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

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

2 9:04 a.m.

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

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

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

1 We also know that this topic is of
2 interest to the Innovation Center at CMS[1]. We are
3 honored to have Dr. Liz Fowler, the Deputy
4 Administrator of CMS, and Director of the Center
5 for Medicare and Medicaid Innovation here with us
6 today to give some opening remarks.
7 Dr. Fowler previously served as
8 Executive Vice President of Programs at the
9 Commonwealth Fund and Vice President for Global
10 Health Policy at Johnson and Johnson. She was
11 special assistant to President Obama on
12 Healthcare and Economic Policy at the National
13 Economic Council.
14 From 2008 to 2010, she also served as
15 Chief Health Counsel to the Senate Finance
16 Committee Chair where she played a critical role
17 in developing the Senate version of the
18 Affordable Care Act.
19 * **Elizabeth (Liz) Fowler, JD, PhD,**
20 **Deputy Administrator, Centers for**
21 **Medicare & Medicaid Services (CMS)and**
22 **Director, Center for Medicare and**
23 **Medicaid Innovation (CMMI)Remarks**
24 Welcome, Liz.

1 Centers for Medicare & Medicaid Services

1 DR. FOWLER: Thank you, Dr. Hardin and
2 Dr. Sinopoli, for your leadership of PTAC. I'm
3 really pleased to be back here for the third
4 meeting of 2024.
5 I'm not going to say too much here at
6 the opening session, because there's a panel that
7 takes place later this morning that's dedicated
8 to the work of CMMI to advance accountable care
9 strategies and support advanced primary care.
10 And I believe I'm kicking off that session. So I
11 will spare you having to hear me speak about
12 these topics more than once.
13 But I do want to emphasize that the
14 topic for this meeting is of great importance and
15 significance to CMS Innovation Center, as you
16 said, Dr. Hardin.
17 The pathway to meeting the ambitious
18 2030 goal that CMS has laid out to have all
19 beneficiaries in traditional Medicare in care
20 relationships with a provider who has
21 accountability for quality outcomes and cost is
22 an issue we spend a lot of time talking about,
23 both within CMMI and CMS, and externally.
24 We know that value-based care and more
25 specifically, as we're discussing today and

1 tomorrow, accountable care, delivers improved
2 outcomes, a better care experience for patients,
3 and can lead to lower health care costs.
4 For providers, payment innovation and
5 incentives, like those in accountable care, can
6 facilitate movement away from the fee-for-service
7 revolving door or hamster wheel of 15-minute
8 patient visits, which means providers can really
9 spend more time focusing on patients that need
10 more attention. And they can provide better care
11 coordination and more patient-centered care.
12 The Innovation Center’s 2021 strategy
13 focused on five objectives to further the
14 Center’s vision of a health care system that
15 achieves equitable outcomes through high-quality,
16 affordable, person-centered care. The 2030
17 accountable care goal is central to achieving
18 this vision and to our overall strategy.
19 Today more than half of Medicare
20 beneficiaries are on Medicare Advantage plans,
21 and those who choose not to join MA, and want to
22 retain the full choice of providers, for them we
23 want to make sure that traditional Medicare
24 remains a viable option that provides high-
25 quality accountable care.

1 And meeting this 2030 goal really
2 requires a multi-pronged approach in coming
3 together as a community of health professionals
4 to understand the changes, opportunities, and
5 challenges of an increasingly complex health
6 system in order to move the needle on broad
7 health system transformation.
8 I’m really looking forward to the
9 discussion today, and we are so pleased to be
10 invited back by PTAC for another CMS panel
11 discussion at this meeting.
12 As I mentioned, I’ll be kicking off
13 the CMS panel where you’ll hear from the
14 Innovation Center senior leaders who’ve been
15 working and leading different parts of our
16 strategy and making progress towards that goal.
17 We’ll be presenting on top priorities,
18 including our vision for primary care, an update
19 on our accountable care vision, our strategy for
20 engaging specialists, and the hard work of
21 aligning across different payers.
22 During the discussion today and
23 tomorrow, PTAC is going to hear a lot about the
24 definitions of what qualifies as accountable
25 care. And we think this could be considered sort

1 of part one of the discussions. We plan to have
2 a lot more to say about how we're thinking about
3 that at the Learning and Action Network annual
4 meeting in November in Baltimore.
5 But I want to highlight how we're
6 thinking about measuring progress towards our
7 accountable care goals, starting with how we
8 define accountable care. And we're focused on
9 that longitudinal care relationship which we
10 define as longer than six months and with
11 accountability for total cost of care and
12 quality.
13 Six months means longer than a knee
14 replacement or acute episode of care and really
15 focused on providers who are addressing chronic
16 health issues that can sometimes be hard to
17 address in a first or single visit with a
18 clinician.
19 We think we've made important progress
20 here, and we'll speak more about that at the CMS
21 panel. But today's focus should not just be on
22 what we've done but where we're going in the
23 future over the next five and a half years.
24 We look forward to hearing from all
25 the speakers that you've lined up. It's going to

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

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

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

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

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

1 components for success. Organizational structure,
2 payment, and financial incentives for supporting
3 accountable care relationships, developing a
4 balanced portfolio of performance measures, and
5 addressing challenges regarding data,
6 attribution, benchmarking, and risk adjustment.
7 The background materials for this
8 public meeting, including an environmental scan,
9 are posted online on the ASPE[2] PTAC website's
10 meeting page. Over the next two days, we will
11 hear from many esteemed experts with a variety of
12 perspectives, including the viewpoints of
13 previous PTAC proposal submitters.
14 Later this morning, CMS and CMMI
15 leadership will join us for a panel discussion
16 and share their vision to achieve the goal of
17 having all beneficiaries in an accountable care
18 relationship by 2030.
19 I also want to mention that tomorrow
20 afternoon we'll include a public comment period.
21 Public comments are limited to three minutes
22 each. If you would like to give an oral public
23 comment tomorrow but have not yet registered to
24 do so, please email ptacregistration@norc.org.

2 Assistant Secretary for Planning and Evaluation

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

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

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

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

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

3 Health and Human Services

1 about submitting a proposal on the ASPE PTAC
2 website.
3 * **PTAC Member Introductions**
4 At this time, I would like my fellow
5 PTAC members to please introduce themselves.
6 Please share your name and organization, and if
7 you would like, feel free to describe any
8 experience you have with our topic. We'll go
9 around the table, and then I'll ask our members
10 joining remotely to introduce themselves.
11 So I'll start. I'm Lauran Hardin, and
12 I'm Chief Integration Officer for HC2 Strategies
13 and a nurse by training. I spent the majority of
14 the last 20 years focused on care model and
15 population health, initially care management and
16 MSSP[4], pioneer ACO[5] and BPCI[6].
17 I was part of the team that started
18 the National Center for Complex Health and Social
19 Needs, and I've spent the last 15 years focused
20 on underserved and complex populations and
21 designing models to meet their needs.
22 Angelo, would you go next?
23 CO-CHAIR SINOPOLI: Yes, thank you,

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

1 Lauren. Angelo Sinopoli, I'm a pulmonary
2 critical care physician by training. I've worked
3 with several large integrated delivery systems
4 and built clinically integrated networks, as well
5 as enablement companies to support those networks
6 and others. And I'm looking forward to the next
7 two days.
8 CO-CHAIR HARDIN: And then let's go to
9 Josh next. Apologies, Jim.
10 And Josh, you are muted. There you
11 go.
12 DR. LIAO: Okay, just wanted to make
13 sure we're going to the web. Good morning,
14 everyone, Josh Liao. I'm an internal medicine
15 physician by training and a professor of medicine
16 and public health at University of Texas,
17 Southwestern Medical Center.
18 Outside of work on this Committee,
19 I've been really fortunate to work on physician-
20 focused payment models in a variety of contexts,
21 one, leading a portfolio of research and
22 evaluation on the topics for episode-based and
23 population-based models and how they interact.
24 In the past, I then served in a kind
25 of leadership capacity to think about payment

1 strategy, and population health, and primary care
2 networks for an integrated regional delivery
3 system and through a variety of engagement with
4 stakeholders and decision-makers.
5 CO-CHAIR HARDIN: Thank you, Josh.
6 And, Larry?
7 DR. KOSINSKI: Thank you, Lauren. I'm
8 Larry Kosinski. I'm a gastroenterologist by
9 training. And after a long career of 35 years in
10 practice in the Chicagoland area, I have devoted
11 the last 10 years of my life to value-based care
12 solutions in the specialty space, specifically
13 dealing with chronic disease.
14 I founded SonarMD which is a national
15 value-based care solution now for patients with
16 inflammatory bowel disease. And I'm now in my
17 third year on the PTAC Committee.
18 CO-CHAIR HARDIN: Thank you, Larry.
19 And Jim, let's go to you.
20 DR. WALTON: Good morning, it's good
21 to be here. My name's Jim Walton. I am a Dallas,
22 Texas, general internal medicine physician
23 retired from internal medicine practice at
24 Waxahachie, Texas. And then I was a CEO. I'm

1 president of an ICO[7] in Dallas for about 10 years
2 and just retired. It's good to be here.
3 DR. MILLS: Good morning, my name's
4 Lee Mills. I'm a family physician by training.
5 I currently am a consultant, but I spent four
6 years as chief medical officer of a regional
7 provider-owned health plan operating in the
8 Medicare Advantage individual exchange commercial
9 space.
10 Over my practice career, I have
11 practiced within, helped operate or lead five
12 different CMMI models and two different ACOs. So
13 thanks, glad to be here.
14 DR. BOTSFORD: Good morning, I'm
15 Lindsay Botsford. I'm a family physician in
16 Houston, Texas, where I also serve as a regional
17 medical director with Amazon One Medical.
18 I also serve as the chair of the Iora
19 Health Network governing body, an ACO REACH[8]
20 entity. I have been in a variety of different
21 payment models including ACOs, MSSP track, and
22 currently see patients as well.
23 DR. FELDSTEIN: Good morning, I'm Jay

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

1 Feldstein. I've trained as an emergency medicine
2 physician. I was in the health insurance world
3 for 15 years handling commercial and government
4 programs.
5 And for the last 10 years, I've been
6 the president of Philadelphia College of
7 Osteopathic Medicine trying to get our physician
8 workforce ready for this new world of total cost
9 of care and value-based care.
10
11 DR. WILER: Good morning, I'm Jennifer
12 Wiler. I'm a tenured professor at the University
13 of Colorado School of Medicine and practicing
14 emergency physician. I've spent the last 20 years
15 primarily on the delivery side working with small
16 and large provider group practices in various
17 leadership roles and also hospital executive
18 leadership in quality and safety.
19 I'm also a co-founder of a health
20 system innovation center where we partner with
21 digital health start-ups to grow and scale their
22 solutions to improve value in care and was also a
23 co-developer of an Alternative Payment Model that
24 this Committee considered and approved.
25 DR. LIN: Good morning, Walter Lin,

1 founder of Generation Clinical Partners. We are
2 a group of providers in the Greater St. Louis
3 area passionate about the care of the medically
4 complex and seriously ill residing in senior
5 living. We are involved with a number of
6 different value-based programs, including
7 specialized ACOs, Institutional Special Needs
8 Plans, as well as the PACE[9] program.
9 DR. PULLURU: Good morning, Chinni
10 Pulluru. I'm a family physician, practiced for
11 about 15 years. I spent about 20 years in value-
12 based care transformation leading clinical
13 operation strategy and access, first at Duly
14 Health in their subsidiary MSO[10], about 5,000
15 physicians, and then as chief clinical executive
16 at Walmart Health.
17 I've developed and led an
18 implementation across the risk continuum to
19 produce, in both Medicare and commercial, to
20 produce quality and financial outcomes. I also
21 sit on the Board of Stellar Health and work with
22 them in value-based care transformation. And
23 most recently I've co-founded a genetics company.

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

1 CO-CHAIR HARDIN: Thank you all so
2 much. As you can see from this group, we have a
3 diverse group of perspectives on value-based
4 payment. And we appreciate each of your
5 contributions.
6 So next let's move to our first
7 presentation. Five PTAC members served on the
8 Preliminary Comments Development Team, or PCDT,
9 which has collaborated closely with staff to
10 prepare for this meeting.
11 Angelo Sinopoli was the PCDT lead with
12 participation from Jim Walton, Josh Liao, Lee
13 Mills, and Chinni Pulluru. I'm thankful for the
14 time and effort they put into organizing today's
15 agenda. The PCDT will share some of their
16 findings from the analysis to set the stage and
17 goals for the meeting.
18 PTAC members, you will have an
19 opportunity to ask questions afterwards. Now I
20 will turn it over to Angelo.
21 * **PCDT Presentation - Identifying a**
22 **Pathway Toward Maximizing**
23 **Participation in PB-TCOC Models**
24 CO-CHAIR SINOPOLI: Thank you, Lauran.
25 And I'd like to also start out by thanking my

1 fellow PCDT members and the ASPE team and NORC
2 teams for all their time and hard work gathering
3 this information and constructing this deck.
4 We hope this presentation will provide
5 some background and context for the discussions
6 with our presenters and panelists over the next
7 two days.
8 So the objectives of this theme-based
9 meeting are to discuss the vision for future
10 accountable care relationships and identifying
11 pathways toward having all Medicare beneficiaries
12 with Parts A and B in some type of accountable
13 relationship by 2030, and to understand the
14 necessary components for success in developing
15 population-based total cost of care models for
16 different types of providers.
17 To discuss the organizational
18 structure, payment, and financial incentives
19 needed to support population-based total cost of
20 care models, and to identify approaches for
21 addressing key issues and challenges, such as
22 performance measures, attribution, benchmarking,
23 and risk adjustment related to facilitating
24 accountable care relationships in population-
25 based total cost of care models.

1 To set some context for this theme-
2 based meeting, PTAC has received 35 proposals for
3 physician-focused payment models. Nearly all of
4 these proposals address the potential impact on
5 cost and quality to some degree.
6 Committee members found that 20 of
7 these proposals met Criterion 2, which was
8 Quality and Cost, including five proposals that
9 were determined to meet all 10 of the criteria
10 established by the Secretary for physician-
11 focused payment models.
12 Additionally, at least nine other
13 proposals discussed the use of TCOC measures in
14 their payment methodology and performance
15 reporting.
16 Now to move on to give you a little
17 bit of background, PTAC is using the following
18 working definitions of an accountable care
19 relationship. That is a relationship between a
20 provider and a patient, or group of patients,
21 that establishes that provider as accountable for
22 quality and total cost of care, including the
23 possibility of financial loss or risk, for an
24 individual patient or group of patients for a
25 defined period of time.

1 It would typically include
2 accountability for quality and total cost of care
3 for all of the patient's covered health care
4 services. This definition will likely continue
5 to evolve as the Committee collects additional
6 information from stakeholders.
7 PTAC is using the following working
8 definition of population-based total cost of care
9 models. So that is an Alternative Payment Model
10 in which participating entities assume
11 accountability for quality and total cost of care
12 and receive payments for all covered health care
13 costs.
14 I'll note that in this model it does
15 not include pharmacy-related costs at this time.
16 But for a broadly defined population with varying
17 health care needs during the course of year,
18 within this context a population-based total cost
19 of care model would not be an episode-based, a
20 condition-specific, or a disease-specific
21 specialty model.
22 However, these types of models could
23 potentially be nested within a population-based
24 total cost of care model. This definition will
25 also likely continue to evolve as the Committee

1 collects additional information from
2 stakeholders.
3 PTAC has identified the following key
4 questions for identifying pathways toward having
5 all Medicare beneficiaries with Parts A and B in
6 accountable care relationships.
7 One is categorizing Medicare
8 beneficiaries by the extent to which they are
9 currently in care relationships with
10 accountability for quality and total cost of
11 care; for characterizing geographic areas by the
12 extent to which their providers are participating
13 in value-based care; identifying model
14 characteristics associated with success;
15 developing approaches, models, target time
16 frames, and intermediate area status for
17 increasing involvement in accountable care
18 relationships for various categories of Medicare
19 beneficiaries, example, dual eligibles; and
20 identifying and addressing gaps and challenges.
21 As you can see from this graph from
22 2021, half of Medicare beneficiaries were in
23 traditional fee-for-service. Half of those that
24 were in traditional fee-for-service were in some

1 type of APM[11]. The vast majority of those were in
2 an MSSP ACO with a smaller amount in a CMMI ACO,
3 and then a small amount in other CMMI models.
4 This is just a reminder of the LAN
5 framework for supporting the transition to
6 Alternative Payment Models payment. And you can
7 see as it progresses from left to right, moving
8 from fee-for-service to Category 4, which are
9 population-based payment models.
10 And this is just a reminder that PTAC
11 at the moment is interested in Category 3B which
12 are models of shared savings and downside risk,
13 and population health models.
14 So as we take those definitions and
15 those interests, and we look at the percentage of
16 payments to providers by Alternative Payment
17 Model category and payer type in 2022, in
18 aggregate that was about 25 percent of all
19 payments.
20 For commercial, it dropped to about 16
21 and a half percent, for Medicaid, 18.7 percent,
22 for Medicare Advantage, about 39 percent. And
23 for traditional Medicare, it was about 30 percent
24 of all those payments going through a Category 3B

11 Alternative Payment Model

1 or Category 4.
2 As you can see from this graphic,
3 multiple APM models have been tested over the
4 last decade. Testing various CMMI and CMS models
5 from 2012 to the present has significantly
6 advanced our understanding of APM model design
7 and adoption.
8 Over time these models have provided
9 key insights into how value-based care can
10 improve quality and reduce cost in health care.
11 Although there have been many episodic bundles,
12 as you can see from the lower half of this slide,
13 the Committee is interested today in the
14 population health and advanced primary care
15 models.
16 The key contributions from the testing
17 over these years has been a gradual shift towards
18 risk with MSSP beginning with upside-only risk
19 and then moving to pathways to success which
20 pushed ACOs toward two-sided risk. Some of these
21 have emphasized care coordination such as Primary
22 Care First and CPC+[12]. Others have emphasized
23 health equity such as Making Care Primary in the

12 Comprehensive Primary Care Plus

1 AHEAD[13] model.

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

7 This iterative testing has led to more
8 sophisticated, tailored models that are better
9 suited to diverse health care environments and
10 needs. But much work needs to be done to
11 determine which models work best and what
12 components need to be integrated as we move to
13 2030.

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

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

---

13 States Advancing All-Payer Health Equity Approaches and Development

1 the addition of Track 1+ which had less downside
2 risk than Tracks 2 or 3 and were designed to
3 encourage more practices, especially small
4 practices, to advance to performance-based risk.
5 In 2019 there was the development of
6 Pathways to Success which had a basic track that
7 started with one-sided risk, shifted to two-sided
8 risk, then phasing in higher levels of risk over
9 time.
10 There was also the enhanced track
11 which had the highest two-sided risk option for
12 more experienced and high-revenue ACOs. ACOs
13 were automatically advanced to the next step on
14 the glide path at the start of each performance
15 year.
16 You can see that from 2012 to 2024
17 that we had increasing numbers of ACOs up until
18 about 2018. Since then, we've had some decrease
19 in the number of ACOs with a leveling off over
20 the last few years. Despite that, we've had
21 increased beneficiaries from 1.7 million
22 beneficiaries to today, to 10.8 million
23 beneficiaries.
24 So the key changes in CMMI model
25 design over time was increasing financial

1 accountability, accommodating providers less able
2 to take on risk, reducing provider burden,
3 increasing the duration of the models, supporting
4 low-revenue ACOs, incorporating health equity,
5 and incorporation of specialists into the models.
6 The Committee thought about various
7 inter-related factors affecting beneficiary
8 practice alignment with APMs. Certainly the
9 first factor to consider is the provider
10 themselves. And things that may help predict
11 their participation include the provider type,
12 their panel size, their already existing level of
13 clinical integration, and their previous
14 experience with value-based care infrastructure
15 and processes.
16 As we move further out to more of a
17 community-level set of factors, such as the
18 primary care provider capacity in that community,
19 provider market consolidation, the number of
20 providers that are actually employed, and the
21 presence of community-based organizations that
22 help these practices address the significant
23 social determinants of health that may be in
24 their market.
25 And, from a broader geographic factor,

1 the penetration of Medicare Advantage and the
2 penetration of MSSP, the socioeconomic status and
3 the Area Deprivation Index in the markets in
4 which these practices exist, and the rurality of
5 the geography in which they practice.
6 Certainly other enabling policies such
7 as the predictability of the APM models in their
8 area, the availability of APM models for
9 different types of providers, and the
10 relationships between APM models and other
11 options in the community.
12 As you can see on the right, ACO
13 participation was less likely in rural areas,
14 less likely in the West, and less likely in lower
15 MA penetration markets.
16 So we're going to move on now to some
17 analysis from ASPE. So ASPE did an analysis on
18 characteristics of the beneficiaries attributed
19 to APMs and the geographic participation in APMs.
20 Some of the research questions included which
21 providers are participating in various types of
22 APMs, and where are these providers located, and
23 how has it changed over the last decade?
24 How does provider participation affect
25 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

1 million beneficiaries in Medicare with Parts A
2 and B, that about half of those were in some type
3 of APM as mentioned previously.
4 As we look at those beneficiaries,
5 what we find is that the vast majority of those,
6 in this case, 36.8 percent, were in MSSP. Only
7 five percent were in other CMMI models like REACH
8 models.
9 And then when you moved on to other
10 CMMI models, there were very small percentages of
11 beneficiaries participating with the exception of
12 Advanced Primary Care which is about 5.6 percent.
13 So the characteristics of
14 beneficiaries who were attributed to APMs in
15 2021, in MSSP, CMMI, ACOs, and advanced primary
16 care models, were more like likely to be white,
17 female, and living in metropolitan areas.
18 Beneficiaries in chronic conditions
19 models were more likely to be Black, Hispanic,
20 male, and to have significantly higher mortality
21 and higher average risk scores.
22 In 2021 roughly 38 percent of fee-for-
23 service beneficiaries had no history of APM
24 attribution from 2012 to 2020. They were more
25 likely to be Black or Hispanic, dual eligible,

1 living in micropolitan or rural areas, and to
2 have lower risk scores.
3 This is just a heat map to represent
4 the growth of APM penetration between 2013 and
5 2022. You can see on the left in 2013 there was
6 a penetration of about 15 percent across the
7 country with scattered participation mostly on
8 the East Coast and Midwest.
9 As we move to 2022 on the right, you
10 can see much more penetration in 2022 of about 49
11 percent, but still most of that participation
12 along the East Coast and the Midwest, with less
13 participation on the West Coast and certainly
14 less participation in the states that certainly
15 had more rural geographies.
16 There's continued to be an increased
17 participation in APMs year over year between 2012
18 and 2022. Even in the rural areas and
19 micropolitan areas, you can see the significant
20 increase but still, because of where they
21 started, lag behind, so certainly in the rural
22 areas an opportunity to focus on increasing
23 participation in those markets.
24 This is another heat map that looks at
25 the significant variation in APM penetration

