources and extend the TCOC reach further along the care continuum. It is challenging to build a coordinated, integrated, sustainable care model for Medicare beneficiaries and across payers; specialized care, social services, technology support, and drugs are still primarily paid through FFS arrangements. A fundamental approach that has shown success in CMMI models, MA, and Medicaid Managed Care is to shift from FFS to a person-based payment for primary care and supplement additional services with FFS payments
    - Dr. McClellan emphasized that multi-payer alignment is essential. Primary care groups in value-based care programs may need to report on over 200 performance measures, many of which are duplicative. This does not exist within FFS where CMS uses a standard set of codes (Current Procedural Terminology [CPT], International Classification of Diseases [ICD], and Diagnosis-Related Group [DRG]). Efforts are underway to support multi-payer alignment at the state level. However, contracts cannot be realigned as quickly at the national level, making short-term CMS programs and CMMI models difficult to join. A pathway should be developed to move toward multi-payer alignment on performance measures, benchmarks, and data sharing.
    - Dr. McClellan noted that longitudinal primary and specialty care coordination is missing from the CMS priorities list. There has been some success with disease-focused models, for example, related to kidney and oncology care where the specialist is responsible for care coordination, that may potentially be nested into more comprehensive models. Further, CMS is progressing with the mandatory TEAM model for common hospital-based episodes and procedures. Some advanced MA, employer, and Medicaid plans also show promise implementing sub-capitated primary and specialist care within the same network.
    - Dr. McClellan noted that payment models should not be under FFS arrangements but rather should be based on person-focused, longitudinal care. For example, during the establishment of MA and the development of the risk-adjustment model, FFS claims data were the best data available at the time. However, if the risk-adjustment model was being designed now, data could be captured accurately and reliably through multiple modalities and incorporated into clinical dashboards with care supports such as frailty, functional status, multimorbidity, and social risk factors. While these data are easily available presently, it is difficult to apply these data to a traditional model. FFS claims data often miss some of the most significant chronic disease risks. Transitioning to more modern data can be less burdensome and provide a better basis for aligning care

reforms with performance measures. For additional details on Dr. McClellan's background and organization, see the panelist introduction slides (slides 13-27).

- Palav Babaria introduced herself as the Chief Quality and Medical Officer responsible for all VBP initiatives across the California Department of Health Care Services. Over 14 million individuals are covered by Medi-Cal. Multi-payer alignment is critical, and most practices in California caring for MA and FFS patients also are heavily involved with Medi-Cal. Efforts are underway to align managed care contract language across California public purchasers to meet downstream APMs and primary care spending expectations. Dr. Barbaria also mentioned the necessity of strengthening primary care across payers. Lastly, populations within a state can vary widely; as such, when developing efforts to align across payers, states need to consider ways to measure the full population while also taking into account various subpopulations. For additional details on Dr. Babaria's background and organization, see the panelist introduction slides (slides 28-30).
- Michael Chernew is a Professor of Health Care Policy and Director of the Healthcare Markets and Regulation Lab at Harvard Medical School. He described concerns with the "test and diffuse" paradigm as model performance depends on other available models. This paradigm creates confusion, burden, and challenges in setting benchmarks when managing multiple models. A related concern with multiple, concurrent models is that savings could be siphoned to an episode model rather than the population model, diluting the model's effects. Population-based models are preferred to move toward system-wide reform and to allow organizations to work internally to build episodes and engage specialists. When designing PB-TCOC models, it is important to avoid the "ratchet effect," improve the ability to detect stinting, provide flexibility in managing ACO activities, and coordinate ACO bonuses with primary care capitation policies. For additional details on Dr. Chernew's background and organization, see the panelist introduction slides (slides 31-35).
- Charlotte Yeh is the founder of Yeh Innovation and former Chief Medical Officer of AARP Services, Inc. Dr. Yeh stated that she brings many perspectives, including one of an emergency physician, a CMS policy administrator and regulator, and Chief Medical Officer at AARP. There are 2 significant omissions in alternative payment and TCOC models. The first is the need for beneficiary engagement, to focus on the needs, wants, and expectations of the beneficiary, and the second is the assumption that all FFS payers are uniform when they are not. Approximately 21% of Medicare beneficiaries (41% of Medicare FFS beneficiaries) pay out of pocket for Medicare supplemental plans. Opportunities exist to work with Medicare supplemental plans to promote whole-person care and reduce adverse events. Dr. Yeh elaborated on the importance of focusing on what is meaningful for the beneficiary and described 5 beneficiary values: cost, convenience, choice, coordination, and compassion. For additional detail on Dr. Yeh's background and organization, please see the panelist introduction slides (slides 36-56).