1 rights and Area Deprivation Index. And as you
2 can see, there's a correlation in that the higher
3 the ADI along that bottom axis, the lower
4 participation in APM models. And contrary, the
5 areas that have higher participation in APM
6 models, there's a lower ADI rating.
7 And as you can see from the heat map,
8 again, those areas of the country that have
9 higher ADI penetration is mostly the East Coast
10 and the Midwest with less ADI issues on the West
11 Coast and some of the rural states.
12 Another interesting factor in
13 participating with APM models is that what we see
14 is that beneficiaries entering an APM model on
15 average have more diagnoses of cardiovascular
16 risk factors, chronic kidney disease, and some
17 other chronic conditions within the first two
18 years of participation. The highest rate being
19 in first year but continued increased diagnosis
20 in the second year which is higher when compared
21 with those that did not participate in an APM.
22 So key takeaways from this ASPE
23 analysis include nearly half of all Medicare fee-
24 for-service beneficiaries were not in APMs in
25 2021. There has been significant growth and

1 variation in APMs over the last decade among
2 Medicare fee-for-service beneficiaries across the
3 United States.
4 Rural counties are still significantly
5 behind in APM participation. Many high ADI
6 counties still have low APM penetration rates and
7 can be a potential target for CMMI health equity
8 models. And APM participation on average
9 increases the diagnosis of certain cardiovascular
10 risk factors and chronic conditions.
11 So we're going to talk now about some
12 potential factors for forming a vision for future
13 models and the necessary components within those
14 models.
15 So the potential factors for forming a
16 vision included the ability to implement a
17 comprehensive framework for population-based
18 total cost of care encompassing population-based
19 models and advanced primary care models, develop
20 multiple pathways with varying levels of risk for
21 different types of organizations to encourage
22 participation in population-based total cost of
23 care models, to align incentives across
24 population models, other Medicare accountable
25 care programs, and all payers to encourage high-

1 value care in all settings.
2 To ensure consistency and longevity in
3 population-based total cost of care models, to
4 involve primary and specialty care providers with
5 clear and complementary roles in accountable care
6 relationships, and to address disparities and
7 health-related social needs by incorporating
8 health equity-related objectives.
9 Potential components for successful
10 models include facilitating participation of a
11 full range of providers in different geographic
12 areas, integrating specialists with a multi-
13 disciplinary patient care team to maintaining
14 patient choice, attributing each patient to an
15 entity or provider that is accountable for their
16 quality outcomes and total cost of care.
17 Providers must have sufficient data to
18 manage their patient care and to ensure timely
19 and usable data at an organization, practice, or
20 provider level to determine their performance.
21 Other components include providing
22 clear incentives for value-based payment, paired
23 with disincentives for fee-for-service payment,
24 questions like should financial risk and savings
25 be shared downstream at the individual provider

1 level, should downsizing risk be incorporated
2 where appropriate, aligning financial incentives
3 across all types of providers, ensuring
4 predictability and adequacy of payments that
5 allows providers and practices to invest in
6 longer-term care transformation activities.
7 And this slide just depicts the need
8 to consider multiple participation tracks based
9 on the nature and size of the organization
10 participating in the APM.
11 As we can see, moving from the small
12 low-revenue PCP[15] practices on the left to larger
13 high-revenue integrated systems on the right,
14 there's likely to be an increasing ability for
15 those organizations to take downside risk and to
16 develop the required expertise and analytics to
17 be successful. And so as we think about various
18 models, we need to take these factors into
19 consideration.
20 So we'll move to potential milestones.
21 So as we think about milestones and components
22 needed to achieve the accountable care
23 relationship goal for 2030, milestone one would
24 be to create a widespread participation in these

15 Primary care provider

1 models to make accountable care a financially
2 viable choice, to adapt the level of financial
3 risk based on organizational characteristics,
4 simplify administrative and technical burden of
5 participation, increase participation in high
6 Area Deprivation Index areas to also support care
7 transformation, to meaningfully engage and
8 integrate primary and specialty care providers in
9 population-based models, to provide technical
10 assistance and resources to build infrastructure,
11 to address technical issues related to
12 attribution, benchmarking, and risk adjustment,
13 to identify and provide health-related social
14 needs to applicable beneficiaries.
15 And the third might be to increase the
16 predictability of population-based total cost of
17 care model elements such as standardized
18 technical aspects of calculations where possible,
19 consider introducing a multi-payer framework into
20 population-based total cost of care models,
21 require all models to collect the same or similar
22 data elements regarding social determinants of
23 health.
24 So we'll move on to addressing some of
25 the technical issues and challenges. So we have

1 earlier discussed the potential broad provider
2 and community factors that facilitate or impair
3 participation in APMs such as provider types and
4 community factors that facilitate or impair
5 participation in APMs.
6 The technical topics are in the
7 middle, and these technical topics are in the
8 shaded area and emphasize the components needed
9 to be addressed from learnings from the past
10 decade of testing to develop processes,
11 infrastructure, and policy to facilitate
12 participation across multiple practice types and
13 geographies to be successful in total cost of
14 care models.
15 We hope to get some insights today
16 from our presenters and panelists to make
17 recommendations regarding policy to support these
18 issues.
19 Challenges for increasing
20 participation in total cost of care models
21 include complexity of the number and types of
22 APMs. The duration of many APMs is not long
23 enough to allow successful implementation.
24 The administrative and infrastructure
25 burden to participation, particularly for small

1 and rural practices, traditional fee-for-service
2 is profitable and does not include risk bearing.
3 Health equity is not a central component of many
4 models. Practices may face challenges with
5 expertise, technology, and cost to participate in
6 APMs. We need to develop new infrastructure.
7 Financial downside risk involved with
8 cost sharing in some APMs is prohibited. And the
9 ability to collect and analyze the necessary
10 performance data is difficult. Barriers are
11 particularly acute for small low-revenue rural
12 practices as mentioned before.
13 Other potential barriers include the
14 size of the practice and patient population.
15 Practices with fewer providers, fewer Medicare
16 beneficiaries within their practices, and a lower
17 proportion of PCPs who are less likely to
18 participate in payment reform programs.
19 The costs associated with ACO
20 participation, Rural Health Clinics, for example,
21 that joined an ACO, experienced a substantial
22 increase in their mean cost per visit over two
23 years compared to RHCs[16] that did not join an ACO.
24 ACO participation decisions may be

16 Rural Health Clinics

1 primarily made by other organizations. This is a
2 reminder that the majority of physicians today
3 are employed reaching about 77 percent in 2024.
4 So perspectives on developing a
5 pathway towards a 2030 goal of having all
6 beneficiaries in care relationships with
7 accountability for quality and outcomes in TCOC
8 is the purpose of this public meeting today.
9 Stakeholder perspectives on the
10 pathway towards developing population-based total
11 cost of care, organizational structure, payment
12 and financial incentives for supporting
13 accountable care relationships, developing a
14 balanced portfolio of performance measures for
15 population-based models, and addressing
16 challenges regarding data, benchmarking, and risk
17 adjustment.
18 And that's the end of my presentation,
19 Lauran.
20 CO-CHAIR HARDIN: Thank you, Angelo,
21 and the PCDT team. That was an incredible
22 presentation and wonderful research as well by
23 ASPE and NORC.
24 Do any of our Committee members have
25 additional comments or any of the members from

1 the PCDT want to add additional comments to
2 Angelo's presentation? And if to, put your name
3 tent up or raise your hand on Zoom.
4 Jim, go ahead.
5 (Simultaneous speaking.)
6 CO-CHAIR HARDIN: Chinni, go ahead.
7 DR. PULLURU: Thank you, Angelo, that
8 was awesome. So, you know, this isn't a
9 question, but it's a comment on what was
10 presented that I think is really important, is
11 that as we look to get more participation in
12 models, especially as people -- we want people in
13 Medicare to go from fee-for-service to
14 accountability, especially at risk, the important
15 thing to realize is that it doesn't exist in
16 silo, and it exists in the context of Medicare
17 Advantage, social vulnerability, and other
18 factors that are provider-based.
19 And I think that was the thing that
20 Angelo's presentation very clearly articulated,
21 that we have to look at it in context.
22 CO-CHAIR HARDIN: And, Jim?
23 DR. WALTON: Thank you. Thank you, it
24 was great. It's been great working with you, and
25 the PCD team. Really, it was a wonderful study

1 by all involved, and thanks for your leadership.
2 CO-CHAIR SINOPOLI: Thank you.
3 DR. WALTON: -- and your comments.
4 I was struck by the slides 20 and 21 -
5 - 21 and 22. And the idea that APMs are finding
6 more chronic diseases is encouraging all, you
7 know, us all that the models are probably
8 working, in so much as helping find more chronic
9 illness in American elders and dual eligibles.
10 And, I think, to some extent that point might
11 need to be elevated.
12 What's interesting is when we look at
13 regional differences, if that is indeed the case,
14 then differences in participation in APMs between
15 regions would be significant. Because you're not
16 finding as much disease out in the field.
17 And what we know is that a lot of the,
18 and the heat map was amazing, right, and it tells
19 us that we have some place to go look. And we
20 see this correlation between high ADI regions, or
21 areas, or counties, and lower participation. And
22 we see a trend there, and it probably is
23 significant since we reported it.
24 And as such, it could be that there's
25 an association between high ADI and high social

1 determinants of needs, higher frustration with
2 providers, because they have less capacity to
3 absorb that challenge. And so they opt not to
4 participate.
5 And we know, based on, you know, my
6 experience, when you develop an APM, an ACO
7 contract, we end up with resources to providers
8 to augment what they do day in and day out with
9 every patient.
10
11 So as doctors chose to opt out of that
12 because of the complexity of change, or the lack
13 of resources in a community that addresses social
14 determinants of health, that then I think has
15 given us the opportunity, I suppose, to talk
16 further about the non-medical determinants of
17 health residing within a high ADI community and
18 the providers.
19 The FQHC[17] is a perfect example. You
20 mentioned that their costs went up significantly
21 by participating, while their rates are their
22 potential compensation to pay themselves back
23 from shared savings, doesn't materialize. Maybe
24 because they don't document quality very good, or

17 Federally Qualified Health Center

1 maybe because they don’t have access to
2 admissions, and discharges, and transfer data.
3 Because the HIE[18] isn't working in the community,
4 or they just never had one.
5 So you see I’m pontificating, right.
6 So I think the changes that are required in the
7 practice of medicine inside APMs is stressful for
8 physicians and providers. But it’s necessary,
9 because it’s actually -- something’s happening.
10 But we see a disparity in participation which is
11 saying, in my community, we can’t achieve this.
12 I was in rural Oklahoma a few weeks
13 ago and found a clinic. And FQHC says could you
14 help -- and I asked them to be here today, I said
15 you help us get access to LGB –- GLP1[19] drugs?
16 They just have a limited access in the pharmacy,
17 because they’re out in rural America. And also
18 maybe the costs are tied to demand and supply.
19 So therefore, they may suggest that
20 their -- that might suggest that their diabetes
21 control data might be skewed, you know, this year
22 versus last year. And maybe they didn’t make as
23 much progress, because they had less access to

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

1 drugs.
2 So I think that this an amazing study,
3 and I'm excited about where this is going to take
4 us.
5 CO-CHAIR HARDIN: And again I think we
6 could make many comments and continue the
7 dialogue, but unfortunately, we have to move to
8 break. But I want to again thank the PCDT, and
9 Angelo for your leadership, for this very
10 comprehensive and helpful analysis.
11 So at this time, we have a break until
12 10:00 a.m. Eastern. So please join us then, as
13 we have a great lineup for our first panel
14 discussion on perspectives on developing a
15 pathway towards the 2030 goal of all
16 beneficiaries in a care relationship with
17 accountability for quality outcomes and total
18 cost of care.
19 We'll see you back at 10:00 a.m.
20 (Whereupon, the above-entitled matter
21 went off the record at 9:55 a.m. and resumed at
22 10:01 a.m.)
23 * **Panel Discussion: Perspectives on**
24 **Developing a Pathway Toward the 2030**
25 **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

1 very robust discussion.
2 First, we have Dr. Michael McWilliams,
3 who is the Warren Alpert Foundation Professor of
4 Health Care Policy and Professor of Medicine in
5 the Department of Health Care Policy at Harvard
6 Medical School. Michael, welcome. Please go
7 ahead.
8 DR. McWILLIAMS: Thanks very much.
9 It's really a pleasure to be with you all today
10 and before getting onto the substance, I just
11 want to reiterate what's in my disclaimer here,
12 which is that I am here with you today as me, as
13 a professor and not in my capacity as an advisor
14 to the Innovation Center. If you could just
15 forward to the next slide.
16 I know the main theme today is
17 participation, but I do want to just level set a
18 bit and note that the goal, the ultimate goal,
19 isn't participation per se, it's we want success,
20 right, and we can debate what success means.
21 But I think it's important for us to
22 talk about participation, not as if we've already
23 figured out the payment models entirely and we
24 just sort of need to coax providers into them or
25 help them succeed, although those things are very

1 important, whether that's through temporary
2 participation bonuses or more technical
3 assistance. I think it's also really important
4 to think about participation as an outcome or
5 marker of sound model design. Because a big
6 reason why we're sort of stuck at 50 percent
7 participation is that the models have basically
8 been designed in a way that can never be
9 advantageous to more than roughly half of
10 providers, even if all providers are capable of
11 succeeding, of generating savings.
12 I tend to think about the goal less as
13 sort of reaching 100 percent participation and
14 more as designing a population-based payment
15 system that gives all providers a chance to gain
16 from doing what it is that we want them to do.
17 Second sort of high-level point here
18 is that ideally, we could articulate a long-term
19 vision for how we want the payment system to be
20 designed and then backs off. A lot of the
21 activity so far has been framed in a sort of more
22 test and scale mindset in which we seek to try a
23 bunch of things, see what moves the needle, and
24 then with an eye to expand on what does. That
25 kind of assumes that short-term progress should

1 dictate long-term policy. I think that mindset
2 has made reform and discussions a little bit more
3 myopic and more atheoretical than it ought to be.
4 And it also fails to acknowledge that there are
5 trade-offs involved. At some point, roads will
6 diverge, and we'll need to choose a path.
7 So instead, I think we can and should
8 think through how various approaches might play
9 out a bit more, try to arrive at an informed
10 direction, then head in that direction in a more
11 deliberate fashion and still while evaluating and
12 recalibrating and pivoting as needed along the
13 way.
14 As an aside, I would say the same
15 about sort of broader Medicare reforms. We really
16 just need to have more discussions about what we
17 want the program to look like and why.
18 Next sort of high-level point, the
19 complexity in the models has gotten really out of
20 hand. This has been sort of brewing for a while.
21 The model proliferation has been a problem, just
22 the sheer number of models, but also each model
23 can get really complicated in its own right. And
24 I think this happens in part because when the
25 destination isn't super clear, a model can take a

1 sort of circuitous route collecting baggage along
2 the way and needing sort of rule changes on the
3 fly. And then there's also been a tendency to
4 pack each model full of its own quality metrics
5 and requirements, and all this creates an
6 administrative burden for providers that makes
7 participation more costly.
8 So my general view is that at this
9 point we should be focusing on fewer models and
10 making them simpler and better and more
11 harmonized.
12 As I've been alluding to, the design
13 of the model is really critical. So, we get out
14 of APMs what we design them to do. What we've
15 seen so far, the modest savings, the selective
16 participation, is all quite predictable based on
17 the model design. I think this has been
18 generally underappreciated in the policy debate
19 with many people conflating the concept here with
20 the execution and concluding that we should just
21 abandon the concept rather than try to improve on
22 the design.
23 And there's a ton of technical stuff
24 here to dig into. Hopefully, we have time to do
25 so. Very briefly, I've sort of listed some of

1 the main issues here with the shared savings
2 program in mind. Savings rates probably need to
3 be higher. Need to work on benchmarks, so that
4 the incentives to participate and save are
5 stronger. The goal is probably not to get
6 everyone in a downside risk contract. In fact,
7 downside risk can be counterproductive in a
8 voluntary model. In contrast to MA plans, ACOs
9 are pretty limited in how they can share savings
10 with beneficiaries, so that's one direction we
11 can think about is how can the savings be shared
12 more directly with patients in more visible ways
13 that can help expand ACO participation as
14 providers sort of compete to attract patients.
15 And then obviously, a lot of work to be done on
16 risk adjustment.
17 And then, a few final points at the
18 bottom here. Maybe I'll jump to the primary care
19 payment reform bullet. Primary care payment
20 reform has been a big topic of late, receiving a
21 lot of attention, probably less attention on how
22 it should fit in with the total cost of care
23 population-based payment system. The key point
24 there, I think, is we can go further with primary
25 care payment reform in the context of an ACO

1 contract because there is less concern about cost
2 shifting and the resources from an added payment
3 should be used more efficiently. I think the
4 recent ACO Flex model is a really good model to
5 build on there.
6 In terms of the portfolio that we
7 want, I tend to favor a streamlined portfolio
8 with a foundational population-based payment
9 system with a fairly limited set of episode-based
10 payments.
11 And then finally, the multi-payer
12 issue here is huge, and this comes up a lot. But
13 I do want to just emphasize that it's also really
14 important to get it right in Medicare, and if we
15 can do that, that should help advance multi-payer
16 alignment to the extent that better designed,
17 more effective models are more likely to diffuse.
18 And then finally, I do want to just
19 note that while some of my comments may be
20 somewhat critical in nature, I wouldn't be a
21 self-respecting academic if they weren't, I do
22 want to commend CMS and the Innovation Center on
23 all their hard work and the progress so far,
24 which I do think has been really substantial.
25 Also, note that there are probably some statutory

1 constraints at play here that probably require
2 some congressional action at some point, and I
3 think what motivates the role for CMMI that much
4 more. So thanks very much.
5 CO-CHAIR HARDIN: Thank you so much,
6 Michael. Next, we will go to Dr. Ezekiel
7 Emanuel, who is the Vice Provost for Global
8 Initiatives and Professor in the Department of
9 Medical Ethics and Health Policy at the
10 University of Pennsylvania. Zeke, please go
11 ahead.
12 DR. EMANUEL: Yes, so from 2011 to
13 today, I have sat Vice Provost. I'm a university
14 professor at Penn, and I co-direct Penn's
15 Healthcare Transformation Institute. I was in
16 the White House working at OMB[20] and the National
17 Economic Council on the Affordable Care Act among
18 other health care initiatives. Particularly on
19 that was, I think I can say, instrumental on
20 things like bundle payments, the design of the
21 ACOs and CMMI. I would say at that time, I had
22 huge frustration when I called around, all right,
23 should we put a particular payment model in, how
24 little we knew about various payment models and

20 Office of Management and Budget

1 how little we had actually tested various payment
2 models. We failed. The government failed. Lots
3 of people failed.
4 On a usual day, I'm a specialist. I'm
5 a breast oncologist, and I think one of the areas
6 we have kind of ignored is specialty payment
7 since it's so much of physician payment and
8 generates so much of the system payment. I think
9 that has to be incorporated here more
10 systematically. Next slide.
11 I just want to talk about the issue of
12 why we have gotten to 50 percent. I think a lot
13 of us, policymakers, academics who don't actually
14 run value-based payment programs, don't quite
15 understand how difficult it is, especially for
16 smaller groups, to transition. Providers with
17 value-based payment have to change their
18 financial and operation management, right. Under
19 fee-for-service, they know how to make money.
20 They know how much money they need to make, and
21 they know what they need to do because they get
22 paid for doing things.
23 Under value-based payment, they often
24 get paid for not doing things and that, I think,
25 is critical which means they have to take on risk

1 in a way that requires a much more sophisticated
2 analysis which they're not experienced in. And
3 one of the consequences is that they end up
4 either having to affiliate with health systems or
5 get MSO services or get consulting services, all
6 of which are extremely expensive and take away a
7 lot of their financial benefits by actually doing
8 value-based payment well. And I think we don't
9 fully appreciate how complex that is.
10 So, what are the kinds of things, both
11 from a design standpoint as Mike suggested, but
12 also an implementation standpoint that would be
13 sort of a bare minimum and make this transition
14 better and helpful and incentivize a lot more
15 practices, especially the independent ones, to do
16 it. I think we have to make data much more
17 readily available.
18 Right now, Medicare gives data back
19 and its raw data, which is not information and
20 not helpful to small practices. They need more
21 timely, accurate, accessible, and actionable
22 financial data, this is possible, easily
23 possible. Rather than giving them raw data, they
24 need something which will tell them how they're
25 performing individually and collectively as a

1 group, their patients, and that's an absolutely
2 essential element to give them confidence they're
3 going to make money. If they can't have that
4 confidence, they're going to sit on the
5 sidelines. They're not going to go into these
6 programs, especially if they're voluntary and not
7 mandatory, and I think that's a critical issue.
8 I think on that path, CMS needs to
9 facilitate the development and adoption of low-
10 cost solutions. Solutions that are in the 10,000
11 to $25,000 range, not hundreds of thousands of
12 dollars or millions of dollars as Acadia and all
13 the similar programs are that are open source
14 that can be used. And here, maybe Mike and I
15 have a slight difference. I think one of the
16 major ways of overcoming the multi-payer problem
17 and being short, is to Medicare use its
18 authorities to extend the same data platforms,
19 providing the same kind of information across all
20 the programs where they give money, MA and
21 exchange plans.
22 This will mean a large portion of what
23 physicians get and other providers get will be in
24 the same format, so a large portion of their
25 practice will have the same information. And they

1 can use that wedge, as they do in many other
2 areas, to get standardization on the data, which
3 I think is critical. They could also get
4 standardization on the payment formats which
5 again is going to be critical.
6 It will also create a marketplace for
7 solutions for financial modeling for practices,
8 which, again, I can’t emphasize I think this is a
9 fundamental lesion and unless we overcome it, we
10 can provide a lot of different incentives but
11 we’ll either facilitate consolidation or people
12 will still remain on the sidelines.
13 The final thing I’d like to say is I
14 do agree with Michael, we need fewer, better
15 design programs. Part of that design we need a
16 lot more interaction with frontline physicians
17 and some real assessment of how these programs
18 change incentives for doctors and whether they
19 inhibit them. The racheting down of the baseline
20 is a perfect case of where I think this is really
21 going to just dissuade people from participating
22 because they can’t make money on that.
23 With that, I’m going to pass it on.
24 CO-CHAIR HARDIN: Thank you so much,
25 Zeke. I can tell from the Committee they’re

1 already ready to ask additional questions and you
2 will have the opportunity to do that. Next, we --
3 DR. EMANUEL: No problem.
4 CO-CHAIR HARDIN: Oh, I'm sorry.
5 DR. EMANUEL: No problem.
6 CO-CHAIR HARDIN: For both of you, for
7 all of you actually. Next, we have Dr. Tim
8 Ferris, who is the founding Senior Vice President
9 of Value Based Performance for Mass General
10 Brigham, inaugural Chief Transformation Officer
11 for the National Health Service in England, and
12 Adjunct Professor of Medicine at Harvard Medical
13 School. As one of our original PTAC Committee
14 members, we're thrilled to have Tim back joining
15 us today. Please go ahead, Tim.
16 DR. FERRIS: Thank you so much. And I
17 want to start off by complimenting all the work
18 the PTAC Committee has done and particularly the
19 ASPE work that we just saw. I thought it was
20 excellent work. I learned a lot from it and was
21 very pleased to see that the baton has been
22 passed and the quality of the work they're doing
23 has definitely gone up since I was a member of
24 the Committee.
25 I'll go to the next slide, if you