Panelists discussed the most critical factors that affect participation in accountable care relationships at the provider level and in different geographic areas. They also discussed strategies to increase participation.

- When choosing to participate in accountable care relationships, providers consider the financial impact, workflow implications, and degree of burden. Limited resources and a lack of infrastructure exist in small practices and small provider groups. Independent physicians are entrepreneurs and look to balance risk and reward.

- Risk models do not capture the risks of frailty, access, and socioeconomic status. Clinical integration can overcome these barriers.
- Benchmarks should be set with a long-term vision. Organizations consider the degree of downside risk when participating, and generally, downside risk is unnecessary for success. Models need to be simple to choose and simple to run administratively. Scale is required to succeed; if the market becomes 90% MA, increasing participation in ACOs will be difficult.
- Simplicity is essential, and there are ways to engage beneficiaries and not place full responsibility on providers. Opportunity may exist with Medicare supplemental plans; however, there are problems with how billing occurs and savings accrue. For example, care coordination efforts are currently treated as administrative expenses rather than medical expenses, so there is no incentive to increase care coordination or bring in a care coordinator. As another example, program interventions that showed reduced hospitalizations, emergency department (ED) visits, and falls are realized as savings under Medicare Part A rather than to the Medicare supplemental plans.
- Many beneficiaries may elect MA because they receive more generous benefits. Those in traditional Medicare have supplemental coverage plans, which will be vital to the future. ACOs and accountable providers need assistance across the whole spectrum of benefits. Currently, CMS is redesigning Medicare Part D to increase benefits; however, prescribers and the Part D plans bear the risk. A redesign may be more manageable within MA plans as there is more transparency and visibility into the beneficiaries' care experience than in Medicare Part D. Opportunities may exist for APMs to increase drug volume and reduce costs by releasing drugs on the market more quickly. Starting with affordability in the traditional Medicare program is important to promote beneficiary engagement.
- From practical implementation experience at the state level, there are many ways to simplify and standardize the reporting of quality measures across models.

Panelists discussed the factors most powerfully affecting primary care and specialty provider incentives to participate in an ACO or other APMs, and the design priorities for increasing participation in TCOC models over the next 5 years.

- Specialty care is complex, and it is important to keep it simple. One way to increase engagement is to provide smaller practices and physician-led ACOs with examples rather than requirements of models that engage specialties effectively. Specialty engagement in California and state transformation collaboration in North Carolina serve as strong examples for providers in ACOs looking to engage more effectively with specialists.
- Some hospital-based systems that are not fully engaged yet may participate in the MSSP. Mandatory payment steps linked to coordination and tracking functional status over time may be necessary for these groups.
- A portfolio of synergistic models is needed to increase participation in accountable care. Models that provide predictability and certainty while balancing risk and reward are key to independent participating physicians. Accurate risk adjustment should include SDOH factors, health disparities, lack of access, and frailty. In summary, increasing participation involves offering a portfolio of synergistic models, simplifying models, standardizing quality measures to eliminate burden, ensuring that success is not punished and targets are not reduced with continued success, and embedding bundled payments.

- It may be necessary to make participation in accountable care mandatory. Reducing the number of models may help solve confusion for providers and organizations about which model to join. If models are well-designed, conveners and other organizations will enable small practices to participate and leverage aspects of being a small practice. Focus should be on population health, and emphasis on episodic care should be minimized. Lastly, it is important to consider where the savings are being generated (e.g., in post-acute care) and who is responsible for receiving the savings (e.g., specialists or primary care doctors).
- Existing risk stratification and prediction models are based on utilization and cost. A clinically informed predictive risk model is currently being developed to meet the needs of the California Medicaid program.
- Emergency departments and urgent care need to be part of this discussion as two-thirds of care happens after hours.