1 will, and say that I'm not going to directly
2 address my assignment. I'm going to think about
3 a slightly bigger picture, which because Michael
4 and Zeke did such a great job of going over the
5 pieces. I want to talk about what I believe to
6 be the biggest risk going forward to the value-
7 based care initiatives and that is given the
8 demographics of the United States, we are
9 projected to have very significant capacity
10 challenges in the delivery of health care to our
11 populations. Most importantly, to the populations
12 where the payer is primarily Medicare and
13 Medicaid, and that problem is not, just to be
14 clear, it is not getting smaller. It is getting
15 bigger, and it's getting bigger and will continue
16 to get bigger for the next 20 to 25 years.
17 That presents a real challenge, right,
18 so I want to underscore something Angelo said, to
19 make accountable care the financially viable
20 model of care. Just to underscore that, so, how
21 will we do that when the literal capacity that is
22 available doesn't meet the needs of the
23 populations? That's really critical. So who is -
24 this is all about accountability and, I wrote
25 here defining accountability, who is accountable

1 for the capacity of the health system. And I'll
2 just project out there that right now we have a
3 system that's set up to say, well, if we fund it,
4 they will come, right? That's how we manage
5 capacity in this country.
6 That's problematic when two of the
7 major payers pay below, generally below, the
8 costs of delivering services. So the costs of
9 delivering services, the unit cost of the
10 delivery of care is the core issue for me in
11 value-based payment care delivery. And so, if
12 health is increasingly determined by access and
13 access is a function of capacity, then how are we
14 going to make sure there is adequate capacity?
15 To me, the solution, the only solution, to our
16 capacity problems is to move from what is
17 generally a one-to-one model of inputs to outputs
18 in health care to a one-to-many model of inputs
19 to outputs in health care. That means we need to
20 undergo a very large and systemic technology
21 moving health care to be much more of a
22 technology enhanced service.
23 Now, what I don't see in all of this,
24 and I want to take Michael's point, I see
25 enormous good here. My job here is not to keep

1 complimenting all the good, my job is to point
2 out risks. I think that's my job. And so I want
3 to make sure that we all think about the capacity
4 issues created through risk-based and
5 accountability-based systems and remind everyone
6 that the fundamental form of accountability in
7 U.S. health care is that every delivery
8 organization, whether it is a private practice, a
9 nonprofit organization or a for-profit
10 organization, is accountable as a business period
11 full stop. And if you can't have a viable
12 business because of the payment system, then you
13 won't have those businesses, particularly in
14 places that are serving the underserved. And so,
15 what is the mechanism by which value-based care,
16 incents the adoption of technology, that allows
17 the transition from a one-to-one model of inputs
18 to outputs to a one-to-many model of inputs to
19 outputs? So that's the concern that I'm most
20 focused on now.
21 I will say there are some smaller,
22 more logistic things. I do think - the previous
23 speakers talked about the burden. I think there
24 is a substantial opportunity to use technology to
25 lower the burden on both individual practices and

1 health systems. I do think quality metrics
2 should not be aggregated at the payer level,
3 that's not the relevant unit of delivery. The
4 relevant unit of delivery is the practice or the
5 health system, and that's where, across all
6 payers, we need to aggregate quality metrics.
7 I do think, you know there's something
8 called payment with evidence at CMS initiated
9 quite a long time ago, but I don't think we
10 should be -- providers shouldn't be delivering
11 services where they're not measuring the outcomes
12 of those services. And again, with technology
13 today measuring those outcomes is not an
14 expensive thing to do, it's just that we don't do
15 it systematically.
16 And then my final comment is even
17 though we're talking about value-based payment
18 and incentives, underneath that we're still --
19 the chassis is still a fee-for-service system. I
20 believe there are significant malalignments
21 between what we pay for the delivery of services
22 and the work required, the input costs to deliver
23 those services. I'll give one example. The
24 input costs in the delivery of the work necessary
25 for an initial visit to a doctor is a 10-fold

1 multiple of the work for follow-up visits and
2 yet, the payment is only slightly more for a new
3 patient visit than a follow-up visit. That is
4 payment nonalignment with work, is creating that
5 systemic problem in the fee-for-service incentive
6 system which roll through into the value-based
7 care models and actually create distortions in
8 the marketplace.
9 So with that, thank you very much and
10 I look forward to the conversation.
11 CO-CHAIR HARDIN: Thank you so much,
12 Tim. Very interesting. And last, we have Dr.
13 Alice Chen, who is the Chief Health Officer at
14 Centene. Welcome, Alice, please go ahead.
15 DR. CHEN: Thank you so much. Good
16 morning. Thank you for having me. Many of the
17 points that the other panelists have made
18 resonate, really delighted to be part of this
19 panel and look forward to the discussion.
20 As you mentioned, I'm Chief Health
21 Officer at Centene, which is a government payer
22 squarely in what I think of as a 3M space, so
23 Medicaid, Marketplace, Medicare. We're the
24 single largest payer in Medicaid and Marketplace,
25 have about a million members in Medicare

1 Advantage, focused on duals.
2 I’m going to spend a little time about
3 my background just so you have a sense of where
4 I’m coming from vis-à-vis our other panelists. I
5 think the bottom line is I come from this work as
6 a PCP internist in withdrawal. I just gave up my
7 panel of 18 years a little less than two years
8 ago. My career has been focused on the safety
9 net, but it's really embedded in practice, going
10 through policy and now as a payer.
11 I’m a little bit of an outlier because
12 most of my career has been focused on the safety
13 net, so primarily Medicaid instead of Medicare.
14 One thing I just want to call out, my very first
15 job out of college back in 1990 was as a medical
16 secretary at On Lok Senior Health Services, and I
17 wish I could see you so I could see how many
18 people actually know who On Lok is, but for those
19 of you who don’t, it was the original PACE model
20 of care. So the first organization that went to
21 HCFA[21] at the time to ask for capitation for
22 duals.
23 So, I imprinted on a model of value-
24 based care in its most fulsome manifestation in

21 Health Care Financing Administration

1 many ways. And spent a lot of time in the
2 trenches as a medical director of a primary care
3 clinic pre-ACA[22], pre-EHR[23], when 60 percent of our
4 patients were uninsured. So in this resource
5 constrained setting, I always think of necessity
6 being the mother of invention. We discovered
7 registries, chronic care management, set up
8 systems for inreach and outreach, worked with Tom
9 Bodenheimer around primary care redesign because
10 frankly it was the right thing to do for our
11 patients. We had no data on total cost of care.
12 We implemented eConsult to rationalize
13 specialty care and then really was at the very
14 beginning of shepherding mandatory CJR model
15 implementation just as an aside. As painful as
16 it was, it was good that it was mandatory so
17 that's a little commentary, as well as the first
18 very large P4P[24] program for our system through
19 the 1115 waiver with about 57 different measures,
20 which was quite overwhelming and has really
21 informed this soap box I have around can we focus
22 on a parsimonious set of measures that matter and
23 I'll come to that in a sec.

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

1 I left, I was at UCSF[25] and San
2 Francisco General, to go work for the State of
3 California. On the policy front what was really
4 interesting having been, again, in the trenches
5 trying to make value-based care happen.
6 Primarily, and you know I think of value-based
7 care you know quality over cost is bifocal, and
8 we were focused very much on quality because,
9 again, I mentioned we didn't have total cost of
10 care data, but were resource constraints that was
11 a constant kind of in the background driver.
12 At the policy lever at the state,
13 helped stand up the Office of Healthcare
14 Affordability, the levers are really broad, you
15 know. Setting up primary care, spend targets,
16 again trying to shepherd the state towards a
17 parsimonious set of measures. And then when I
18 got to Covered California, that was where I felt
19 like we could really make progress on this idea
20 of alignment. So when I was at Covered
21 California, we worked with Medi-Cal and CalPERS,
22 which is the public benefits manager, for the
23 State of California, to land on a parsimonious
24 set of measures in order to create clarity for

25 University of California San Francisco

1 the payers that we contracted with and hopefully,
2 through those payers down to the provider level.
3 Because what we realized is all the purchasers,
4 which together covered 42 percent of
5 Californians, were contracting with largely the
6 same payers, and then the payers were contracting
7 with the same providers. But because there
8 wasn't alignment, there was a lot of kind of
9 diffusion of intent or voltage drop from
10 purchaser to payer to provide.
11 And so I took that experience with me
12 when I came to Centene last January, and I walked
13 in the door with a lofty goal of driving
14 population health agnostic of line of business.
15 And I will say I had a rude awakening from a
16 payer perspective. Medicare VBC[26] is fundamentally
17 different from Medicaid, which is again different
18 from Marketplace. A lot of it has to do with the
19 provider landscape and capabilities, how much
20 clarity there is in terms of what you're driving
21 towards for better or for worse. In Medicare
22 Advantage, STARS performance is the North Star,
23 so there is zero doubt about what you're driving
24 towards. And then there's also the issue of

26 Value-based care

1 churn.
2 Let me just move to the next slide so
3 we can start the discussion. While there are a
4 lot of things that we can address in order to
5 make value-based care and accountable care more
6 feasible, I think a relatively low-hanging fruit
7 would be measure alignment and focus. As a
8 company, we track 170 measures across the 3Ms and
9 UDS[27], which is for those of you who don't know,
10 is the measure set for community health centers.
11 As the single largest Medicaid payer, we are
12 partnering with community health centers, FQHCs,
13 because they are such a critical part of the
14 safety net primary care landscape.
15 Out of 170 measures, aside from
16 CAHPS[28], there are four that are common across all
17 programs. What we've done is in terms of our
18 value-based care or strategy is, again, by line
19 of business, Medicare is focused on STARS,
20 Marketplace is focused on Marketplace QRS[29], and
21 Medicaid is focused on primarily the state
22 withhold measures and hopefully in the future,
23 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

1 incentives to quality performance on these four
2 measures that span all four lines of business, as
3 well as because we are the largest Medicaid payer
4 pre-, post- and well child visits.
5 So trying to figure out from a payer
6 perspective, how we create greater clarity and
7 simplicity and easy button for providers very
8 much depends, for us as a 3M payer, on clarity
9 from CMS.
10 So, I will pause there and look
11 forward to the discussion.
12 CO-CHAIR HARDIN: Thank you so much,
13 Alice, wonderful presentation. These were great
14 introductions so, next, we're going to move on to
15 some questions. In the interest of ensuring
16 balance across different perspectives and
17 questions, we encourage each of you to keep your
18 response to a few moments and, Committee members,
19 I want to encourage you to tip your table tents
20 up when you're ready to ask questions. I know I
21 can see you chomping at the bit to jump in, so
22 please feel free to do that.
23 But I'll kick us off with one
24 overriding question. What should be the vision
25 for developing total costs of care models that

1 can help to ensure that every Medicare
2 beneficiary with Parts A and B is in a care
3 relationship with accountability for quality and
4 total cost of care? And let's start with Michael
5 and then go to Tim.
6 DR. McWILLIAMS: Great, thank you. I
7 did want to just loop back and say that I think
8 Zeke and I are actually in violent agreement
9 about multi-payer alignment and where the focus
10 should be in terms of where the federal dollars
11 are. I think it's just important that we
12 acknowledge that even if we didn't have the
13 multi-payer problem, that the models currently
14 are probably not in a state where we get what we
15 want from them and so we need to sort of work on
16 those things, but trying to wind across Medicaid,
17 the Marketplace, and Medicare seems to be where
18 the focus should be.
19 In terms of vision, I mean I think
20 ultimately what we want here is more efficient
21 and more flexible care delivery. I think
22 sometimes in conversations about payment reform,
23 the framing can get a little contorted and imbued
24 with a little bit of magical thinking, and while
25 we certainly should hope for some direct benefits

1 for patients from efficiency and flexibility, not
2 being subjected to harmful procedures, being able
3 to get remote case management instead of having
4 to come to the office or getting home care
5 instead of facility care.
6 I think there's a broader system goal
7 here in which people benefit more indirectly that
8 we shouldn't lose sight of, which is lowering the
9 cost of health care, and just to pick up on one
10 of Tim's points. If we can do that, then with
11 all this great stuff coming down the pipeline, we
12 just have more money to spend on valuable things,
13 whether that's health care, things like GLP-1s,
14 or non-health care things like food and housing.
15 If we can just figure out a way to try to wring
16 some of the waste out of the system through the
17 payment system through payment reform, everyone
18 wins. And so, I think that just deserves
19 reiteration in terms of sort of what the ultimate
20 vision and goal is.
21 And then in terms of accomplishing
22 that, I think we've already hit the high points
23 in terms of the pieces, maybe digging into them a
24 little bit more on the model design front and, as
25 Zeke mentioned, getting the benchmarks right is

1 probably the foremost thing to do and there are a
2 couple dimensions that we really need to work on
3 more there.
4 One is the sort of rachet effect that
5 Zeke alluded to where if an ACO lowers spending,
6 its benchmark comes down. The shared savings
7 program this year introduced a prior savings
8 adjustment that helps mitigate at least some of
9 that during the sort of rebasing between
10 contracts. But also, I think a lesser
11 appreciated part of this is ensuring that the
12 benchmarks accommodate more participation by
13 basically allowing every provider a chance to get
14 under their benchmark. And that can't happen if
15 we grow benchmarks at realized rates of spending
16 growth because then the benchmarks just are
17 continually dragged down as providers save, and
18 then the model can never be appealing to more
19 than roughly half of providers.
20 And so there are various ways to
21 approach this, but I do think these are the types
22 of things that we need to be talking about, and
23 they get pretty technical. One way is to have a
24 sort of preset administrative benchmark trend
25 that's just fixed over time to help that sort of

1 wedge between benchmarks and claims expenditures
2 emerge as ACOs save. The shared savings program
3 introduced the accountable care perspective trend
4 this year to sort of introduce that, or we can
5 have add-on payments so that might look like a
6 permanent APM bonus or an enhanced primary care
7 capitation payment that’s sort of permanently in
8 place for participants in ACO programs or a
9 combination of the approaches.
10 But I think we kind of need to think
11 about how do we think benchmarks should be set 10
12 or 15 years down the road that might involve sort
13 of like a risk adjusted rate book but not one
14 that’s said, like average realized spending and
15 then ask the question how do we get there? And
16 then there, you know, the rest of the pieces like
17 savings rates and you know risk adjustment
18 deserves a lot of attention right now.
19 But I think this conversation gets
20 pretty technical pretty fast. This may not be
21 the forum to do that, but these are the
22 conversations that we do need to be having.
23 CO-CHAIR HARDIN: Zeke, did you want
24 to comment on that or ask a question?
25 DR. EMANUEL: You wanted Tim to -- I

1 just want to get in before you move on.
2 CO-CHAIR HARDIN: Oh definitely, we'll
3 make sure.
4 (Simultaneous speaking.)
5 DR. EMANUEL: I can see Tim is also
6 chomping at the bit so.
7 (Laughter.)
8 CO-CHAIR HARDIN: This is great. This
9 is exactly what we want to see.
10 DR. EMANUEL: I don't want to stand
11 between him and the race.
12 CO-CHAIR HARDIN: Great. Go ahead,
13 Tim.
14 DR. FERRIS: Sorry, I'm hearing an
15 echo. Okay, I just want to, if people have spare
16 time, looking back at the recording of what
17 Michael just said would be well worth their time
18 because it was really, really important and I
19 couldn't agree more with what Michael just said.
20 I will put out there, Michael, just to have the
21 conversation that the benchmark should be general
22 inflation.
23 Health care rises at twice inflation.
24 If it rose at general inflation, it would not be
25 confiscatory, and none of the problems created by

1 health care for the rest of society would exist
2 if it simply rose at inflation which it has not
3 done in the past 50 years.
4 With that aside, because I think
5 Michael answered the question very well, I wanted
6 to go in a little deeper about the implications
7 inside a delivery organization of being in value-
8 based contracts and just say that I think it is -
9 - and actually Don Berwick wrote a paper for the
10 New England Journal about this, I think in '99 or
11 2000, which is clinicians shouldn't be directly
12 exposed to incentives on total costs of care for
13 populations. That is a very problematic place
14 for a clinician to be and so internal to an
15 organization, the bigger the organization the
16 better because the more stable the population,
17 the more predictable the expenses. It looks like
18 Zeke might have an issue with that, but just
19 saying that I believe it is for the executives
20 within a provider organization to have incentives
21 in their pay around total costs of care for
22 population, but then they need to transform those
23 incentives into quality outcomes and medical
24 management decisions for the providers within
25 that organization. I wrote a paper about this a

1 dozen years ago that sort of explained the layers
2 of transforming the total cost of care incentives
3 at the highest level down to physician-level
4 incentives.
5 So, I just wanted to emphasize that
6 important piece of this puzzle.
7 CO-CHAIR HARDIN: Thank you so much,
8 Tim. And Zeke, I want you to go ahead and
9 please, part of bringing all of you together with
10 your brilliant perspectives is the dialogue and
11 interactions so please, everyone, feel free to
12 jump in. Zeke, please go ahead.
13 DR. EMANUEL: So, again, I just want
14 to iterate I think what I disagree with, Tim, is
15 that bigger is always better. There’s a
16 capacity, a maximum size. I don’t know what it
17 is. I suspect it’s around 40 or 50,000 people
18 that the group needs to be, that’s a sort of
19 minimum. I don’t know what the maximum is.
20 Anyway, I do think there are several things that
21 need to be addressed simultaneously, and I think
22 disengaging them and only focusing on payment is
23 going to be a mistake.
24 Payment is critical but as Michael
25 said, you know, risk adjustment is critical here

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

1 metrics across a wide swath of payers. You need
2 risk adjustment now here I can say definitively
3 because we are doing machine learning-based risk
4 adjustment, and CMS is fully aware of this, we
5 can improve the HCC[31] score three- to four-fold
6 with the simplest, simplest machine learning
7 program using the simplest data that Medicare
8 uses. HCC is broken, and they have to get off
9 it. It just, we cannot continue with it. It's
10 not state-of-the-art, and it creates all sorts of
11 perverse incentives.
12 Risk adjustment isn't going to work
13 until you cream off the top 5 percent for a
14 reinsurance program because they drive 45 to 50
15 percent of spending, and it makes a huge
16 difference to doctors if you cream that off. I
17 mean not just doctors, but health system.
18 And the last thing, I think you're
19 going to establish this risk adjusted capitated
20 payment with a reinsurance program for the top 5
21 percent. You have to combine that with bundles
22 and reference pricing, I think, for as many
23 specialties as you can, certainly procedure-based
24 specialties. We've got enough data on hips and

31 Hierarchical Condition Category

1 knees. We're going through to get bundles on
2 spines and cataract surgery. Lots of the very
3 common surgeries need to be bundled. Are you
4 going to get the bundles for, you know, you
5 probably can get the bundles for stent placement
6 and things like that. I don't know another way
7 to get the specialties in, you're not going to
8 capitate them, but you've got to get them in on
9 the bundles to lower where that bundle payment
10 has specialty involved. And I think that
11 combination is where we're going, and to
12 standardize it across as many payers as possible
13 is the only way forward at the moment.
14 DR. CHEN: Can I just jump in with a
15 couple of additional comments given what people
16 have said, which is I couldn't agree more that
17 clinicians shouldn't be exposed to direct total
18 cost of care pressures and that does assume, I
19 think as Zeke said, like a certain size and
20 sophistication that just isn't there for a lot of
21 providers. And then you have this whole layer of
22 intermediaries who come in, and I think the jury
23 is out in terms of the role of these groups and
24 the total value add both to the practice and the
25 system, but I think we're seeing that happen not

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

32 Healthcare Effectiveness Data and Information Set

1 perspective I'll just say once you have a score
2 as labeled on the forehead of each provider, the
3 next thing obviously is to selectively contract
4 with those who have the highest quality scores.
5 The issue being obviously there's the tension of
6 network adequacy and essential providers and
7 things like that, but I worry about the safety
8 net providers in particular who, for a whole
9 variety of reasons, are unable to perform at the
10 same level.
11 CO-CHAIR HARDIN: So helpful. Go
12 ahead, Michael.
13 DR. McWILLIAMS: So, I just wanted to
14 do some combination of piling on and maybe trying
15 to cinch one of the points that came up here,
16 which is -- and it's sort of I think we hear a
17 lot of conversation about -- I need to figure out
18 how to lower my hand here. It's often said that
19 people are frustrated with how the incentives
20 aren't making their way down to the physician
21 level, and I think Zeke and Tim and Alice all
22 just said that maybe that's actually not what we
23 want to have happen.
24 We certainly don't want physicians
25 exposed to fee-for-service incentives purely, and

1 something more like salary is probably more
2 desirable, but we don’t want the incentives in an
3 organizational contract to just be devolved down
4 to physician level because that defeats the
5 purpose of having an organization which is to
6 pool risk and to get organizations to do things
7 that individuals cannot. I think that’s just a
8 really important point that I just wanted to
9 cinch there.
10 CO-CHAIR HARDIN: Excellent. I’m
11 going to go on to our next broad question.
12 You’ve already started to tap into this. So, why
13 have some providers not been signing up to
14 participate in total cost of care models, and
15 what can be done to address barriers to
16 participation? We thought we’d start with Zeke
17 and then go to Alice.
18 DR. EMANUEL: So, I mean, look I’ve
19 already weighed in almost all of my bit. Look,
20 you have to being with giving them enough data
21 and a reliable financial model that they don’t
22 have to pay through the nose for. I think
23 Michael just talked about or Tim, someone talked
24 about all the -- no, Alice was the one, getting
25 confused here, about the financial

1 intermediaries. Those intermediaries are really
2 expensive, and they take a lot of the savings,
3 and they take the incentive away from
4 participating. And I think if Medicare gave away
5 or made very cheap a lot of the data that is
6 needed and the financial model that could be
7 built on it, so people could pay in the 10,000 or
8 $20,000 range rather than the half-million-dollar
9 range, that is a very important thing. People
10 need to have a model, a financial model that they
11 can then understand if they change their clinical
12 practice this is the implications on the
13 financial model. They don't have that, they
14 ain't gonna do this, it's just that simple.
15 And so I think – and ee don't have
16 that financial model out there. When we've
17 talked to CMS about it, their first reaction is
18 we give out raw data. Raw data, it's not
19 something doctors can use. They need it
20 processed for them, and they shouldn't have to
21 pay a lot of money for that processing, and then
22 above the processing they need models. If I
23 change my clinical practice this way, what are
24 the financial implications? That's not obvious
25 in a value-based payment world or a capitated

1 world. And so those are the two things I would
2 say to begin with.
3 And then I think I want to emphasize
4 things that others have said, which is we've got
5 to have a benchmark established where primary
6 care doctors especially can make money. I mean
7 specialists are already making a lot of money,
8 but the primary care doctors need to have a
9 benchmark where they can see how they can make
10 money, and they can make a substantial amount by
11 providing more as bonuses by providing high-
12 quality care. If they can increase by 50 percent
13 their income, that's a very big incentive for
14 them, and screwing around with 10 percent just
15 it's screwing around, it's just not going to do
16 it from an incentive standpoint given all the
17 work they're going to have to put in to
18 transforming their processes of care.
19 DR. CHEN: Yeah, I would second,
20 third, and fourth Zeke on data. I think data is
21 foundational. I do think as a plan we are
22 working very hard on trying to figure how do we
23 get the right data at the right time to the right
24 people. I think, you know It's interesting. I
25 think in the U.S. health care ecosystem, payer

1 and provider tensions are large and sometimes
2 unrelenting, and I heard a great quote recently,
3 which is you squeeze a vendor and you hug a
4 partner. And I do think that in terms of
5 payer/provider relations, we need more hugging
6 and less squeezing. I know that’s Pollyannaish
7 and easier said than done, but I do think that
8 particularly for us in the Medicaid space, there
9 just aren’t that many margins to go around and so
10 it is essentially by necessity. It's like you
11 have to partner, so I do think data on timely,
12 actionable, relevant data that people then
13 actually have to have capabilities on.
14 So, I think from the delivery system
15 side I would say one of the big barriers is, I
16 mean, primary care is exhausted. You have
17 primary care providers who are just burnt out.
18 Supply exceeds demand, and it is really hard in
19 that setting when you are just trying to get the
20 people you’ve been caring for 10 or 20 years in
21 the door, to think about people who aren’t coming
22 in, let alone people who are assigned to you, but
23 you’ve never even laid eyes on. I think the
24 capabilities in terms of just the plain old
25 primary care redesign, I mean, again, you’re

1 giving me flashbacks to 20 years ago around
2 through next available, same-day access, team-
3 based care, leveraging technology. I do think
4 leveraging technology is a huge, huge piece of
5 it. That was where eConsult became kind of our
6 solution to a huge supply demand mismatch for
7 specialty care. With that said, I just want to
8 put a note of caution in terms of technology as I
9 do worry particularly with telehealth that we
10 will move towards a future where poor people get
11 virtual care, and rich people get the care they
12 need, at the time they need it, in the form they
13 need or they want it. Right, so I think
14 technology is an enabler. We need to lean very,
15 very hard into it, but there is an equity aspect
16 of it that I don't want to lose track of.
17 CO-CHAIR HARDIN: Very important
18 points. Tim, Michael, do you want to comment on
19 that question?
20 DR. McWILLIAMS: I agree with
21 everything that's been said, and may I add just a
22 couple other potential sources of sort of
23 friction or slowness in the participation curve.
24 One, just picking up on what Alice just said,
25 because of the way that we've traditionally set

1 benchmarks according to sort of an organization's
2 own history, for providers that serve
3 historically disadvantaged populations and
4 therefore for whom we may underspend, it may be
5 really unattractive to enter a payment model in
6 which that sort of historically low spending is
7 entrenched. And so, that goes, in my view, to
8 sort of a new frontier in risk adjustment which
9 we, I don't think, should think about as
10 improving the statistical or predictive accuracy
11 alone, but also thinking about where we want
12 spending to be, where it ought to be for some
13 populations and not where it's been. And so
14 that's one thing that I think could help bring in
15 some providers who otherwise just wouldn't, the
16 models would be unappealing.
17 And then, similarly with risk
18 adjustment, you know, if you think about how the
19 ACO programs have handled coding incentives, it's
20 to cap risk or growth. And obviously, for the
21 providers who have not gotten good at the coding
22 game yet, then they just might want to sit on the
23 sidelines a little longer until they find the
24 resources to invest in that capacity as opposed
25 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

1 is the future of health care, and I immediately
2 implemented it at Mass General Hospital. I've
3 never done that where I read a paper and I said,
4 this is the future and then just did it, so,
5 Alice, you're one of my heroes, so thank you.
6 DR. CHEN: And you were totally ahead
7 of the curve because I will say that initially
8 the only people who were interested in eConsult
9 were safety net settings. I think you were the
10 first non-safety net group that I know of.
11 CO-CHAIR HARDIN: I'll just add to
12 that, Alice, I followed On Lok, changed
13 everything. Michael, please go ahead.
14 DR. McWILLIAMS: I just wanted to
15 follow up on something both Tim and Zeke have
16 touched on in terms of risk adjustment, and that
17 is that going forward it's just going to be
18 criminal not to use these new predictive
19 techniques that we have absolutely. A regular
20 linear regression OLS[34] is just going to be a
21 thing of the past in many cases. I'll become a
22 relic since that's what I was trained to do.
23 But I do want to note a couple of
24 things. One, it's not necessarily better to be

34 Ordinary least squares

1 more predictive if the inputs are the same, and
2 they're manipulatable, that just sort of rachets
3 up the incentives to code, and also the HCC model
4 has this problem that more profligate providers
5 get paid more because if you do more stuff,
6 they're more claims and more diagnoses and so
7 that sort of destroys the payment incentives in a
8 population-based payment model. So we have to be
9 careful about using things like R^2 or
10 predictiveness as sort of like the North Star of
11 risk adjustment. And then, just sort of thinking
12 about equity considerations, again what's right
13 and what's better may not be more predictive, and
14 so we need to think about getting new inputs that
15 aren't manipulatable and also thinking about
16 bringing in other information about what's right
17 from a social values perspective in setting
18 payment.
19 CO-CHAIR HARDIN: Key points. Walter,
20 I'm going to go to you and, PTAC members, I want
21 to encourage you I'm opening it up for you to
22 start asking questions. Walter, please go ahead.
23 DR. LIN: This has been a really
24 phenomenal session, and I just really appreciate
25 all of our subject matter experts coming and

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

35 Medicare Payment Advisory Commission

1 DR. McWILLIAMS: So, I guess I would
2 say that certainly you can't have a successful
3 voluntary payment system if no one is
4 participating. So, this is like really important
5 goal and metric, but I do think it's worthwhile
6 taking a step back and wondering whether the
7 model is designed in a way to really accommodate
8 high participation and other sort of more
9 ultimate social goals like spending less on
10 health care where it's wasteful and more on other
11 things or more on high-value health care. I guess
12 I would reframe this as sort of thinking about
13 participation as a marker of success, a
14 correlate, but we do have to think about how
15 we're designing the payment system in a voluntary
16 population-based model in such a way that it
17 gives providers an opportunity, and it's not
18 clear to me that the models have given providers
19 a huge opportunity to date.
20 CO-CHAIR HARDIN: Tim, please go ahead
21 and then Zeke. You're muted, Tim.
22 DR. FERRIS: I keep doing that, sorry.
23 I'll just put it out there and restate something
24 that I said before. While I agree with everything
25 Michael just said, I'll be maybe a little bolder

1 and just say the outcome that we're looking for
2 is health care costs to rise at inflation period.
3 General inflation. That should be our goal, and
4 that's the denominator. The numerator, of
5 course, is better health, but since we're
6 focusing on total costs of care here, I think
7 total costs of care should rise at general
8 inflation, that would be a massive victory for
9 the country and achieve all of the future
10 predictions about the impact of health care
11 spending on the U.S. budget would go away if it
12 were simply true that health care rose at general
13 inflation.
14 CO-CHAIR HARDIN: Zeke, go ahead.
15 DR. EMANUEL: I would say that
16 participation is one metric. The other two or
17 three I would agree with Michael, you need
18 financially successful providers. The vast
19 majority, 85 percent, 90 percent have to be
20 financially successful. And the reason is we
21 can't repeat the mid-1990s when managed care came
22 in, lower payments and a bunch of docs went belly
23 up. We don't have enough primary care doctors as
24 Tim started with. The system doesn't have the
25 capacity to have a lot of our providers go belly

1 up so, financial success has to be there, and we
2 have to design the system with that in mind
3 because that goes along with participation.
4 The other thing is, I think many of us
5 have said, you know, you need to deliver high-
6 quality on a core set of metrics. And we can
7 argue all day about the core set of metrics, but
8 you've got to look at the common things and the
9 common things that cause a lot of disease down
10 the line. So, hypertension, number one thing we
11 did over the last 60 years that brought mortality
12 down, control hypertension. Today, we're doing
13 an absolutely abysmal job as the standards have
14 come down to 120/80, that has to be the metric.
15 We're at 24 percent, I believe the CDC[36]'s latest
16 data on hitting that metric, and we have to hold
17 all the groups accountable to that metric. Same
18 thing with diabetes, five critical things. Those
19 both have very long-term downsides.
20 And then there are very specific
21 things for very specific populations. We can't
22 have a proliferation of 64 outcome measures, but
23 I think five or six that are really big and
24 impactful and easily measured, you know, is the

36 Centers for Disease Control and Prevention

1 HbA1c over 7 or under 7? Is the blood pressure
2 controlled? Is the cholesterol controlled?
3 These aren't complicated, they really aren't, and
4 I think having that high-quality on a few core
5 chronic illnesses that are very prevalent.
6 I love Tim's pounding away at, you
7 know, if we just keep health care cost increases
8 to inflation, the world will change. Now, we
9 have done that very well or at least we kept it
10 to the growth of the GDP[37], which is a different
11 metric. We've done that very well for 15 years,
12 but all the predictions are for everything is
13 coming unglued in the next decade, and I think
14 keeping that as a metric, we're not going to
15 increase the amount we pay more than inflation,
16 and that's the end of the day. We're going to
17 have just live with it.
18 DR. CHEN: Do you mind if I jump in
19 before we change --
20 CO-CHAIR HARDIN: Please go ahead,
21 Alice.
22 DR. CHEN: Topic or another question.
23 I think this is a really critical question
24 because health care is full of really good test

37 Gross domestic product

1 takers, and if you say the goal is participation,
2 we'll figure out how to participate. I mean I
3 remember 10 or 15 years or talking to a friend
4 and partners, and they were saying 50 percent of
5 our patients are in some value-based arrangement,
6 and I was like but what percent of your revenue
7 is at risk? I was like a penny a patient, I mean
8 I'm exaggerating, but it was not a lot of revenue
9 at risk, and then getting to Covered California
10 in our contracts, we said our payers have to 30,
11 20, 30 then 40 percent of their contracts with
12 PCPs in HCPLAN[38] three or four. But like the
13 devil's in the details, right? So, I think
14 people hit these marks and even here at Centene
15 just having the internal conversation, where we
16 have 45 percent of our Medicaid providers, 46
17 percent of our Medicare providers, but again, if
18 you're measuring it by actual outcome, is the
19 total cost of care stabilizing? Are we doing
20 better in terms of clinical outcomes? The answer
21 is no. And so, I think that's where you see a
22 lot of states in particular leaning into the
23 Massachusetts Health Policy Commission,
24 California has the Office of Healthcare

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38 Health Care Payment Learning and Action Network

1 Affordability.
2 It's like we need multiple tacks
3 because frankly and I forget who said this in the
4 beginning, but value-based care needs to really
5 mature. I think part of it is that partnership
6 model, like how do we really align incentives
7 between purchasers, payers, and providers to
8 really drive the outcomes we want in a singular
9 way, and there are going to be other avenues. So
10 setting cost targets, setting mandatory measure
11 sets, a number of the state transformation
12 collaboratives in HCPLAN are again landing on a
13 parsimonious set of measures that they're trying
14 to put through their Departments of Insurance or
15 their Medicaid, like really trying to do some
16 convergence because ultimately, I think we need
17 to hold ourselves accountable for the outcomes,
18 not just participation.
19 CO-CHAIR HARDIN: Thank you so much.
20 We're going to go to Chinni and then, Larry, be
21 prepped and then Jay. Go ahead, Chinni.
22 DR. PULLURU: Thank you for the panel.
23 This has been an incredible dialogue. A quick
24 question that I wanted to actually first ask of
25 Tim and then would love the rest of the panel to

1 weigh in. I want to double click on something
2 you had said, Tim, that clinicians should not be
3 exposed to incentives in total cost of care.
4 Having led a large, multispecialty group through
5 transformation into value-based care, where 95
6 percent of our revenue came from fee-for-service
7 and only 5 percent came from value-based care
8 incentives or value-based care revenue. We were
9 allowed to do 30 percent of our primary care and
10 hospitalist income in a bonus structure and 15
11 percent on specialty, including our spine
12 surgeons, retinal surgeons. So, that was really
13 powerful for us in transforming the organization
14 into thinking about total cost of care because we
15 did have total cost of care platforms we were
16 trying to implement.
17 So, I guess the question to you is
18 that experience has shaped, at least for me, the
19 fact that providers do need, or physicians do
20 need to have some money on the line here. The
21 other thing that I'm concerned about is that we
22 do capitate primary care but we don't allow the
23 incentives for actions to flow down to the
24 providers that the people in the middle will
25 ultimately take the benefit of the money that's

1 produced by bending the cost curves, so I'd love
2 to hear your opinions on that.
3 DR. FERRIS: Great, and I don't have
4 my mute on this time. It's a great question and
5 the answer, unfortunately, for me I'm sure
6 someone smarter than me can explain it in a
7 simpler way. I'm happy to get you the paper, it's
8 Brian Powers, et at. on aligning incentives. It
9 was basically the construction of what we call
10 the internal performance framework. And
11 basically, what we did, and this is directly
12 related to what Alice said about what was going
13 on in Massachusetts, and the Massachusetts Health
14 Policy Commission. Once we had all commercial
15 payers, all Medicare business and all Medicaid
16 business, all were risk contracts, basically
17 everything we did had to be in the context of a
18 risk contract, but nothing lined up in terms of
19 the incentives. So, we created an internal
20 performance framework that created a set of
21 metrics, different for primary care, specialty
22 care, procedure-based care, across that health
23 system. And so, yes, our clinicians did have
24 incentives, but how we performed in those
25 contracts, like literally the contractual basis,

1 and how we built the incentives were different.
2 Now, they were aligned, and there was
3 a lot of angst from my CFO about, Tim, the
4 farther you remove yourself from the contractual
5 target, the more anxious I become that how we
6 perform in the contracts will be different than
7 how we perform. I said, you know what, it's
8 going to work out in the wash as long as we keep
9 the North Star of better outcomes and more
10 efficient delivery of care, and honestly, it
11 doesn't matter what the payers are incenting us
12 on if we construct this. It turns out it worked
13 incredibly well after the first couple of years
14 of a lot of anxiety. We've actually, my former
15 group, has performed for over a decade actually
16 quite well in these contracts across all types of
17 payers. And so, it is a complex process of
18 translating the higher-level metrics and some of
19 the detailed metrics into what is it the provider
20 thinks is best for patient care.
21 And can I just add as a codicil to
22 that, that actually the internal process of
23 saying what do we think we should be measured on
24 was a very healthy process because it actually
25 got people in the room saying, okay, the payers

1 think it’s this, we don’t think -- it’s not that
2 they’re completely off target, but that’s
3 actually not the right way to measure, for
4 example, hypertension in our populations. We
5 have much better data on this that we can extract
6 from our electronic medical records. Why don’t
7 we make a better metric on what we have a shared
8 agreement on as an outcome. I’m sorry, that was a
9 bit of a long answer, but the real answer is
10 actually quite detailed and is in the paper.
11 CO-CHAIR HARDIN: Go ahead, Alice.
12 DR. CHEN: At the risk of just like
13 piling on and echoing, I just have to say I do
14 think the role of clinical leadership is both
15 translating and being nuanced about what you pass
16 through and not, because you want to tap into the
17 psychological raison d'etre of providers and,
18 like I say to my payer colleagues all the time,
19 we don’t want to contract with a provider who the
20 first thing they do look is their insurance card
21 and what line of business. I mean you want
22 providers who take care of patients, but then how
23 do you then align the incentives for us coming
24 from purchasers, government, through us to our
25 provider partners in a way that really, again,

1 makes sense on the provider side, but also allows
2 us to succeed. I mean that's where a lot of the
3 conversation is for us.
4 CO-CHAIR HARDIN: Michael, go ahead.
5 DR. McWILLIAMS: I do think we need to
6 be careful here. There are some real downsides
7 in passing through risk to the individual
8 physician level. It gets very noisy, risk
9 adjustment falls apart. It can be demoralizing.
10 You end up introducing financial conflicts of
11 interest at the sharp point of care, where
12 perhaps they ought not to reside, and we'd rather
13 have physicians' intrinsic motivation pushed back
14 against organizational incentive. So, they're
15 just -- things can go badly when this is done.
16 I think also it's important to think
17 about what it is that's eliciting the behavioral
18 change. As a physician, I've always just been
19 exposed to very symbolic financial incentives on
20 the quality or cost front. So, these are fairly
21 meaningless from a financial perspective, but
22 they can nevertheless elicit behavioral change
23 because physicians are super competitive with
24 themselves and others, and they pay attention to
25 data. And they open their eyes to various things.

1 There have been papers in the economics
2 literature that shows that just presenting data
3 to providers actually can change their behavior.
4 That was sort of the story behind surgeon report
5 cards, for example, in large part.
6 And so, I think it goes to something
7 that Alice just mentioned, which is we should be
8 thinking about this debate about how much to pass
9 along to individual physicians, but we also
10 really ought to be thinking about the science of
11 management and updating that and not having it be
12 too tailoristic and using behavioral insights in
13 trying to tap into people's professionalism.
14 CO-CHAIR HARDIN: Zeke, did you want
15 to add on?
16 DR. EMANUEL: No.
17 CO-CHAIR HARDIN: Okay, Larry, please
18 go ahead.
19 DR. KOSINSKI: Well, I have to pile
20 onto what Walter said, this has been just a
21 fantastic session. What I've loved is the
22 interaction between the four of you, and that's
23 something we don't always get, but it's been a
24 great discussion.
25 I was feverishly taking down notes to

1 capture statements that were meaningful, and I
2 have some from all of you, but there’s a theme
3 that permeates this when I look at capacity
4 challenges, the statement if we fund it, they
5 will come, that we have to have systems that are
6 accountable as a business. We need to focus more
7 on where we’ve been ignoring specialists’
8 payments. Revenue at risk. What’s come through
9 to me from all of this is that we’re not just
10 providers, we’re businesses, and these businesses
11 have to succeed. The physician practice has to
12 succeed, and so does the health system have to
13 succeed. And our payment systems have to find a
14 way to align business success drivers with
15 population health needs, and right now that isn’t
16 occurring. And I guess my major question is
17 should we instead of focusing on providers, have
18 a focus on the provider businesses to create the
19 payment solutions that will allow everybody to
20 thrive?
21 DR. EMANUEL: Can you clarify that? I
22 mean, I --
23 DR. KOSINSKI: Well, for instance --
24 for instance, I'm a gastroenterologist, so I've
25 lived in the GI world my entire 40-year career.

1 And in my last 10 years, I've been involved in
2 value-based care for patients with significant
3 chronic GI diseases.
4 We can't get the attention of the
5 providers because they'd rather be in the GI lab
6 doing colonoscopies on healthy patients, because
7 that's what's driving their revenue. And when we
8 come in with a value-based care program that may
9 give them a percent or two percent, the answer
10 would be I'll just do another colonoscopy.
11 DR. EMANUEL: Well, let -- okay. Let
12 me at least address that in particular. Because
13 I -- and you know, we've been trying to work with
14 some GI docs for and the same thing is the case.
15 First, as I said, you're going to have to revalue
16 those fee-for-service payments.
17 There's just no two ways about it. We
18 overpay for lots of procedures. We know we
19 underpay for E&M[39]. I mean, I think Mike gave an
20 absolutely fantastic example about, you know, the
21 initial visit being under -- grossly underpaid.
22 Whereas for some other things, the initial visit
23 is excessively paid. I believe ophthalmology is
24 one of those cases.

39 Evaluation and management

1 So I think, there's just no way of
2 moving forward without revaluing that element.
3 And you know, it's one of the reasons I suggest,
4 you know, bundle payments for upper and lower GI
5 scoping is going to be critical to doing that.
6 So that's absolutely essential.
7 And I think -- this is where I think
8 voluntariness -- I've been against voluntariness
9 from day one. I lost out to many people inside
10 because I don't think if we make it too
11 voluntary, you know, then the people who are
12 going to win, enter, and if they can leave,
13 they'll leave if they're not succeeding.
14 And I think mandatory is very
15 important going forward. So I think that is
16 going to be the case. An individual -- the last
17 thing I would say is, you know, one of the
18 reasons I keep emphasizing the data and the
19 financial modeling is you have to show doctors
20 how they can succeed, and if you don't have that
21 modeling, you can't. I also agree with you.
22 I think I've said it very explicitly,
23 unless you make the bonuses really big, this is
24 just not -- I mean with all due respect for
25 professionalism, in the end if you can't make 30,

1 40, 50 percent more by doing a very good job,
2 then, you know, you're not going to get people's
3 attention. I don't think one or two or five
4 percent does it.
5 And so I think those are the two
6 things I would focus on, revaluing, and keep the
7 AMA[40] out of it, and making sure the bonuses for
8 really high quality are really big.
9 DR. KOSINSKI: Zeke, If I could just
10 follow up one quick question on what you said
11 earlier. You've said that primary care should be
12 capitated, and procedural specialists should have
13 episodes in bundles.
14 DR. EMANUEL: Yeah.
15 DR. KOSINSKI: What about the
16 cognitive specialist?
17 DR. EMANUEL: Yeah. Look, I'm an
18 oncologist, and I helped design the original OCM[41]
19 model. I think it's way more difficult to do
20 that right. I think there are ways of fixing
21 that system to, at least of my specialty.
22 You've got adjuvant care, which is
23 well defined, good standards for a lot of good

40 American Medical Association
41 Oncology Care Model

1 guidelines that you can base things off of. And
2 then, I think you need some triggers for
3 examining or limiting, you know, third line
4 chemotherapy for metastatic disease is, you know,
5 just not on, or you know, triggering a review at
6 -- when the ECOG[42] status goes down. Then it
7 really gets into the weeds.
8 I think it's just much, much harder
9 there, you know. And I think a generalized
10 solution is probably not likely, you're going to
11 need some specialty specific stuff.
12 CO-CHAIR HARDIN: Michael, please go
13 ahead.
14 DR. MCWILLIAMS: Just pulling on that
15 thread a little bit more. So if we're thinking
16 about large bonuses for quality, you know, we --
17 given that we can only put so much money on the
18 table, and I think, Zeke emphasized this before,
19 we're going to have to get pretty selective with
20 the measures, right?
21 And then so that's sort of one thing
22 we need to think about. And I'm -- trying to
23 think through the best way to say this. But I,
24 you know, going back to sort of thinking about

42 Eastern Cooperative Oncology Group

1 who should bear the risk and thinking about
2 quality in particular, so that's a good example
3 perhaps.
4 The bonuses could be quite
5 significant. We probably still want them at a
6 practice or organizational level, given that that
7 aggregate sort of actor is going to be able to do
8 more about the system's problems at play, right?
9 And so, I think in thinking about sort
10 of management and professionalism, the real trick
11 here is for an organization to be able to respond
12 to a large bonus for a measure that we really
13 care about, can measure well and do all the risk
14 adjustment for, et cetera, in a way that changes
15 clinician behavior without necessarily relying on
16 passing through the incentive in full because of
17 all the problems that -- that comes with that.
18 And I think that's where certainly, a
19 lot of action, a lot of research, is being done
20 in terms of nudges and sort of behavioral – you
21 know, drawing from behavioral science. But I do
22 think that's something that still does not get
23 talked about as much, and we need to be working
24 on more.
25 CO-CHAIR HARDIN: I'm going to go to

1 Jay next for the sake of time. Please go, Jay?
2 DR. FELDSTEIN: So I'm going to pile
3 on, this has just been an incredible discussion.
4 The only downside, it makes me feel old because
5 we were having these same conversations at U.S.
6 Healthcare 30 years ago. And it's a flash
7 forward, capitated primary care physicians,
8 bundling for specialists.
9 But see, if you triggered on -- on
10 something which is my real question, is we always
11 talk about getting rid of waste, you know, how do
12 we pay differently. How do we address demand?
13 What can we build in the system to reduce demand?
14 Especially in the context of social determinants
15 of health with fixed budgets.
16 Are we going to pay for housing costs?
17 Are we going to pay for food as medicine, which
18 is now being more prevalent in Medicare and
19 Medicaid programs?
20 Or are we going to pay primary care
21 physicians more and specialists less and
22 hospitals less? How do we work that into the
23 system?
24 DR. EMANUEL: Well, I -- well, that's
25 a more general complicated question in the

1 following sense. Right. We have a food stamp
2 program, a WIC[43] program, and a bunch of other
3 food programs, we have a dysfunctional housing
4 system.
5 And yet we know all of those things
6 have a big impact on health spend, transportation
7 added to it. I think, you know, and health care
8 isn't great at its own administration and to ask
9 it to administer food and to ask it to administer
10 housing is probably a bad idea if we had
11 functioning social systems.
12 So I'm not a big advocate of let's
13 layer on everything onto the health care system.
14 But I do think two things. I'll go back to what
15 Tim said, which is, you know, the part of the
16 strain on things like food stamps and housing,
17 are a direct result of the increases in health
18 care costs.
19 And if we could moderate those
20 increases while the GDP grows, I think we'd
21 create a, you know, some -- a left -- or some
22 extra money that can be spent for various things
23 that are super important.