Panelists discussed the most important incentives for encouraging FFS beneficiary participation among those not currently in an accountable care relationship.

- Beneficiaries appreciate convenience, coordination, and simplicity. Further, it may be worthwhile to measure beneficiary total out-of-pocket expenses.
- Meeting patient needs, such as receiving timely appointments, having short wait times, and finding a relatable provider, is an incentive for participation.
- It is hard to improve beneficiary participation when it is not measured consistently.
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are currently used to measure patient-reported outcomes and experience. However, CAHPS does not have a strong response rate and is available in only 2 languages (English and Spanish). Patient-reported outcome measures and universal experience measures need widespread adoption.
- Demonstrating the value of ACOs more transparently will allow beneficiaries to better understand and participate in ACOs.
- Additional benefits within traditional Medicare are billed through codes and copays. CMS has created additional billing codes for care coordination, telehealth, and remote monitoring. However, CMS has not identified how to combine billing code utilization with TCOC and beneficiary management. A two-tier solution is one option.
- ACOs must be measured to ensure that the right incentives are being provided and performance is high on cost and outcome metrics. Many MA benefits are financed with a generous Medicare advanced payment model, and ACOs would not be paid the same amount.

The panelists discussed what lessons could be learned from other markers inside and outside the U.S.

- The United Kingdom and Netherlands both have health care systems that have mandatory components and were built in a value-based care, non-FFS environment.
- It is helpful to recognize common themes, such as more robust primary care and linking some accountability for coordinating care and managing total costs. Areas of focus will differ between Medicaid, Medicare, and commercial insurance, but having state transformation collaborations is an excellent way to harmonize across payers.
- One suggestion is to inform CMMI on models that need refinement and to perform a rapid evaluation. Models must be refined based on results of the rapid evaluation.

- State transformation collaborations should occur more frequently as states consider waiver renewals.
- The MA and ACA markets require network adequacy. Because the network is defined upfront, coordination can occur more easily. Hospitals, primary care, specialists, and post-acute care should all be included within a single network.
- A care coordination effort with Medicare supplemental plans involved assigning a care manager for high-risk, high-cost patients, which resulted in reduced hospitalizations and emergency department visits. The care managers established trust with the patients and helped navigate insurance, appointments, and medications. Results from care coordination programs may take at least 12 months within the Medicare FFS environment.
- Increasing participation is largely about scalability and aligning payers.

Committee Discussion

Co-Chair Hardin opened the floor for Committee members to reflect on the day's presentations and discussions. The Committee members discussed the topics noted below. For additional details, please see the transcript and meeting recording (00:00:17-00:26:01).

- Practices should have access to data that provide information on their performance and help them understand how to manage patients. It is important to move beyond providing raw data to providing actionable data.
- Measures should be simplified, fewer measures should be developed, and standard definitions should be created across Medicare and all payers.
- Fewer models should be developed at this stage. There are too many opportunities to participate in many different models.
- Experts presented strong arguments to provide direct, positive rewards rather than move downside risk directly to physicians.
- Additional work is needed to understand how to measure beneficiary needs and incentivize activities for beneficiaries to participate in models.
- Future models should be designed to pay for team-based care.
- Benchmark ratcheting should be avoided.
- Business success drivers should be aligned with population health needs using simple methods with actionable data.
- Additional work is needed to understand what to do with the cognitive care model for specialists. Existing structures in the current hybrid models can be utilized to help specialists become part of the solution.
- Predictability and certainty are needed. It is problematic if everything is done correctly and the outcome is unpredictable.
- Success should be rewarded generously. Rewarding success can be impacted by model design (e.g., benchmark ratcheting is a model design issue), the size of incentives (e.g., 2-3% versus 10-30%), and the ways that rewards are transmitted to clinicians and groups delivering care. Democratizing and flattening data and creating financial buffers can help with rewarding success.
- Model participation decisions are not made in a vacuum. The environment in which a model operates must be considered, including predictability, certainty, and the generosity with which success is rewarded.
- The desire for fewer and simpler rational models must be balanced with the desire for more tailored models.