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

1 Until we can get to that kind of
2 space, I think that there are -- my personal view
3 is, there are two things we should substantially
4 encourage the system, the health care system, to
5 take over.
6 I do think nutritional food is
7 exceedingly important. And health care either
8 directly to work with provider -- to make sure
9 people get enough food and to work with the
10 schools for kids. The second thing I would say
11 is, you know, this is part of long-term
12 prevention strategy. And we don't invest enough.
13 And if I were God, the thing I would
14 force us to invest more in is early childhood
15 interventions. Because they are critical for,
16 you know, developing kids, they're critical for
17 their brains, they're critical for their
18 nutrition and avoiding obesity and the subsequent
19 hypertension which we're seeing a whole lot of in
20 children, diabetes as well. So those are the two
21 things I would make us pay for.
22 Now the latter, early childhood
23 interventions do fall directly under health care.
24 And I do think those are things we ought to
25 mandate, sorry Alice, I'm going to say this,

1 every Medicaid program be responsible for -- I
2 don't know whether it serves family partnerships,
3 I'm not going to specify the exact kind of
4 program, but early childhood interventions that
5 take kids all the way through two-years-old.
6 But I do, you know, we have a
7 dysfunctional social system on lots of levels
8 which is why it's getting, all this stuff is
9 getting layered on health care. Not that we're
10 going to manage it so much better. But, you
11 know, providing people food is critical to them
12 recovering.
13 CO-CHAIR HARDIN: Let's to go Tim,
14 then Michael, and then Alice. We've got about
15 three minutes, just to give you context for your
16 comments. I know we could talk a lot longer
17 about this. But, Tim, please go ahead?
18 DR. FERRIS: Yes. I will go really
19 quickly. So I just want to underscore everything
20 Zeke said. I completely agree that the movement
21 of moving more and more social care under health
22 care, it just -- it is probably not the right way
23 to do it, even though that the incentives are
24 actually moving us to do that.
25 I'm going to say something, I think,

1 you know, helpfully controversial, and just say
2 that it is not great incentives for the demand on
3 health care if you or your employer pays an
4 annual fee, no matter what happens.
5 I just want to emphasize that. We
6 have designed a commercial insurance where you,
7 as the person who is consuming health care and
8 paying into that, gets no benefit from not
9 utilizing those services, none.
10 It is like, think about that for a
11 second. So what Zeke said about prevention, so
12 prevention is a long-term thing. Why, if you
13 spend an annual amount out of your paycheck, and
14 your employer sends an annual amount, like 50 to
15 60 percent of all health care costs are a 100
16 percent predictable.
17 Do you -- so it's like, there is no
18 insurance for a predictable cost, it is a
19 predictable cost. So getting the consumers in
20 the current design of commercial insurance is a
21 strong incentive against the self-management of
22 the use of health care services, and also
23 prevention, because Medicare picks up the tab
24 after age 65.
25 So that is a fundamental flaw in our

1 system that affects the demand side of care
2 actually quite strongly.
3 CO-CHAIR HARDIN: Thank you. And,
4 Michael?
5 DR. MCWILLIAMS: So 100 percent agree.
6 Having dollars for social services flow through
7 the health care system is just not efficient.
8 And ideally, we would be doing in that in some
9 other way.
10 I think an argument is that well, the
11 dollars are in the health care system and so
12 let's use them as efficiently as possible. And
13 that is a reality, and so we should do that.
14 Even thinking in an ideal world,
15 clearly, we want the health care system, to the
16 extent that they interface with patients and
17 their social problems, to be trying to help at
18 the margin, at least insofar as it helps their
19 health care, right?
20 So you can think about arranging
21 transportation so that patients can get to
22 important visits or waiving parking or giving
23 tablets so that they can be -- they can have
24 virtual care.
25 So you know, certainly there's some

1 very reasonable things to be doing. And one
2 might ask, what is the role of payment reform in
3 that, and I think that goes back to risk
4 adjustment. If we have more generous payments
5 for certain populations, that creates sort of
6 like a surplus without a behavioral change.
7 As long as providers are competing for
8 patients, then that should be passed through in
9 the form of those things. And so, that's sort of
10 like the major reason for trying to shift payment
11 in a, you know, from between populations in ways
12 that we think align with our social agendas.
13 CO-CHAIR HARDIN: Thank you. And
14 Alice, I'm going to ask you to as part of your
15 comments, if possible, add in what are you
16 learning in California related to the waiver, and
17 what did you learn in the uninsured populations
18 you paid for?
19 DR. CHEN: Oh, that is not fair.
20 Because I actually have a couple other comments--
21 CO-CHAIR HARDIN: So take us home.
22 DR. CHEN: Very briefly, like, agree
23 like, probably 95 percent with my colleagues
24 here. I would say demand reduction is absolutely
25 a long-term play. Zeke, I have said exactly the

1 same thing as you. Like if you're going to
2 invest in one place, it's early childhood
3 development.
4 But it's not just like, continuous
5 eligibility for kids, but it's also Head Start,
6 and things that actually don't fall in the health
7 care system.
8 And as an aside, I think the beauty of
9 Medicaid is, MCOs[44] are fierce competitors as
10 we're going for the RFP[45]. But many states after
11 you get it, are like, you need to play together
12 because this is actually a population health
13 move.
14 Which actually circumvents a little
15 bit of one of the problems with using the health
16 care system for long-term demand reduction and
17 prevention is, right now, 54 percent of Medicare
18 goes through managed care, right, Medicare
19 Advantage. Seventy-plus percent of Medicaid, a
20 hundred percent of marketplace, ESI[46].
21 Churn is a huge issue. I've seen
22 proposals saying like, oh, members have to stick
23 with an MCO. And my colleagues will kill me, but

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

1 I do not think that's the answer, that is not
2 patient or member centric.
3 But I do think we need ways to figure
4 out how to create multi-payer alignment in a way
5 that really circumvents some of these
6 constraints.
7 Quickly on health-related social
8 needs, and this does tag back to California and
9 CalAIM, which is, I think if there are two things
10 that we know from looking at international
11 comparisons, it's like investment in primary
12 care. Right?
13 Other states are 67 percent primary
14 care, 30 percent specialists, we're inverted.
15 Similarly, health-related social needs, if there
16 is one thing take home, it's Betsy Bradley. If
17 you haven't read Betsy Bradley's book, go read
18 it, right? Because what she found is, we were
19 looking for our keys under the lamp post.
20 On every graph, we are the highest
21 spending country per capita by 50 percent. But
22 when you widen the spend to health and social
23 services, we are middle of the pack. We just
24 spend it differently.
25 Other industrialized countries, for

1 every dollar on health care, it's two dollars on
2 social services. For us, every dollar on health
3 care is 55 or 60 cents on health-related social
4 needs, social services.
5 And so what I would say in terms of
6 the health care system is, I have also been
7 saying, like, you know, everyone basically says
8 there's 30 percent waste in the health care
9 system. Although when you ask them where it is,
10 they're like this. Right?
11 No one's going to -- no one's saying
12 that it's like health care waste is over there,
13 but it's 30 percent. You don't want to put all
14 this other spend through it unless it's really
15 surgical.
16 So I do think that evidence-based
17 things are food as medicine for certain
18 conditions, like post-discharge for CHF[47], or HIV,
19 it's transportation for prenatal visits, it's
20 supportive housing for people with SMI[48] and SUD[49].
21 So I think again, don't just throw
22 everything in there. Because we know that that
23 will just generate waste. But how can we be

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

1 evidence-based about it and targeted in a way
2 where given our short-term thinking constraints
3 and health care in the U.S. political system at
4 large, we can get some short-term gains to free
5 up some of those resources for other important
6 social goods, including primary care payments?
7 CO-CHAIR HARDIN: We want to thank
8 each of you for this excellent dialogue. You
9 know we could keep going all the way through
10 lunch, but I don't think -- I think they're going
11 to be very angry with me if I don't break for
12 lunch.
13 So we want to thank you for your
14 contributions. You've helped us cover a lot of
15 ground today during this session. And you're
16 welcome to stay and listen to the rest of the
17 meetings as much as you can. At this time, we
18 have a short break until 11:40 Eastern.
19 And please join us then for a panel
20 discussion from CMS and CMMI leadership, who will
21 discuss their vision to achieve the goal of
22 having all beneficiaries in accountable care
23 relationships by 2030. We'll take a 10-minute
24 break now until 11:40. Thank you.
25 (Whereupon, the foregoing matter went

1 off the record at 11:34 a.m. and went back on the
2 record at 11:42 a.m.)
3 *** CMS Panel Discussion**
4 CO-CHAIR SINOPOLI: So welcome back.
5 At this time, I'm excited to welcome staff from
6 the CMS Innovation Center, who will discuss their
7 vision to achieve the goal of having all
8 beneficiaries in accountable relationships by
9 2030.
10 First, we'd like to welcome back Dr.
11 Liz Fowler, Deputy Administrator of the Centers
12 for Medicare and Medicaid Services and Director
13 of the Center for Medicare and Medicaid
14 Innovation. Liz?
15 DR. FOWLER: Thank you, Dr. Sinopoli
16 and Dr. Hardin. And just thanks for the PTAC for
17 inviting us to be part of this meeting and
18 dedicating a panel to this really important
19 priority for us.
20 As I said in my opening remarks
21 earlier this morning, the theme for this meeting
22 is of great significance to us.
23 Promoting accountable care and
24 providing the right opportunities for providers
25 is central to meeting our 2030 goal of having

1 every Medicare beneficiary and the vast majority
2 of Medicaid beneficiaries in an accountable care
3 relationship for quality outcomes and costs.
4 The CMS accountable care goal is
5 grounded in primary care because we believe that
6 a strong primary care infrastructure is the
7 cornerstone of a high-performing health system.
8 Health systems around the world that
9 have invested in primary care, including
10 prevention screening and reinforcing healthy
11 behaviors, managing and coordinating care for
12 patients with chronic conditions, spend less and
13 do a better job keeping people healthy and out of
14 the hospital.
15 But we also know that we need to
16 include specialists in accountable care as well.
17 So today to that end, you'll be hearing from our
18 chief strategy officer, Dr. Purva Rawal, on our
19 vision for primary care.
20 And she deserves a lot of credit,
21 along with our Deputy Directors, Ellen Lukens and
22 Arrah Tabe-Bedward, for crafting, honing, and
23 advancing our overall strategic objectives and
24 accountable care goals. She's also a prolific
25 writer and has spent a lot of time thinking about

1 how to communicate with the provider community
2 about our goals, progress, and signaling what
3 comes next.
4 Pauline Lapin is not able to join us
5 today, so instead you'll be hearing from Pablo
6 Cardenas, from our Seamless Care models group.
7 This group has launched, led, and currently
8 houses all of our ACO models, like the Pioneer
9 model, ACO Investment model, both of which are
10 now a permanent part of the shared savings
11 program, as well as the NextGen ACO model and
12 currently ACO REACH.
13 You'll also hear from Sarah Fogler,
14 Director of our Patient Center, Patient Care
15 models group, which leads our advanced primary
16 care models, Primary Care First and Making Care
17 Primary are the current ones.
18 And her team also leads our specialty
19 care strategy which includes current and past
20 bundle payment models and the new team model that
21 we'll launch in January 2026.
22 As part of her work on specialty care,
23 she and her team have given a lot of thought
24 working with Pauline and Purva into how we might
25 engage more specialists in accountable care.

1 And then finally, Kate Davidson, who's
2 sitting here today in person in D.C., is Director
3 of our Learning and Diffusion group, which leads
4 our multi-payer alignment efforts and works
5 closely with the Health Care Payment Learning and
6 Action Network, or the LAN.
7 Kate's remarks are going to focus on
8 our multi-payer alignment efforts. But I think
9 it's also worth noting that the LAN, which
10 includes stakeholders from across the health care
11 ecosystem, including patient and beneficiary
12 organizations, recently launched the Accountable
13 Care Action Collaborative, that's really an
14 important partnership with us at the Innovation
15 Center in promoting efforts to advance
16 accountable care.
17 The collaborative also helps foster
18 partnerships and spread learning and best
19 practices. I really consider myself lucky to
20 have the opportunity to work with all of these
21 talented leaders and their teams.
22 Before closing, I'd be remiss if I
23 didn't mention our work with other components
24 within CMS. I've said in other settings how
25 important it is for us to work with our

1 colleagues in CMS, the Center for Medicare,
2 Center for Medicaid and CHIP Services, and the
3 Center for Clinical Standards and Quality.
4 We do our best work when it's in
5 collaboration with our colleagues, and you'll
6 hear that in each presentation today. And
7 particularly, we've worked closely with
8 colleagues in the Center for Medicare who lead
9 the Shared Savings Program to outline a shared
10 Medicare-wide ACO vision.
11 And as we think about opportunities
12 and options to scale or expand successful
13 innovations in care delivery changes into
14 something more permanent, this partnership is
15 really critical.
16 And finally, the last thing I want to
17 remind everyone is that the Innovation Center has
18 been trying to be transparent as possible with
19 our work.
20 We've made data for our models
21 available for researchers. We have a proposed
22 rule to make many of the terms of our
23 participation agreements public.
24 And we've published articles and
25 posted materials on our website to provide

1 hopefully a signal as we think about our primary
2 care, accountable care, and specialty care
3 strategy.
4 So look forward to your questions
5 after our speakers and the conversation with all
6 of you. And with that, I will turn it over to
7 Dr. Purva Rawal.
8 DR. RAWAL: Thank you, Liz. Thanks
9 for the opening and remarks. And I just also
10 want to say thank you to the PTAC for having us
11 here and our ASPE colleagues as well.
12 This is kind of a foundational element
13 of the Innovation Center's strategy, to get all
14 of our beneficiaries in accountable care
15 relationships. And so to have the chance to talk
16 to you all about it today and take your
17 questions, I think will be really helpful to us.
18 Liz already talked about the fact that
19 there are -- that primary care and advanced
20 primary care is the cornerstone of our strategy
21 and our work. And so I'm going to just do a
22 little bit of a deeper dive and talk about our
23 work in the advanced primary care space across
24 the portfolio.
25 It is the key kind of mechanism and

1 pathway for us to be able to achieve our 2030
2 goals. And then I'm going to, Liz also mentioned
3 scaling and how the importance of being able to
4 scale our successes in permanent ways.
5 And so we'll talk about some of the
6 work that we're doing in ACO and advanced primary
7 care space as well. I think it will tie nicely
8 to the remarks that Pablo, Sarah, and Kate will
9 be giving as well.
10 And I'll just say, when I'm talking
11 about advanced primary care, a lot of that work
12 is led by Sarah Fogler's team, who is -- and
13 Sarah's going to be speaking later, so, you know,
14 sharing all of this on behalf of lots of other
15 leaders at the Innovation Center and members of
16 our teams as well.
17 So what you see, this slide up here
18 goes through three of the guiding principles that
19 are informing all of our advanced primary care
20 work across the portfolio.
21 So again, our ACOs, our state-based
22 models we will talk about, and also our fourth-
23 generation advanced primary care model. These
24 were really informed by expert voices, the NASEM[50]

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50 National Academies of Science, Engineering, and Medicine

1 2021 report, and our own learnings from over a
2 decade of testing ACOs and advanced primary care
3 models at the Innovation Center.
4 And what you'll see is, these are
5 three guiding principles that we're carrying
6 through all of our advanced primary care work.
7 The first is financing.
8 It's not going to be a surprise to
9 anybody that we have to change the way that we
10 finance and pay for primary care in order to
11 strengthen the primary care infrastructure in the
12 country and achieve these accountable care goals.
13 And so we are moving , in all of those
14 models, we are finding different ways of moving
15 providers away from fee-for-service payments to
16 hybrid or fully population-based payments that
17 provide the flexibility for them to be able to
18 tailor their care to the needs of beneficiaries
19 and really focus and be compensated for those
20 non-face-to-face activities as well, that we know
21 are always going on in primary care and often not
22 adequately compensated for.
23 The second is advancing health equity.
24 If we want to achieve our accountable care goals
25 and get all of our traditional Medicare

1 beneficiaries in an accountable care
2 relationship, we have to reach all of our
3 beneficiaries.
4 And so we know historically, we have
5 not been able to serve a representative group of
6 our beneficiaries through our models. And so we
7 are very focused on and have a multi-pronged
8 health equity initiative.
9 But in all of our primary care work,
10 we're looking at payment adjustments, data
11 collection, health equity plans, and a real focus
12 on bringing safety net providers, in particular,
13 into our primary care models. And I'll give you
14 one example where I think we're starting to see a
15 good response from the market.
16 But in Making Care Primary 41 percent
17 of our practices that are starting --
18 organizations starting in that model, are
19 actually Federally Qualified Health Centers. So
20 we know that some of the ways that we're
21 designing for health equity are attracting
22 interest.
23 And now I think we have to, you know,
24 get past enrollment to really understanding what
25 their experience is and seeing how we are able to

1 support them in being successful in a value-based
2 care construct.
3 And then the third is sustainability.
4 And I think this will connect nicely to Kate's
5 remarks that when practices and organizations are
6 investing in transformation and care delivery
7 change, we need to be thinking about the
8 sustainability of those investments over time
9 beyond our model tests.
10 So one way to do that is multi-payer
11 alignment, which Kate will talk about. And then
12 another way that Pablo will talk more about, is
13 for us thinking about permanent pathways in the
14 Medicare program.
15 So in our ACO work, for instance, we
16 have our ACO Primary Care Flex model, we want
17 to -- we are testing that within the Shared
18 Savings Program to create that permanent pathway
19 for sustainability. Next slide. Thank you.
20 And this, I'm not going to spend a ton
21 of time here, but what you see here are all of
22 the different advanced primary care models that
23 we are operating at the Innovation Center right
24 now from ACO REACH all the way through to ACO PC
25 Flex, which is supposed to start January 1st,

1 2025.

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

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

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

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

1 primary care Medicaid programs running, and we're
2 bringing Medicare fee-for-service to amplify what
3 those states are already doing.
4 So we know there's multiple pathways
5 here, that we can also be working with states to
6 support advanced primary care efforts.
7 And then the last, I won't spend a lot
8 of time on because I think Pablo's going to cover
9 our ACO Primary Care Flex model which is an
10 ACO-based model.
11 So what you see here is kind of a
12 diverse strategy, we're trying to meet practices
13 where they are and make sure that they have a
14 different -- that they have a range of options
15 depending on where they are in that value-based
16 care journey. Next slide.
17 And then the last thing I'll talk a
18 little bit about, and Liz spoke about how
19 important it is for us to be working with the
20 other components and CMS.
21 We've been doing a lot of work at the
22 Center for Medicare on a shared ACO visioning
23 strategy which Pablo will talk about. We've also
24 been doing more and more work again, led by Sarah
25 Fogler and team, on the Medicare fee-for-service

1 side as well, to think about how do we create and
2 use the traditional Medicare program to create
3 advanced primary care options outside of ACOs as
4 well.
5 This past year we worked with the
6 Center for Medicare to propose a new set of
7 advanced primary care management codes, or APCMs,
8 in the fiscal year 2025 physician fee scheduled
9 proposed rule.
10 Through that bundle, that proposed
11 bundle, physicians and other practitioners who
12 deliver advanced primary care could bill for
13 these services on a monthly basis for as long as
14 they are the beneficiaries' go-to point for
15 health -- for the management of their health
16 care.
17 Bundling those key services such as
18 care management and communication-based
19 technology codes into these APCM codes, we hope
20 would help providers who want to provide these
21 services but oftentimes are discouraged by
22 complex and numerous codes that they have to
23 bill.
24 Importantly, we -- CMS views this
25 proposed bundle as the start of a multi-year

1 effort to inform a hybrid payment and coding
2 option to deliver advanced primary care services
3 in traditional Medicare.
4 And so we really view this as a first
5 step along with that proposed APCM bundle, code
6 bundle. There was a request for information that
7 also went out to help inform this multi-year
8 effort with our colleagues in the Center for
9 Medicare. So I'm going to stop there and turn it
10 over to Pablo.
11 MR. CARDENAS: All right. Thank you.
12 The Innovation Center's vision is to drive a
13 health care system that achieves equitable
14 outcomes through high-quality, affordable,
15 person-centered care.
16 And as part of the Innovation Center's
17 2021 strategic refresh, we identified five
18 objectives to guide our work. One of which is to
19 drive accountable care that results in the
20 delivery of whole-person integrated care with
21 accountability for outcomes and quality, as well
22 as total costs.
23 Since 2022, CMS ACO initiatives have
24 been guided by the objectives of alignment,
25 growth, and equity to meet the 2030 accountable

1 care goals. In 2024, there were about 13.7
2 million people with traditional Medicare aligned
3 to an ACO across the Shared Savings Program, our
4 permanent ACO program, and the ACO REACH, and
5 Kidney Care Choices models.
6 ACOs are now serving nearly half of
7 the people with traditional Medicare. And as we
8 look to the future, and increasing the number of
9 beneficiaries in accountable care, it is
10 important to look at what we have learned over
11 the last decade from our model evaluations, as
12 well as the Shared Savings Program.
13 Our ACO models have shown that ACOs
14 can reduce spending and improve quality of care.
15 Both Pioneer and AIM achieved savings and were
16 included in the Shared Savings Program, with
17 Pioneer as a high-risk option and AIM leading to
18 advanced investment payments in the Shared
19 Savings Program that started in 2024.
20 In addition, the current year
21 physician fee schedule, in the current year, the
22 health equity benchmark adjustment is being
23 proposed in the Shared Savings Program informed
24 by the ACO REACH experience, where we have seen
25 this benchmark adjustment along with other health

1 equity focused features of ACO REACH have
2 contributed to a doubling of safety net provider
3 participation in the model from '22 to '23 and a
4 25 percent increase in 2024.
5 Bringing this innovative payment
6 adjustment to the broader Medicare Shared Savings
7 Program would provide greater resources to ACOs
8 serving underserved beneficiaries.
9 Evaluations of other ACO models have
10 not found savings and have shown that when ACOs
11 have losses, they tend to drop out of models.
12 Management companies play an important role
13 providing infrastructure and support for care
14 management and data analytics.
15 Cash flow mechanisms like population-
16 based payments have been helpful for ACOs to make
17 investments. And while they were underutilized
18 in NextGen, we learned that those who did use
19 them achieved greater savings.
20 We are continuing to test cash flow
21 mechanisms in ACO REACH, along with additional
22 flexibilities in the form of benefit
23 enhancements, which waive Medicare payment rules
24 to allow ACO providers to provide additional
25 services and more care in the home, as well as

1 incentives to help ACOs better engage
2 beneficiaries and address health-related social
3 needs like transportation.
4 In previous models, ACOs have not
5 leveraged the flexibilities we provided as much
6 as we expected. And we are hoping to continue to
7 learn more about which are of high value to ACOs,
8 like the three-day SNF[51] waiver and parking
9 cautioning support and what other flexibilities
10 they would like in the future.
11 One other common theme from our
12 models, as well as the Shared Savings Program, is
13 that physician-led ACOs have been more successful
14 at reducing spending than hospital ACOs. In the
15 NextGen ACO model, we found that hospitals
16 affiliated ACOs lower costs for ambulatory
17 spending, while physician affiliated ACOs lowered
18 costs for hospital spending.
19 CBO[52], in its evaluation, came to the
20 same conclusions, that one, physician-led ACOs
21 had strong incentives to reduce higher cost
22 hospital care while hospital-led ACOs had
23 conflicting incidents.

51 Skilled nursing facility
52 Congressional Budget Office

1 And two, hospitals have less direct
2 control over their types of services provided to
3 their patients. Physician groups were able to
4 redirect patients away from low-value care more
5 easily. Next slide.
6 CMS recently released a second
7 evaluation report from the first two years of the
8 GPDC[53] model. In the second year of GPDC, the
9 model showed mixed results in growth spending,
10 but consistent, significant increases in net
11 spending relative to a comparison group of
12 similar fee-for-service Medicare beneficiaries in
13 their markets. Standard DCEs[54] improved multiple
14 quality measures, but increased gross spending,
15 particularly from acute care hospitals.
16 New entrants and high-needs DCEs
17 reduced gross spending through improvements and
18 utilization and minor improvements in quality.
19 We found that standard DCEs affiliated with
20 health systems drove most of the increase in
21 gross spending among all the standard DCEs.
22 On the other hand, their peers led by
23 primary care companies were associated with gross

53 Global and Professional Direct Contracting
54 Direct contracting entities

1 reductions in spending. However, when you factor
2 in the Shared Savings payments, all DCE types
3 increased net spending. The takeaway for us from
4 these evaluations is two-fold.
5 First, we need to be able to better
6 design for hospital-led ACOs to both do away with
7 conflicting incentives and capture their ability
8 to reduce other types of low-value care. And
9 second, we need to get more physician-led ACOs
10 into the program to drive higher savings overall.
11 The second point, along the NASEM's
12 landmark primary care report and feedback from
13 clinicians, ACOs, and beneficiary and consumer
14 organizations, informed the design of the ACO
15 Primary Care Flex model.
16 In its report, NASEM said primary care
17 is a central component of ACOs, and organizations
18 differ in the extent to which they emphasize,
19 incorporate, pay for, and support it.
20 NASEM made two recommendations.
21 First, primary care payments should shift from
22 fee-for-service to hybrid or part fee-for-service
23 part perspective. And two, sufficient resources
24 and incentive should flow to primary care within
25 ACOs to provide team-based care, to risk adjust

1 for medical and social complexity, and to support
2 infrastructure, including digital health.
3 The ACO Primary Care Flex model will
4 test a novel way of formulating monthly
5 perspective primary care payments, or PPCPs, to
6 ACOs. The PPCP is composed of two parts, a
7 county base rate and payment enhancements.
8 Rather than basing the county base
9 rate on each ACO's historical claims experience,
10 as is done in ACO REACH, the county rate will be
11 a common risk-adjusted capitated county rate for
12 primary care.
13 The enhanced amount portion of the
14 PPCP is based on characteristics of the ACO and
15 its assigned patient population and is not at
16 risk.
17 For most flex ACOs, we expect that the
18 PPCP will increase primary care funding relative
19 to ACOs historical expenditures. The ACO PC Flex
20 model is a five-year voluntary model, with remote
21 revenue ACOs on the Shared Savings Program, and
22 it begins on January 1st, 2025. Next slide.
23 In addition to ACO PC Flex, we are
24 thinking about what comes next after ACO REACH
25 ends in 2026. We have heard a lot of feedback

1 from our participants, as well as ACO
2 organizations and providers.
3 We also included an RFI in the PFS[55]
4 asking for feedback on a higher-risk option in
5 the Shared Savings Program, financial
6 methodologies for high-risk ACOs, and future ACO
7 models. Thank you to all who responded to the
8 RFI.
9 When designing financial methodologies
10 for models, we consider what participants value
11 and what CMS must accomplish. For participants,
12 it's prospectivity and predictability, and for
13 CMS, accuracy and budget neutrality. Balancing
14 these goals is challenging.
15 The dynamic that underpins most
16 parameters of financial methodologies for models
17 like ACO REACH, is a necessary tension between
18 participant predictability and model accuracy.
19 We will draw on lessons learned from
20 previous models, as well as feedback from
21 interested parties as we consider where we go in
22 the future to design ACO models that can inform
23 and grow the Shared Savings Program.
24 These include changes to benchmarking

55 Physician Fee Schedule

1 to continue to make long-term participation
2 sustainable and attract new ACOs, improve
3 beneficiary attribution that can support
4 meaningful specialty engagement and care,
5 strengthen relationships between ACOs and
6 community-based organizations to address health-
7 related social needs, and assess the impact of
8 voluntary participation in model tests on
9 quality, access, and saving. I think now we're
10 turning it to Sarah.
11 DR. FOGLER: Thank you much, Pablo.
12 Hi everybody, great to see you. Sorry for not
13 being there in person, but I think you will be
14 pleased with our portion of the presentation
15 today, which is really focused on how the
16 specialty side is complementing the Center's
17 vision for driving accountable care in the health
18 care system.
19 So I don't have to reiterate, we have
20 heard, and this group knows more than most, we
21 are driving this accountable care infrastructure
22 through our advanced primary care models and our
23 accountable care organizations.
24 But I think we all recognize, and I
25 would just point you to this quote in our 2021

1 strategic refresh materials, that team-based
2 accountable care can't be accomplished with just
3 primary care.
4 We have to recognize the important
5 role that specialists play in our nation's health
6 care system. Delivering person-centered care
7 that's whole-person requires addressing the full
8 range of patients' needs from primary and
9 preventative care services to managing chronic
10 conditions longitudinally and episodic care needs
11 acutely. Much of this is provided by specialty
12 care providers.
13 So in 2022, we developed and released
14 a specialty care strategy that's really about
15 enabling better communication, coordination, and
16 integration between primary care and specialty
17 care providers.
18 Each element, there are four elements
19 of this multi-prong strategy, is consistent with
20 the Center's broader accountable care goals. And
21 in my opinion, I think the beauty of the
22 specialty strategy is that it considers data and
23 learnings from the previous decade worth of model
24 testing, it capitalizes on existing model
25 implementation, and it introduces new model

1 concepts and initiatives that fill gaps.
2 So let me take us to the next slide.
3 We can go to the next one. So these are the four
4 elements, and I expect this audience to be quite
5 familiar, but I just want to briefly re-anchor us
6 in them, because we have so many short- and
7 long-term plans associated with these four
8 elements, it can be kind of easy to get lost in
9 the details or the independent milestones we're
10 tracking to across all four of these elements.
11 The first element, and you know, I
12 should say too, I called into the morning panels
13 this morning, and I heard a lot of themes with
14 Zeke and Michael and others on the panel, Tim,
15 too, I think they were talking about making sure
16 you have different incentives for primary
17 specialty and procedural care, you know, the
18 mandatory design of some models, the need for
19 data sharing.
20 So all of these themes, I think, are
21 woven throughout, I am happy to say, in the
22 specialty care strategy that's really outlining
23 our path for many years to come here.
24 So this slide just quickly summarizes
25 those four elements. The first is really about

1 enhancing data transparency on specialty care
2 performance, sharing data on specialists who
3 provide high-quality care that is at potentially
4 lower costs, can inform referral decisions,
5 again, help primary care practitioners and ACOs
6 identify good partner specialists, et cetera.
7 The second element really entails
8 maintaining momentum. On more than a decade
9 worth of work that we've embarked on with
10 provider partners, on conditioned-based models
11 like kidney, oncology, we have a new dementia
12 care model, and episode-based payment models that
13 I heard mentioned a bunch this morning as well.
14 The third element of our specialty
15 strategy is really a nuanced idea here, although
16 probably not an aha moment for many of us that
17 have been at this for a while.
18 And it's really about, you know,
19 continuing with the efforts that we have put into
20 bolstering primary care in that infrastructure,
21 but also really, you know, and we've done, I will
22 say in the, as Purva would say, we just embarked
23 on our fourth successor model here in the primary
24 care space. So we've been at this awhile.
25 And I will say in the first three

1 models, we implicitly were encouraging specialist
2 engagement and involvement through our primary
3 care models. But we didn't really have levers to
4 pull in specialists into those arrangements.
5 And with the new Making Care Primary,
6 we have introduced those types of explicit levers
7 to really do a better job through our primary
8 care models, pulling specialists in through new
9 types of incentives.
10 The other really neat part of this
11 element, in my opinion, is that it's married up
12 with plans that we have for ambulatory specialty
13 care. And I will talk a little bit more about
14 that in a couple minutes.
15 But the idea here is that we are
16 pulling multiple levers. So we have work
17 occurring in the primary care space, again, to
18 bolster that infrastructure and resourcing for
19 primary care practices.
20 But we're also making incentives
21 available for specialists providing chronic
22 condition management new tools and incentives to
23 engage in value-based care.
24 The fourth and final element has
25 flavors of the preceding three. It's really

1 about providing more data, it's really about
2 providing tools and incentives for specialists to
3 meaningfully engage with ACOs. There's some
4 specific levers we’re exploring here, but this is
5 a longer-term feature of our specialty strategy.
6 So early thinking, kind of playing off
7 Pablo's statements about kind of the next
8 generation of the ACO work we'll be embarking on,
9 we'll look specifically at our attribution
10 methodologies, certain quality measures that we
11 might contemplate to better engage specialists in
12 the ACO framework, and then of course, some
13 financial incentive opportunities to actively
14 engage specialty care.
15 Let me take us to the next slide,
16 which is really around the accomplishments in
17 2024. Oh, I'm sorry, we're not there yet. I got
18 too excited to share our accomplishments.
19 What I wanted to point out on that
20 next slide, though -- we can go there, on slide
21 4, is the Innovation Center's work in the
22 specialty care space has really been -- you can
23 see on this patient care journey map, in the
24 acute medical event post-acute care space. CJR,

1 BPCIA[56], for example, we've really engaged
2 proceduralists in those models.
3 But there was all this remaining space
4 on the care continuum that we really didn't have
5 explicit levers at play to engage specialists in
6 value-based care.
7 So a lot of our work and it's
8 oriented, these four elements and especially
9 strategy along this continuum of a patient
10 journey, because it helps us kind of organize
11 those multiple models at play here and are really
12 trying to address all points on a patient care
13 journey and engage specialists in the value-based
14 care along and in partnership with primary care
15 physicians.
16 So let me now take us to our 2024
17 accomplishments, just so we can report out and
18 hold ourselves accountable for some of the work
19 that we have done in the past year. So some
20 early successes here, we have started to release
21 data to ACOs.
22 And this data is really constructed
23 episodes, 34 episodes that are currently tested
24 in BPCIA, we're now providing that information on

56 BPCI Advanced

1 attributed beneficiaries to ACOs.

2 I was just on a webinar last week with

3 six representatives from different ACOs about

4 their experiences with this data, and it's

5 really -- the early feedback has been really

6 positive.

7 Folks are really excited about the

8 opportunities associated with this data, just to

9 better understand the specialized services that

10 their beneficiaries are receiving, which

11 providers, you know, they might want to engage in

12 conversation with about some of the data

13 performance.

14 We also published an implementation

15 update on our strategy blog in March, again, just

16 trying to highlight how we're progressing along

17 the elements, the strategic elements that we laid

18 out.

19 Folks may be familiar with the new

20 TEAM model, Transforming Episode Accountability

21 model, and this is a successor, a little bit of a

22 Frankenstein version of some of our CJR

23 activities and our BPCIA episodes, but really

24 focused narrowly on five surgical episodes in our

25 model we did finalize, a mandatory episode base

1 payment model that will launch January 1, 2026.
2 And we'll be working with the
3 mandatorily assigned hospitals for that model
4 over the 2025 calendar year to prepare them. We
5 also released and just received comment on
6 September 9th, an ambulatory specialty care RFI
7 in the calendar year 2025 Physician B schedule.
8 So we are actively combing through
9 comments. But what I just wanted to highlight
10 was again, Element 3 of our specialty strategy
11 where we had explicit features of our new primary
12 care model, and we're trying to marry those up
13 with some specific incentive structures for the
14 ambulatory care specialty practices, so that
15 we're working from both sides of the equation
16 here. So excited to see how people received and
17 thought about that.
18 We also are launching data dashboards
19 and are making sure primary care participants are
20 able to see within their market, specialist
21 performance across their -- or, I'm sorry, their
22 primary care attributed lives, but also just all
23 Medicare beneficiaries in a given market.
24 So if they haven't identified a
25 specialty program in the past, they may decide

1 they want to by combing through this data. And
2 also just wanted to put a plug in for our
3 condition-based models here.
4 We did launch GUIDE[57], which is a
5 dementia-specific model July 1st, so we'll be
6 kind of watching how that unfolds, along with the
7 Making Care Primary model. And for an oncology
8 model, we've just -- or are just, I think we're
9 right on the cusp of closing a second application
10 period for that model.
11 So lots of what feels like disparate
12 work here, but there's a method to the madness
13 that all of this is tied to one or more of the
14 four elements of the specialty care strategy. So
15 let's move to the next slide, and I'll tell you
16 where we're headed.
17 And this is really again, a lot of
18 these milestones are going to take us for way
19 beyond just the next two years here. But for
20 what we're focused on for 2025 and 2026, here's a
21 list of six things that come front and center for
22 me.
23 All of the specialty strategy work
24 that we have published has really been fed by

57 Guiding an Improved Dementia Experience

1 engagement with stakeholders, so beneficiaries,
2 physicians, non-physician practitioners that are
3 working in the specialty care space, health
4 policy experts, so we plan to continue that.
5 We're working a lot with specialty
6 societies at the moment. Talking about measures,
7 for example, we've had a number of RFIs. So that
8 continued robust engagement will hopefully be
9 maintained in the coming years just so we can
10 right the ship if we get sideways.
11 But also be, you know, staying ahead
12 of trends in a way that makes the elements of the
13 specialty society successful over time. We also
14 plan to expend -- extend, I'm sorry, and expand
15 on our data sharing offerings, so we, I
16 mentioned, are sharing episode data.
17 We plan to, soon, in 2025, share
18 episode-based cost measure data, so more on the
19 chronic condition specialty care services and
20 costs. And so that again, will go out initially
21 to ACOs and then we'll be expanding that data
22 sharing offering over time.
23 I mentioned combing through comments
24 that we're getting on a potential new concept in
25 the ambulatory specialty care space. Also

1 supporting hospitals that will be mandatorily
2 required to participate in the new TEAM model.
3 We have data sharing plans for that, we have
4 webinars on the docket to help them prepare.
5 I also mentioned our condition-based
6 models continuing to support those. And the
7 final one on here, a kind of late breaking, and I
8 just want to share with this group, I won't go
9 into depth here, but we are planning to publicly
10 release implementation performance metrics
11 specific to the specialty care strategy.
12 So everyone may remember that the
13 strategic refresh a year or two thereafter was
14 followed by what metrics the Innovation Center
15 would be holding themselves accountable for to
16 drive these accountable care goals and the other
17 strategic objectives.
18 We're going to do a similar process
19 for the specialty care strategy, so in 2025, look
20 for a handful of metrics that we will be publicly
21 reporting on at some frequency to demonstrate our
22 progress towards better engaging specialists,
23 better meeting beneficiaries' specialized needs.
24 All of what we just talked through in the
25 preceding slides. So let me stop there. And

1 hand it, I think back, maybe to the moderators.
2 MS. DAVIDSON: I think I'm up, Sarah.
3 Thank you.
4 DR. FOGLER: Sorry, Kate. And now
5 Kate Davidson, with no further ado.
6 MS. DAVIDSON: It’s good to be there
7 with you all day. I think that you heard across
8 the board today all of us mention, the goal that
9 we've set at CMMI to try to ensure that 100
10 percent of Medicare beneficiaries and the vast
11 majority of Medicaid enrollees are in an
12 accountable relationship by 2030.
13 And as we set out to make progress
14 against that goal, it was really important for us
15 to understand what the barriers were to be able
16 to achieve that, and also what some of the
17 potential solutions would be.
18 We know that one of the real reasons
19 why providers are not adopting APMs or moving
20 into value-based care, is because of the
21 administrative burden that comes along with
22 participating in some of our models, as well as
23 in value-based care arrangements across other
24 payers in the landscape.
25 And so we've heard very clearly from

1 providers that some of the challenges that
2 they've experienced are related to reporting and
3 collecting data, as well as to -- as well as
4 analyzing their data and aggregating that.
5 So for this reason, the Innovation
6 Center set a goal within our strategic refresh to
7 include a multi-payer alignment strategy across
8 100 percent of the new models where applicable.
9 I was really glad to hear this morning that a
10 number of the presenters also focused and talked
11 about multi-payer alignment in their remarks as
12 well.
13 So there's a real, I think, focus on
14 this across the industry. But in addition to
15 setting a goal to include payers in our models,
16 we've also shifted our approach to partnering
17 with payers.
18 In the past we've asked payers to
19 largely adopt the models that CMMI has developed.
20 But we know that just like us, our payer partners
21 have also learned a lot over the 12 -- over the
22 last 10-plus years that they've been testing
23 APMs.
24 They've invested in operational
25 changes within their own organizations, and they

1 are also serving different patient populations
2 with different needs across their lines of
3 business. So we're testing a new approach to
4 alignment that is predicated on payer
5 partnership.
6 You can see here on this slide, how we
7 are approaching this work across the life cycle
8 of our models, working to create industry buy-in
9 and align priorities early at the concept or
10 ideation phase, actively recruiting payers
11 through individual and group conversations to
12 participate in our models, understanding what
13 their priorities are, and what the value
14 proposition is for them to align with us,
15 increasing the number of lives that are covered
16 across lines of business through the
17 implementation of our models, and continuing to
18 adopt the learning store models across our
19 portfolio and into successor models to sustain
20 industry changes, which is like what Purva talked
21 about earlier in her remarks.
22 In addition to all of this, and as Liz
23 mentioned, we're actively working across all of
24 our partnerships in CMS, across the lines of
25 business in Medicare, Medicaid, and the

1 Marketplace, to pursue all the potential policy
2 levers that we have in order to support alignment
3 efforts. Next slide, please?
4 The graphic on this slide was taken
5 from a policy report and framework recently
6 published by the Duke-Margolis Institute for
7 Health Policy.
8 The Health Care Payment Learning and
9 Action Network, or the LAN, adopted this
10 framework and are leveraging its approach as we
11 align efforts across payers and other industry
12 parties to reduce provider burden.
13 We're also using a similar directional
14 alignment approach across the Innovation Center's
15 model portfolio. You can see on this graphic on
16 the left, the functional areas of directional
17 alignment, performance measurement and reporting,
18 health equity initiatives, which I know that
19 Alice Chen mentioned earlier today, technical
20 model components that Michael McWilliams really
21 mentioned in his remarks earlier, data sharing
22 and aggregation, and technical assistance.
23 And the idea is that we are leveraging
24 shared goals across lines of business to promote
25 alignment in these key areas. And we know that

1 you can't just turn alignment on like a switch.
2 It takes time, effort, and resourcing for payers
3 to align.
4 So on the right hand side, you can see
5 a graphic that shows the process for which we are
6 aligning as payers over time, assessing needs and
7 gaps, engaging stakeholders, developing concrete
8 action plan, leveraging existing trusted local
9 and national conveners, such as the LAN, and
10 implementing and continuing to iterate and refine
11 over time. Next slide, please.
12 And finally, I want to share an
13 example of this alignment work in action through
14 one of our newest models that Purva mentioned
15 earlier, Making Care Primary or MCP.
16 We're so pleased with the initial
17 response that we've received from our payer
18 partners in MCP. We received over 50 letters of
19 interest from national and regional payers
20 interested in the setting of shared vision and
21 goals for primary care across the eight states
22 where we are testing MCP.
23 In MCP, we worked with the payers
24 prior to the model launch to identify shared
25 vision for goals and primary care, completed an

1 environmental scan of the most common measures
2 used across payers, and identified a parsimonious
3 set of quality measures that we are testing in
4 the model, that is also aligned with the
5 universal foundation set.
6 We also developed a data sharing
7 strategy with the goal of having a shared all-
8 payer data aggregation approach for providers so
9 that we are supporting them to look across their
10 entire panel rather than a slice of their
11 population covered by any one specific payer.
12 We worked with the state Medicaid
13 agencies before the announcement and launch of
14 the model to support a deeper understanding of
15 the policy and care delivery context specific to
16 their states.
17 And finally, we developed a hyper-
18 local approach. The Innovation Center is
19 resourcing local infrastructure in recognizing
20 the need for flexibility with our payer partners
21 to include additional design elements based on
22 their local priorities.
23 This is a ten-and-a-half-year model in
24 primary care. So this is just the beginning of
25 our partnership and alignment efforts. We see

1 this as an iterative process and an opportunity
2 to refine the design elements within our models
3 over time as we work together with those partners
4 at a local level.
5 And with that, I would like to thank
6 the PTAC, as well as ASPE for bringing all of us
7 here together and for having me here today.
8 CO-CHAIR SINOPOLI: Thank you all.
9 And we really appreciated all your comments,
10 there is some great insights. And now, if the
11 Committee members have questions for our guests,
12 if you will flip your name tent up, and we will
13 recognize you to ask questions.
14 So I have one question. I think early
15 on, you mentioned support for team-based care and
16 bundling that payment for team-based care. I
17 would like to understand a little bit more what
18 you mean by that and how you're defining the
19 team. And when you say bundling that for
20 payment, is that putting the teams at some kind
21 of risk or is that -- what does that mean
22 exactly?
23 DR. FOWLER: I think this might be for
24 Sarah?
25 DR. FOGLER: I'm happy to take this.