- It remains an open question whether participation will increase or decrease if the number of rational models is reduced.
- PCPs and providers should receive higher payments. A small bonus will not change behavior; the payment must be consequential.
- It is important to consider how to address SDOH. Some experts believe that addressing health care costs will allow more spending on SDOH, whereas others feel more spending on SDOH will reduce health care expenditures. The panelists favored the latter.
- There is an opportunity for CMS to have a significant impact on the effort to democratize and standardize data. The ability to standardize and syndicate data should not be expensive so that small and rural practices can participate.
- There are important nuances to consider when passing down incentives at the provider level and conducting quality measurement at the clinic level. Flexibility should be provided in the ACO.
- Beneficiary adoption is essential and should not be left out of realignment efforts. The cost of the beneficiary should be considered.
- Caution should be used when comparing MA and ACO models because the models have different funding mechanisms.
- There is a mismatch now and over the next 20 years between the provider community's capacity and the population's needs and demands. The physician-provider enterprise should be aligned with the population's health needs. Provider and specialty options should not be limited because of a lack of capacity across geographic locations.
- Models and payers sponsoring value-based care could be more proactive in conducting analytics. Data should be provided to physicians as actionable intelligence.
- The models are too complex. People want to work with the existing models rather than introduce new ones.
- Although there is a tendency to focus on the dichotomy between Medicare FFS and MA beneficiaries, 40% of Medicare FFS beneficiaries have Medicare supplemental plans. These beneficiaries pay more out-of-pocket but do not receive any additional benefits. If an ACO provides care management, those services are billed as administrative expenses rather than medical expenses. This issue is amendable to policy changes.
- A Committee member was unsure how they felt about an earlier point that instead of focusing on beneficiary choice and incentives, building a system in which physicians are successful should be the priority. Doing so would allow beneficiaries to receive the care they desire from their chosen physician.
- Open questions remain regarding how savings can be shared with beneficiaries, what beneficiaries want and need, and why beneficiaries choose to get a supplemental plan or go to MA.
- In the journey to value-based care, other definitions of success may be needed beyond achieving 100% beneficiary participation in an accountable relationship by 2030.
- Methods of risk adjustment need improvement. HCC scores do not work. A redesigned risk-adjustment system would not use old FFS claims data today. Frailty, functional status, and cognitive status could be alternative approaches to risk-adjustment methods.
- Some Medicare FFS codes should be revalued to move forward on the glide path toward 2030. For example, an initial patient visit is 10 times the work of a follow-up visit, but it is paid just a fraction more.
- Nearly 50% of Medicare beneficiaries are in MA plans, yet 30% or less of provider payments are based in APMs. Reframing CMS' 2030 goal may be necessary.

- There is a mismatch between supply and demand when the unit cost exceeds the payment and participation is voluntary. More investigation is needed to determine who is accountable for creating capacity.
- Involuntary model participation may be more impactful than voluntary participation.
- Risk-adjustment benchmark goals should consider a rate commensurate with inflation. Future risk-adjustment methods could be more sophisticated using LLMs. LLMs could allow industry innovation to leverage big data and create benchmarks.
- There is a universal need to address health equity through payment rates and upfront investments for building infrastructure.
- HRSNs should be addressed universally across payment models. Emerging needs are related to nutrition, transportation, and housing.
- An integrator can help support longitudinal care management and engage beneficiaries in a partnership to participate in their care.

Closing Remarks

Co-Chair Hardin adjourned the meeting.

The public meeting adjourned at 3:49 p.m. EDT.

Approved and certified by:

//Lisa Shats//	12/10/2024
_____	_____
Lisa Shats, Designated Federal Officer Physician-Focused Payment Model Technical Advisory Committee	Date