1 Yeah. So thanks for asking that question. I
2 think that we have some proposals in the, again,
3 this calendar year 2025 physician fee schedule
4 that were about this advanced primary care
5 management bundle.
6 And so, you know, we're tracking to
7 the annual cycle of the physician fee schedule
8 rule that any clinician enrolled in Medicare is
9 able to bill for services. But there's really a
10 grander plan, and we asked some questions and
11 accompaniment with those proposals around this
12 APCM code.
13 And it was really asking about a
14 future state scenario where we might be able to
15 introduce hybrid prospective payment into primary
16 care through the physician fee schedule.
17 So we're just asking a lot of
18 questions but starting out of the gate with a
19 very small bundle of care management codes that
20 we've historically seen as being underutilized,
21 but also being like, just really hard to bill
22 because there's lots of documentation associated.
23 I would say this year's proposal is
24 really a toe dip in the water of trying to pay
25 differently for team-based primary care. But it

1 would be a multi-year effort.

2 So there's not really specificity yet

3 around how to construct the team. For example,

4 the level of detail that you would see in terms

5 of eligibility requirements in an advanced

6 primary care model in the Innovation Center we're

7 not to that point yet in the physician fee

8 schedule. But the idea here is to translate

9 learning, as Purva was describing, the same way

10 that we translated ACO learning into the

11 permanent Medicare Shared Savings Program and

12 taking some of those learnings from our Advanced

13 Primary Care model and translating them into

14 permanent pathways in traditional Medicare.

15 And so, again, APCM proposals are

16 really around small bundling of care management

17 codes to reduce administrative burden in the

18 initial years of implementation.

19 But we do have a vision for trying to

20 drive team-based care and payment through the

21 physician fee schedule in future years, which is

22 why we have an RFI accompany those proposals in

23 this cycle. I hope that's helpful.

24 DR. FOWLER: And we would welcome your

25 input once we get the responses to the RFI, we

1 have a chance to review them, we can share those
2 and really talk about what those next steps are.
3 So happy to involve you in that future
4 conversation.
5 CO-CHAIR SINOPOLI: Thank you. I
6 appreciate those comments, and I think it is very
7 important to address that topic, so thank you.
8 Lauran?
9 CO-CHAIR HARDIN: So as you're looking
10 across lines of business and across -- and
11 towards an all-payer model, I'm curious what
12 themes are emerging as universal practices that
13 you might consider to address health equity and
14 also health-related social needs? That's the
15 first level of question.
16 MS. DAVIDSON: Sure. I'll start and
17 then I'm sure Purva, who is leading our health
18 equity efforts, will have a lot to say on this
19 front. I think first, and foremost, there's a
20 lot of focus on data collection around REaL[58] and
21 SOGI[59] data.
22 I think folks are really interested in
23 getting that right. There's a lot of technical

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

1 aspects of that and a lot of things are changing
2 and evolving with the -- with a lot of the data
3 infrastructure across the country.
4 I think that we want to get to a place
5 where there's alignment in collection efforts, as
6 well as some of the technical aspects of how
7 we're defining REaL and SOGI data across our
8 payers, so we don't get to a place where there's
9 so much fragmentation, much like we are in the
10 quality space right now.
11 So that's one major area focus, and
12 we've been doing a lot of thinking along with our
13 payer partners around just that. And then also
14 thinking about how we can pull in some of our
15 other stakeholders across the work across the
16 field and in implementation. So that's one
17 piece.
18 I think the next piece is also around
19 screening and referral. There is so many efforts
20 that are happening across providers, across
21 payers, and really happening in the local context
22 of referring to -- or for screening for social
23 needs.
24 But then there's that connectivity
25 piece about how do we ensure that then we are

1 finding them services that are very hyper-local
2 and in the community. So we've been, you know,
3 working across all of our models and to have a
4 strategic way of understanding best practices for
5 that.
6 And then thinking about how we scale
7 that. So you'll see that the LAN is getting a
8 lot of work through the Health Equity Advisory
9 Team, as well as the ACAC that was mentioned, the
10 Accountable Care Action Collaborative, to
11 understand just those best practices that we're
12 seeing emerging across the field.
13 And then paying that into the work
14 that we're doing around multi-payer alignment, so
15 that we're actually able to scale and implement.
16 DR. RAWAL: I think you did a pretty
17 good job of covering it. I will just take us
18 back a little bit to, you know, how we were able
19 to get to a point where we can have health-
20 related social needs screening and referral in
21 all of our models is really the work that the
22 Accountable Health Communities model did.
23 Where we were able to demonstrate
24 through that model that you can screen for HRSNs[60]

60 Health-related social needs

1 at scale in different geographies, regions, and
2 different settings. Unfortunately, we identified
3 a high level of need when the screening was
4 occurring.
5 But that we can also successfully --
6 people were very willing to also take navigation
7 services. And I think that's the picture that
8 Kate is painting as well.
9 That we set a baseline for screening,
10 and now what we're really trying to do is find
11 ways through, some of like, for instance, our
12 health equity payment adjustments that we're
13 making in all of our models to make sure that
14 we're resourcing those providers that are caring
15 for more complex populations, underserved
16 populations, to get beyond being able to screen
17 to refer, work with like, local community-based
18 organizations.
19 And our learning system has been doing
20 some really great work in highlighting some of
21 those best practices. For instance, an ACO REACH
22 model really understanding what some of the ACOs
23 are doing around building partnerships and
24 longer-term connections to ACO -- to community-
25 based organizations.

1 Because we know that, you know, across
2 a patient's journey, those health-related social
3 needs are often shifting and changing. So you
4 might resolve one, you might have another one,
5 you know, down the road. And so those long-term
6 connections are really meaningful.
7 CO-CHAIR SINOPOLI: Thank you. Larry?
8 DR. KOSINSKI: Just a quick question,
9 probably for Sarah. Do you see any roles for
10 APCM codes for cognitive specialty work?
11 DR. FOGLER: It's a great, great
12 question. And I think, was it the last meeting
13 that PTAC had, someone had shared a slide, I
14 don't know who constructed it, but it talked
15 about all the various ways primary and specialty
16 care coordinate over time and in some, it's more
17 intense, in some it's less intense. And when is
18 the specialist being the quarterback versus the
19 primary care physician?
20 I think the honest answer to that,
21 Larry, is we're still sorting through what our
22 intentions would be in the long-term for
23 cognitive specialists to bill APCM regularly for
24 chronic condition management.
25 So I think in the short-term, there's

1 no limitation on other than the eligibility
2 requirement as proposed in the rule to bill an
3 APCM code. I think the longer-term vision, you
4 know, we're still coordinating with input from
5 all of the experts here about how do you really
6 drive accountability when you have multiple
7 players at play?
8 And I think this is the question that
9 always comes back and resurfaces. And in these
10 meetings, but in all sorts of meetings, we've
11 talked about weighted attribution, or just
12 primary care attribution, or shared
13 specialist/primary care attribution, or just pure
14 specialist in the case of oncology and kidney.
15 So I think, again, the honest answer
16 to those questions, I think we're still debating
17 and batting around. But at this time, as
18 proposed, any physician or non-physician
19 practitioner billing the physician fee schedule
20 would be eligible to bill such care management-
21 oriented bundles.
22 Dr. Fowler: I think we're also
23 watching what happens in the GUIDE model, where
24 we do have a lot of, obviously, because the
25 patients are with dementia and all stages of

1 dementia, so we'll be watching very closely to
2 see what happens in that model and some of the
3 patterns and behaviors and what's working and
4 what's not.
5 CO-CHAIR SINOPOLI: Perfect. Thank
6 you. And Jim?
7 DR. WALTON: Thank you. Great
8 presentations. Thank you. I was going to pick
9 up on the comment you made about the
10 health-related social needs. And I, you know,
11 I've been doing some work in rural Oklahoma, and
12 what I was finding in a high ADI region where
13 there's low participation, where I didn't find
14 low participation.
15 The capacity to address health-related
16 social needs is the rate limiter. And I was
17 curious whether or not there was a model in your
18 mind's eye around capacity development through
19 the safety net infrastructure because that's
20 within the purview of HHS.
21 And I asked -- I posed this question
22 to some of the FQHCs, and it was with mixed
23 result, you know, because of it's out of scope,
24 oftentimes, you know, it would be way out of
25 scope.

1 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

1 lot of folks -- one of the things that Keith
2 Davidson and team just did was a series of rural
3 hackathons in Montana, Texas, and North Carolina.
4 And where we're trying to understand again, some
5 of those local needs, but also source innovative
6 and novel ideas.
7 And we did hear a lot about ideas
8 around health-related social needs and the need
9 to link communities to organizations, a lot of
10 them are under-resourced and overwhelmed as well.
11 And we can't really resolve those health-related
12 social needs without better partnerships across
13 providers in the CBOs[62].
14 But we're also really open to ideas
15 there as well, so you know, in your discussions
16 with FQHCs, Jim, if there's anything you can
17 share with us, I think we'd really welcome that.
18 DR. WALTON: Yeah. Just my, just one
19 comment here is that -- is that, you know, the
20 indexing around health equity oftentimes feels
21 like it's indexed to screen and maybe refer.
22 But if there's no place to send the
23 patients -- and so the question would be
24 somewhat, could it be indexed for places that we

62 Community-based organizations

1 know that in fact there's a problem with any
2 capacity and say we would love for you to develop
3 this, you know, adjacent to the health center
4 somehow, you know.
5 Make it be marketed if we can, if we
6 can find someone to do that, to come in, like
7 aggregators that does with primary care
8 aggregation, could do the same thing in other
9 areas if there were funds available through the
10 PMPM.
11 DR. RAWAL: Yeah. I think we'd be
12 open to hearing more and hearing about some of
13 those ideas.
14 CO-CHAIR SINOPOLI: Thank you. I think
15 Chinni is next?
16 DR. PULLURU: This is a question for
17 Sarah and Kate.
18 As you think about specialty spend and
19 integration, has there been any thought put to
20 sort of downstream product such as
21 pharmaceuticals, Part B, immunologics, you know,
22 the spend variation that happens there between
23 specialties?
24 And also as far as end-of-life care,
25 you know, productizing downstream to compensating

1 for hospice utilization or palliative care
2 utilization?
3 DR. FOGLER: I can start. And others
4 may have thoughts on this, too. But Kate and I
5 can maybe take a stab. I think the first, I
6 guess what I want to answer your question is I
7 think the first step in that -- in that process
8 is really about providing the data and
9 information to shine a light on where there is
10 differential patterns of services or as you were
11 describing, you know, downstream products or
12 services costs.
13 So I would say the specialty strategy
14 right now is really trying to arm model
15 participants, providers, and organizational
16 entities with more information so they can garner
17 insights specific to their network. So that's
18 what we're focused on right now.
19 I think on the question about
20 palliative and care for the serious ill
21 population, I think we have spent a lot of time
22 at the Innovation Center thinking about how to
23 best build a value-based care models for those
24 individuals.
25 And there's flexibilities for example,

1 that we've introduced into a number of our models
2 to promote and encourage better care delivery and
3 more team-based care for those individuals.
4 I think others may be able to speak to
5 that better than I can, like what they have seen
6 in terms of outcomes of those additional waiver
7 authorities, for example, to care for those
8 populations.
9 But the biggest parallel I can draw is
10 the work in GUIDE, which is not the same thing as
11 caring for a serious ill population or
12 end-of-life care and hospice, but there's some
13 overlaps there.
14 And that model has specifically
15 incorporated design parameters that really are
16 around building partnerships both with multiple
17 different provider types, specialty types, but
18 also community-based organizations.
19 And I was just reviewing data the
20 other day that came in for the applications for
21 the GUIDE participants The number of partners,
22 those, you know, Medicare provider types but also
23 community-based partnerships, it's just mind-
24 blowing, really, how communities have constructed
25 their participants and the theme-based care that

1 they're going to provide to individuals with
2 dementia and their caregivers.
3 So I would just -- that may be a long-
4 winded, slightly tangential answer to your
5 question. But I just wanted to point out like,
6 one, I think the data sharing is a big way to get
7 at those downstream, what's kind of happening on
8 the ground.
9 But also just expanding the
10 participant view so that we're promoting these
11 partnerships and we're bringing in different
12 types of providers. You mentioned pharmacy, we
13 certainly have those as a named participant or
14 provider partner in our Making Care Primary model
15 as well.
16 So the more we can promote different
17 types of providers and different types of, you
18 know, community-based organizations in the
19 construction of these models, I think we are
20 interested in doing that and have demonstrated
21 that in several of our model opportunities right
22 now.
23 CO-CHAIR SINOPOLI: Thank you, Sarah.
24 And I think our last question will be from
25 Jennifer?

1 DR. WILER: I think on behalf of all
2 of us, I just want to echo the thanks for
3 spending your time with us. We find these
4 sessions so valuable. I have a quick comment and
5 then a question.
6 My first comment is as a co-creator of
7 what I believe were the first care coordination
8 codes that went before CPT[63], that went down in
9 flames and were not approved, I'm so happy to see
10 the APCM codes being put forward.
11 And would just comment that I hope
12 that in the future that there's an opportunity to
13 expand those defined services also for specialty
14 care providers to participate meaningfully in
15 value-based care coordination.
16 My question is around pivoting from
17 just data sharing to insights through analytics.
18 We heard a lot about that this morning. And I'm
19 just curious, there's an important first step
20 that you all have described around data sharing,
21 which is fundamental.
22 But I'm curious how you all are
23 thinking about insights? And whose responsibility
24 is it to deliver that, and specifically from the

63 Current Procedural Terminology

1 Innovation Center's perspective?
2 DR. FOWLER: Sarah and Kate, probably,
3 do you want to take that, one of you?
4 DR. FOGLER: You should definitely
5 start, and then I can pick up.
6 MS. DAVIDSON: Yeah, I think there is
7 so much evolving in this space right now, which
8 is really exciting. I think that we -- there's a
9 real recognition that data and both reporting,
10 but also through the collection and through the
11 aggregation process is really important in order
12 to enable a population health approach to the
13 work.
14 We are watching and collaborating
15 very, very closely with our partners across HHS
16 to think about what are some of the policy
17 changes and shifts, and the opportunities that
18 are coming along with bulk FHIR[64] and APIs[65].
19 And how our models can support and
20 accelerate the adoption of some of that
21 technology and infrastructure. You know, I think
22 that from our perspective, we -- number one, we
23 want to see this kind of arc of a change and

64 Fast Healthcare Interoperability Resources
65 Application Programming Interface

1 shift.
2 Right now, I think CMS is really
3 taking the perspective that we need to make sure
4 that all of the providers that are engaged in our
5 models have the data in order to be able to
6 understand how they are -- how they are
7 performing within our models.
8 And so Sarah talked a little bit
9 around the data that's coming out of our
10 specialty care models. But we also have data
11 feedback tools that are across all of our primary
12 care models as well. We really think about what
13 the infrastructure is and what the providers need
14 in order to be successful in the models
15 themselves.
16 So all of that is to say, I think that
17 will shift over time as some of the data and
18 technology shifts as well. So we would love for
19 providers to be able to make decisions themselves
20 about who those aggregators are that they're
21 engaging with, whether that is, you know, an
22 enabler that is supporting their work within an
23 ACO, or whether that's an HIE that is supporting
24 the aggregation.
25 And in the meantime, CMS is ensuring

1 that we're providing those reports and the
2 information that those providers need to be
3 successful within our models as well.
4 CO-CHAIR SINOPOLI: Thank you.
5 DR. FOWLER: Maybe I want to add one
6 thing, is we just published an article in Health
7 Affairs, August 21st, talking about our data
8 sharing strategy. So I might refer folks to
9 that.
10 And if you wanted to have a further
11 conversation, Dr. Will Gordon, another of our
12 medical officers, is also a clinical
13 informaticist by training and leading a lot of
14 these efforts in conjunction with our leaders
15 here that you heard from today.
16 CO-CHAIR SINOPOLI: Perfect. And I
17 will echo again, statements have been made about
18 how much we appreciate you all's participation
19 with us and just enjoy talking to you and hearing
20 from you. So that's very much appreciated. So
21 thank you all, you know.
22 Right now we're going to take a break
23 until 1:40 p.m. Eastern time. And join us back
24 then. We'll have another great lineup of experts
25 for our roundtable panel discussions, which

1 focuses on stakeholder perspectives on a pathway
2 towards TCOC models. Thank you.
3 (Whereupon, the foregoing matter went
4 off the record at 12:43 p.m. and went back on the
5 record at 1:41 p.m.)
6 *** Roundtable Panel Discussion:**
7 **Stakeholder Perspectives on a Pathway**
8 **Toward Developing PB-TCOC Models**
9 DR. MILLS: Welcome back and good
10 afternoon. I'm Lee Mills, one of the PTAC
11 Committee members. At this time, we’re excited
12 to welcome five amazing experts for our next
13 roundtable panel discussion, who will share their
14 stakeholder perspective about a pathway towards
15 developing population-based total cost of care
16 models.
17 You can find their full biographies
18 and slides posted on the ASPE PTAC website. At
19 this time, I will ask the panelists to go ahead
20 and turn on their videos if you haven't already.
21 I will briefly introduce each of our guests and
22 give them a few minutes to give some introductory
23 comments.
24 And after all five introductions and
25 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

1 15 different networks that are consisting of both
2 employed and independent physicians.
3 Five of those networks are MSSP or
4 REACH, and if you break those down further, three
5 are MSSPs, two are an enhanced with significant
6 downside risk, one is Track C, and then we have
7 two REACH programs.
8 One is primary care capitation, and
9 one is total cost of care capitation.
10 Collectively, these five networks serve about
11 250,000 beneficiaries, 77 percent of which are in
12 some significant form of downside risk, meaning
13 greater than 40, 50 percent.
14 Collectively, if you look at this, our
15 MSSP and REACH organizations have saved about
16 three-quarters of a billion dollars since about
17 2015.
18 Our experiences, as you see at the
19 bottom of the slide, tell us there's three key
20 success factors. Number one, the adaptability to
21 policy change. And what we mean by this is, you
22 have to be willing to participate early in any of
23 the CMMI Medicare waivers or even commercial ACO
24 risks.
25 One of the things I like to say

1 though, is you need to do it with a purpose. It
2 can't be a side hustle or something some
3 department's doing independently of itself.
4 The second part of adaptability that I
5 want to be clear with is, sometimes these
6 programs change. And so that stroke of a pen can
7 immediately change the dynamics, for the better
8 or for the worse, such as in the BPCIA or REACH
9 changes. So adaptability is key to success number
10 one.
11 Number two, size, scale, multi-
12 disciplinary clinical integration across the
13 continuum is key. As you talk to people across
14 the country, some point fingers at specific
15 stakeholders in the value chain, thinking that
16 the cost is a particular person's problem or
17 person's provider type problem.
18 We actually firmly believe that
19 inclusion of primary care, specialty,
20 hospitalist, post-acute, are the only way you're
21 going to succeed in true total cost of care
22 models.
23 And one of the things we point out as
24 an example, is Advocate Physician Partners, where
25 I'm president of currently, is a 4,500-physician

1 clinic-integrated network. It includes employed
2 and independent doctors, primary care
3 specialists, post-acute networks hospitals.
4 And we've been clinically integrating
5 for the better of part two decades. And the
6 results are clear across all forms of lines of
7 business of our success. So we firmly believe
8 that's a key success factor.
9 And then the last success factor I
10 threw out is the sophisticated pop health
11 platform. You may think of it as infrastructure
12 cost, but to succeed, you do need advanced
13 analytics and risk modeling.
14 And all that starts with just
15 capturing and organizing the data, which is not
16 easy, nor is it cheap. But it also requires
17 equal parts of folks on prevention, as well as
18 managing acute episodes, and often through team-
19 based care, such as pharmacists doing that form
20 of dosing.
21 And then lastly, we'd say evidence-
22 based protocols that are tied to learning health
23 system are absolutely key. You can go to the
24 next slide. So if you take those three success
25 factors, we really see them manifesting

1 themselves across the domains PTAC's interested
2 in today, as you see in this chart.
3 I'll just call out two areas. At the
4 basic level, and I consider this table stakes, is
5 the willingness to participate. There's several
6 areas you can focus on.
7 But the general theme comes down to
8 this: one, there's a cost to participate, either
9 very currently financial or secondly as an
10 opportunity to cost.
11 And two, you have to consider the
12 opportunity to improve care and be financially
13 beneficial, not a deficit for you. So we think
14 that's what causes people to decide to
15 participate or not participate. Once you move on
16 to the advanced level, however, the thing gets a
17 little different.
18 And here we think to be advanced, you
19 do recognize the role of the hospital specialist
20 or primary care that you have to manage across
21 the continuum. Now, you'll see at the top there,
22 we do believe that are a need for different
23 degrees of flexibility in the models.
24 The way I engage a specialist might be
25 different than how I engage a primary care

1 doctor. And then lastly, we would say think
2 about risk adjustment differently. It's not
3 about HCCs, it's factors like frailty, SDOH[67],
4 polychronic conditions, et cetera.
5 So the current model that we are in
6 today, or the current environment, as you see at
7 the bottom of my slide, there's a lot of
8 competing CMS or CMMI programs. And we firmly
9 believe this leads to fragmentation.
10 Give you an example, when the Oncology
11 Care Model came out in 2015, our integrated
12 oncologists joined the OCM model, and it impacted
13 the network by allowing the oncologists to put
14 costs into MSSP while capturing more money
15 themselves.
16 Today we see the same thing happening
17 with Comprehensive Kidney Care Contracting, CKCC
18 versus MSSP. And it's even the little things
19 like identifying participating providers. MSSP
20 does it the TIN[68] level, REACH does it at the 10
21 NPI[69] level.
22 So Advocate alone had to spend over
23 $100,000 creating a separate TIN to be able to

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

1 participate in REACH. So thank you. I look
2 forward to the discussion today.
3 DR. MILLS: Thank you so much, Don.
4 Next, we're excited to welcome back Dr. Mark
5 McClellan, Director and Professor of Business,
6 Medicine, and Policy at the Duke-Margolis
7 Institute for Health Policy at Duke University.
8 Welcome back, Mark.
9 DR. MCCLELLAN: Thanks, very much.
10 It's great to be back with PTAC and great to
11 follow Don and be on such a terrific panel. Go
12 to the next slide, just a few comments I want to
13 make to start.
14 First off, some disclosure that people
15 might view as relevant. Next slide. One of the
16 things on that list is that I am one of the
17 co-chairs for the Health Care Payment Learning
18 and Action Network which reference the background
19 materials for this meeting, which is showing that
20 while we have made some important progress
21 towards a whole-person or person-first care, with
22 some direct intentional link to total costs and
23 important outcomes for the population treated, we
24 still have a long way to go. This varies across
25 programs.

1 What I would note is two things. One
2 is that CMS, under both the current
3 administration and previous administration have
4 been consistently committed to this goal. And if
5 you ask private payers or for that matter, most
6 other stakeholders, most of them believe that
7 these shifts in payment and shifts in care models
8 that those payment shifts support, are part of
9 the future.
10 So even though this has been slow
11 progress, a long way to go, not a sense that
12 there's a better solution out there, so that's
13 why this meeting is so important. Yeah, next
14 slide.
15 But say on just a 40,000-foot level,
16 made considerable progress in getting these kinds
17 of models adopted into primary care. I think
18 that's a great place to start.
19 Without advanced primary care, as many
20 of these models have shown, it needs more
21 resources, more reach, throughout the care
22 continuum.
23 It's very hard to build up a
24 coordinated longitudinal sustainable care model
25 for Medicare beneficiaries, as well as across

1 other payers.

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

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

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

70 Center for Medicare

1 supplemented perhaps with fee-for-service
2 payments for additional kinds of services, is a
3 fundamental approach that seems to work.
4 I'm not sure that CMMI needs to keep
5 setting up additional models separately on five-
6 year tracks to add into that. Probably more
7 important to have predictability that while the
8 details may continue to evolve as Don mentioned,
9 there will be different levels of moving away
10 from fee-for-service that will be sort of a high
11 end, direct contracting or REACH type option that
12 goes beyond the two or three years left in any
13 particular one of those models.
14 An overall framework that, I think
15 there's a growing amount of consensus to support,
16 and it should be a continuing area of focus for
17 further development.
18 Related to that, multi-payer alignment
19 is key. There have been a number of studies,
20 including a few more, just in the last month
21 showing that even primary care groups that are
22 pretty far along are facing 200 or more
23 performance measures that are covering a lot of
24 the same things.
25 And we just don't have that on the

1 fee-for-service side, where there's a standard
2 CMS developed and backed set of CPT, ICD[71], DRG[72]
3 type codes.
4 There's a lot of effort under way, and
5 I mention it in my appendix slides in the Health
6 Care Payment Learning and Action Network to
7 support multi-payer alignment at the state level.
8 And with national health care payers
9 and purchasers, people can't realign their
10 contracts on a dime. So asking people to join
11 the CMS program in the short-term is tough.
12 But again, with those predictable
13 signals about where we're going, there's a lot of
14 interest in getting on a pathway towards
15 increasing directional alignment, not just on
16 measures, but on everything else that matters,
17 benchmarks, data sharing, et cetera.
18 Third, we have a lot more work to do
19 on specialty care. Some good models like Don
20 mentioned for kidney care, where the nephrologist
21 kind of coordinate all of care, for oncology care
22 that can plug into these comprehensive models.
23 CMS is moving forward with their TEAM

71 International Classification of Diseases
72 Diagnosis-related group

1 model, a mandatory version for short-term common
2 episodes and procedures that are hospital-based.
3 The big missing area that is on the
4 CMS strategic priority list, is longitudinal
5 primary specialty coordination where there are a
6 ton of good ideas out there that are being taken
7 up in advanced Medicare Advantage plans with
8 sub-capitative primary care and specialists that
9 are in the same network moving further away from
10 fee-for-service care, and some employer plans and
11 Medicaid plans.
12 Finding ways to build these nested
13 models, you know, again, you need that primary
14 care, whole-person base for these models to work,
15 but supporting them.
16 For example, by giving specialists who
17 are participating in these models more
18 flexibility to bill on a person basis, to support
19 those longitudinal care coordination steps
20 instead of just getting paid for the procedures
21 and admission under fee-for-service, that's an
22 important area for further steps as well.
23 Next on the list is making sure that
24 our payment models are really based on person-
25 focused longitudinal care, not fee-for-service.

1 At some point, we’ll know we've kind of gotten
2 there when these models are no longer called
3 Alternative Payment Models, but they're kind of
4 the base.
5 This is an example of how this is
6 still playing out. When we set up the Medicare
7 Advantage program, I just had the privilege of
8 being there at CMS. We were looking for a way to
9 do risk adjustment to make this accountable
10 person level care work.
11 This was in 2004,2005, best available
12 data of course was fee-for-service claims at that
13 point. If you were designing risk adjustment
14 today, getting to Don's earlier comment, I don't
15 think you'd be using fee-for-service claims.
16 I think you'd be using data that can
17 now be captured accurately and reliably through
18 multiple modalities incorporated in the clinical
19 dashboards and care supports that clinicians
20 think really matters.
21 Things like frailty, things like
22 functional status, multi-morbidity, social --
23 social risk factors, et cetera. Those are all
24 doable today, just very hard to do in this
25 traditional model.

1 And it's leading to some growing
2 challenges in applying a fee-for-service reported
3 data which is often missing for some of the
4 biggest chronic disease risks based on
5 fee-for-service practices, which are not
6 representative of these emerging successful
7 models.
8 So transitioning to more modern data
9 can be less burdensome and can get a better basis
10 for aligning care reforms with the performance
11 measures that we're using in these now hundreds
12 of billions of dollar programs and getting
13 bigger.
14 Also with this evolution in making the
15 alternative models more the norm, person-based
16 care the norm, is recognizing that if we have a
17 good core structure to build on, shifting from
18 five-year evaluations, some more rapid learning
19 approaches, where more contained steps can be
20 tested.
21 Things like ways of sharing data more
22 effectively, between primary care and specialty
23 providers, things like making those adjustments
24 and the models that are inevitable as learning --
25 as evidence improves and technology improves,

1 they can be more predictable in ways in which can
2 be piloted with participants and with CMS, maybe
3 with other payers.
4 Rapid learning is an area where can
5 complement these five-year big long-term
6 evaluations. Got a lot to say about engaging
7 beneficiaries too, but we've got some other
8 panelists who have also some excellent ideas on
9 that. So I'll stop there and thank you for the
10 opportunity to join.
11 DR. MILLS: Thank you, so much, Dr.
12 McClellan. We're happy to welcome back as well,
13 Dr. Palav Babaria, Chief Quality Officer and
14 Deputy Director of Quality and Population Health
15 Management at the California Department of Health
16 Care Services. Welcome, Palav.
17 DR. BABARIA: Thank you so much for
18 having me back. And I think as many of you
19 probably know from last time, I serve as our
20 department's Chief Quality and Medical Officer.
21 And in that capacity, responsible for
22 all of our value-based payment initiatives across
23 the California Department of Health Care
24 Services, which is our state Medicaid agency here
25 in California.

1 So a few just grounding facts and
2 figures. In California, we currently cover more
3 than 14 million individuals, so on average about
4 one in three Californians are enrolled in
5 Medi-Cal, depending on what part of our state you
6 are in. Sometimes that proportion goes up to
7 close to 50 percent or more and in other places
8 it is a little bit lower.
9 More than 65 percent of our enrollees
10 identify as people of color, and we also have an
11 outsized coverage of children. So we cover about
12 40 percent of all births in California, and about
13 two-thirds of the children who are enrolled in
14 Medi-Cal identify as Black and Latino.
15 Like many other states, we also really
16 bear the majority of care and payment for
17 individuals with complex needs and unmet care.
18 So more than two-thirds of all of our long-term
19 care facility days are covered by Medi-Cal.
20 And then we currently also have a
21 number of justice involved initiatives that are
22 ongoing, where about 80 percent of individuals
23 cycling through our correctional system are also
24 eligible or enrolled in Medi-Cal.
25 So I give those backgrounds, you know,

1 as you heard from some of the previous folks on
2 the panel, multi-payer alignment is critical.
3 And in California it is hard to find practices
4 that are caring for Medicare Advantage or
5 Medicare fee-for-service patients who don't also
6 have a significant footprint in the Medi-Cal
7 space, just given how big our program is in
8 California. You can go to the next slide.
9 So I tried to keep it really simple
10 and focused for our feedback for this Committee.
11 I think the multi-payer alignment is critical.
12 We, as a state Medicaid agency, have definitely
13 been on a journey to improve Alternative Payment
14 Models and improving and supporting total cost of
15 care models for all of the reasons that this is
16 also being explored in the Medicare program.
17 We recognize that as we approach our,
18 you know, managed care plans, because about 99
19 percent of our 14 million individuals are
20 enrolled through a managed care plan, and then
21 there are downstream providers.
22 Doing this and having broadscale
23 uptake is really contingent upon how simple we
24 can make it for practices. For some of our
25 practices, they are working with five different

1 Medi-Cal managed care plans in their geographic
2 region.
3 They then have additional Medicare
4 plans that they are working with, commercial
5 lines of business Covered California, and it does
6 definitely, you know, lead to exponentially
7 worsening sort of burden to do all the reporting
8 to track the quality measures.
9 So we started several years ago and
10 were part of the HCPLAN state transformation
11 collaborative to really bring together at least
12 the public purchasers in California.
13 So DHCS covers about 14 million
14 people. Covered California is our state health
15 exchange, covers an additional over 1 million
16 individuals. And then CalPERS is our state
17 retiree, sort of pension public purchaser, who I
18 think is the second largest purchaser behind the
19 federal government of health care insurance.
20 And so collectively we cover almost
21 about half the state. And so we have aligned
22 across those three purchasers. So that link
23 that's in the slides here is our contract
24 language that all three of us, it is almost
25 identical, inserted for our managed care plans

1 about what our expectations are for downstream
2 Alternative Payment Models and primary care
3 spending that we are requiring consistently
4 across our three organizations.
5 We now have a state entity called The
6 Office of Healthcare Affordability that did not
7 exist when this multi-payer alignment contract
8 language was issued a few years ago.
9 That state department and office is
10 now issuing further guidelines statewide for how
11 we're going to achieve total cost of care
12 targets, how we're going to move into
13 establishing benchmarks and requirements for both
14 primary care spend, as well as Alternative
15 Payment Models.
16 And so we are updating our sort of
17 prior multi-payer alignment to now align with
18 that statewide effort, but we have gotten great
19 feedback that I think that has, you know, at
20 least brought more of the public purchasers to
21 the table.
22 And definitely, I think, as was
23 mentioned before, figuring out, you know, how do
24 we do that across Medicare and Medicaid,
25 especially in states where Medicaid is a

1 significant payer is going to be critical.
2 And exploring, you know, how can some
3 of these same efforts be spread across the
4 Medicaid program nationally would help with that
5 alignment for providers that really serve both
6 populations.
7 The second bullet here is really
8 around strengthening and centering primary care.
9 As, you know, Mark McClellan and others pointed
10 out, there is no future where we can really
11 achieve total cost of care targets that does not
12 involve improving and changing how primary care
13 is practiced in America today.
14 And I say that as still a practicing
15 primary care clinician who sees patients every
16 week that exactly that fragmentation, lack of
17 care coordination, is, you know, we all know
18 resulting in completely unnecessary and
19 burdensome and costly utilization.
20 And so we also have very specific
21 targets around what we expect of primary care and
22 have aligned those expectations and targets
23 across those same public purchasers in
24 California.
25 And then the last bullet is really,

1 you know, we recognize as you saw on that slide
2 right before this that states are very different.
3 We all have very different
4 demographics within Medi-Cal. Who we cover, you
5 know, is different than who my other public
6 purchasers are covering, who mostly are covering
7 older individuals, retirees, fewer children,
8 fewer pregnancies.
9 And really thinking about how do we
10 take a quality measurement approach that can span
11 the totality of all of the populations, but then
12 be sort of, you know, create subcomponents that
13 individual practices can adhere to, even if they
14 don't cover all of those lives, is really
15 critical.
16 And when we have explored, you know,
17 greater participation in some of the federal
18 models as a state, that has often come up as a
19 barrier that the model is really, you know,
20 designed for Medicare and does not exactly
21 translate to the Medicaid world.
22 And if we are going to actually get to
23 this multi-payer alignment, thinking about that
24 upfront and figuring out how do you do
25 measurement on a full population basis and think

1 about some of those sub-populations will be
2 really critical. Thank you.
3 DR. MILLS: Outstanding. Thank you,
4 Dr. Babaria. Next, we're excited to have back,
5 Dr. Mike Chernew, Professor of Health Care Policy
6 and Director of Healthcare Markets and Regulation
7 Lab in the Department of Health Care Policy at
8 the Harvard Medical School. Welcome back, Mike.
9 DR. CHERNEW: Thank you so much. It's
10 great to be here. A perfect panel, I've enjoyed
11 the comments that have been made so far. And
12 hopefully mine will be somewhat synergistic. I'm
13 looking forward to discussion.
14 So first a disclaimer, what I say
15 today is going to represent my personal views and
16 don't necessarily reflect the views of
17 organizations I'm affiliated with and that is
18 just an easy way of saying, I'm speaking as me,
19 not MedPAC. So anyway.
20 CO-CHAIR HARDIN: Michael, you're
21 muted, so after, if you could start at the
22 beginning of this slide, you're still muted.
23 DR. CHERNEW: How about now?
24 CO-CHAIR HARDIN: Now you're good. So
25 all we heard was MedPAC and then you were muted.

1 DR. CHERNEW: Yeah. I'm speaking as
2 me not MedPAC. But we'll go on. Let me -- I
3 just -- I only have two slides, so I'll give you
4 main thoughts.
5 The first one is, I'm not a fan in
6 general, or at least not a big fan, of the test
7 and diffuse paradigm that was put in place. And
8 I think this is going to be consistent with what
9 a lot of folks have said, and I think we're kind
10 of moving past it which is the performance of any
11 given model is going to depend on other available
12 models.
13 One thing that I thought was really a
14 shame, Don said was how many models did they have
15 at Advocate, so issues around which groups you
16 put in which models.
17 And remember everyone is trying to
18 decide which models to be in and if you're -- it
19 creates a lot of, I think, confusion, some
20 burden, and maybe some challenges in getting all
21 of the benchmarks and everything right when
22 you're juggling a whole bunch of different
23 models.
24 So I don't have a problem with
25 different models, but I think you have to be very

1 careful when there's too many models and you're
2 launching them all similarly.
3 There's a separate concern that
4 happens, I think, between episodes and
5 population-based payments, there has been a lot
6 of discussion on population-based payments, which
7 is the models can end up siphoning off savings.
8 So for example, if you avoid a post-
9 acute stay, which is an important thing to do,
10 and you have patients that could be in one model
11 or a population model.
12 If you run the models at the same
13 time, the savings can get siphoned towards say
14 the episode model, not the population-based
15 model.
16 So it's hard to get the population-
17 based model to work, and so you have to think
18 through how these models are going to work when
19 you have multiple people claiming that they're
20 the folks getting rid of the waste. I tend to be
21 a fan of population-based models.
22 I think that's the only way that
23 you're broadly speaking going to get the system-
24 wide reform and allow organizations within their
25 own context, so in this case, say advocates, to

1 build episodes they need internally to try and
2 engage with specialists in a whole bunch of ways.
3 So that would be my view of how to build those
4 models.
5 I also think there's a big concern
6 with some sunsetting models, which I think is
7 very much in the spirit of what Mark said in
8 terms of getting a long-term vision of where
9 you're going. If a model's a few year trend,
10 you've got to make a lot of investment to make
11 them work.
12 It's one thing, Don, when you said
13 there's a cost here, and you have to think about
14 how to manage the cost, you tweak it. But when
15 the whole model might go away, your real ability
16 to commit and invest becomes actually quite
17 challenging.
18 And so I think we just really need to
19 think of this as we’re transforming the way that
20 payment is done, more so than we are testing a
21 bunch of things and now we're going to launch a
22 bunch of new models, because that's what we do,
23 we launch models.
24 So the MedPAC recommendation is
25 basically to create a portfolio, synergistic

1 models built around a foundation of population
2 models and add episodes, and this part's
3 important, where the episodes are synergistic
4 with the underlying population-based model.
5 So where you think you can really add
6 to savings synergistically as opposed to, well,
7 we needed a model for this group, or we needed a
8 model for that group.
9 Or even worse, we didn't have enough
10 models, so we put some more models in. I think
11 you really have to worry about that sort of
12 mindset of building more, diffusing more. I
13 think the key point is to improve and execute on
14 the models that you have.
15 So I'm not saying the models should be
16 written in stone and never changed, I used the
17 word tweaked. But I think – you're going to have
18 to learn and tweak things.
19 But I don't think it's going to be
20 successful to continually redesign, you know,
21 sunset models, redesign models, and then re-
22 launch new models but different program
23 parameters in a whole range of ways.
24 The amount of effort it's going to
25 take organizations to figure out is this model

1 good, how does the benchmark working, you know, I
2 think it's just way too much to get real system
3 transformation. So next slide. I should have
4 said last slide.
5 So here's my top few four-ish design
6 and polish issues. Number one, avoid the ratchet.
7 You can't have organizations that succeed get
8 paid less in the future. There's a number of
9 ways to deal with that. They have a prior savings
10 adjustment that deals with part of it.
11 There's regional benchmarks that deal
12 with part of it when they blend it in. I'm a fan
13 of something called administrative benchmarks.
14 Administrative benchmarks is closer to what they
15 do here in Europe. I happen to be in Amsterdam.
16 Not exactly what they do, but they
17 have a sense of a budget, and then you have to
18 live in the budget, and you have rules for how
19 the budgets go up and down, and you're not
20 ratcheting it based on your performance or the
21 performance of everyone else in the market so
22 everybody's chasing everybody down. And
23 eventually that model's going to lose.
24 So you're going to get to a point
25 where you're not going to be able to save more

1 money. So I think we need to think through,
2 whether you agree with me or not, it would be a
3 wonderful discussion, but we really need to think
4 through how to avoid the ratchet of being a
5 victim of the organizations that are successful.
6 You want those successful organizations to really
7 be able to succeed long run, not just in the
8 short run.
9 Second thing is you have to improve
10 the ability to detect stinting. Mark said a
11 little bit about quality. I broadly agree. I
12 won't go into my ideas about how to do that, but
13 I think there's one view, which is reward
14 everybody and try and make sure that, you know,
15 everybody is getting paid more for doing better.
16 And I don't know how the, you know,
17 philosophical opposition to that, but I think
18 it's much more important than these models that
19 you worry that they're under-delivering care
20 because that's what their incentives are.
21 You need better measures to make sure
22 when that's going on. And those measures and the
23 systems around those measures might not be the
24 same measures as you would come up in a quality
25 measurement program like many of the ones we have

1 now.

2 Third point, I think the key thing
3 here is don't micromanage ACO activities. So a
4 lot of people think well, we believe that they
5 need to set contracts, not just at the ACO level
6 as population-based, but they need to push the
7 population-based down to the clinician level, or
8 they need to engage specialists with this type of
9 contract in a whole bunch of ways.

10 My general view is success is context
11 dependent. And what they do at Advocate is not
12 going to be what they do at MGH[73] or wherever in
13 California, you're going to do things
14 differently.

15 You have to allow the organization's
16 flexibility to do that and not expect that you
17 can build a contract that says even if it worked
18 on average, it's the way every organization
19 should manage their internal incentives and
20 reward systems and payment models.

21 And so again, I think that matters.
22 Sometimes you have salary, sometimes you need
23 bonuses for productivity. Organizations have to
24 be able to do that.

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73 Massachusetts General Hospital

1 The key point I'm trying to make is
2 ACO success requires flexibility of the
3 organizations to build the programs that they
4 need to build to be successful in their context,
5 and you shouldn't have limitations based on the
6 regulations where they're making decisions about
7 what they're doing because of the regulatory
8 requirements as opposed to what they think is
9 efficient for delivery and care.
10 Last point is, there's a lot of stuff
11 going on on the Hill and a lot of discussions
12 about how to support primary care. There's an
13 Alternative Payment Model bonus.
14 I have some ideas about the design of
15 that we can talk about later. But there's also
16 primary care capitation policies. There's a
17 physician piece -- physician pay bill, for
18 example, that's got a primary care capitate –
19 sub-cap primary care.
20 And then there's a bunch of global
21 service and care management codes, largely, I
22 typically call them the G-codes and had a bunch,
23 they've changed a bunch.
24 They all have this sort of flavor
25 providing some level of sub-capitation,

1 particularly for primary care in the case of
2 ACOs, maybe for total capitation. Those things
3 all inter-relate. So they create incentives for
4 what programs you want to be in.
5 And I don't know who, Don, you can
6 send me an email about the person's name, but
7 someone's got to be running an analysis to see
8 what works best for Advocate Health given if
9 there's all these new programs running around.
10 And will we actually be better if we
11 went back to MIPS[74] and took the partial cap
12 through the G-code as opposed -- you know, with
13 less risk, as opposed to the total cost of care
14 model which a ratchet that's moving us forward in
15 a ratchet way.
16 And these -- these sort of complexity
17 of decisioning when I listen to myself talk, I
18 realize how complex it is. The complexity -- you
19 know, the decision is such that I think the core
20 thing to do here is to slow down and try and
21 build something that's more synergistic that
22 works together, and not continually launch new
23 things to try and get at the same basic goal of
24 creating payment models that allow and incent

74 Merit-based Incentive Payment System

1 efficiencies.

2 So I think that's my last slide, so I

3 think we're going to go on to Charlotte, but I'm

4 glad I didn't -- if I had another slide, I was

5 going to be surprised. So, you're up Charlotte.

6 DR. MILLS: Very good. Thanks so

7 much.

8 DR. CHERNEW: And you're going to get

9 introduced and everything.

10 DR. MILLS: We're thrilled to have Dr.

11 Charlotte Yeh join us again, founder of Yeh

12 Innovation, Chief Experience Officer of Cherish

13 Health and former Chief Medical Officer of AARP.

14 Welcome, Charlotte.

15 DR. YEH: Thank you very much. So I

16 just want to be clear that I'm going to be

17 bringing in a number of perspectives. I've been

18 an emergency physician for over 20 years, and

19 that is really highlights the underbelly of the

20 health care delivery system and the shortfalls in

21 the community and social support.

22 But I've also been a policy and

23 regulator as the CMS Regional Administrator. But

24 most importantly, for the last 16 years, I've

25 been part of AARP as their Chief Medical Officer

1 in the business community doing a deep dive into
2 the consumer engagement within the private health
3 care sector.
4 And finally, the beautiful part is I'm
5 free of organizational constraints, you're going
6 to hear my personal insights, since I am now
7 free, and I am an advisor now for AgeTech, for
8 Innovation for Healthy Aging, and bringing
9 together all of these experiences. So next
10 slide.
11 So what I'd like to say is kudos to
12 PTAC and the staff, and I love our panelists. I
13 would say ditto to everything that they've said.
14 But I believe that there are two major omissions
15 that we have in these alternative payment and
16 total cost of care models, that if are not
17 addressed, these programs will not succeed.
18 First and foremost, I really haven't
19 heard anyone short of Mark saying beneficiary
20 engagement, anything about meeting the needs,
21 wants, expectation for the beneficiary.
22 You can build the most beautiful
23 program that then invites every provider and
24 specialist and primary care to participate. You
25 can build it, but the beneficiary won't come.

1 And we'll dive into that.
2 If we do not create the kinds of
3 incentives, infrastructure, and support structure
4 to be meaningful to the beneficiary, why would
5 they sign up?
6 And the second is, we -- the second
7 major omission is we talk about fee-for-service,
8 and we talk about the payers in fee-for-service
9 as they're all uniform and they're like every
10 other payer in the system. And the answer is
11 they're not.
12 About 21 percent of Medicare
13 beneficiaries actually pay out-of-pocket for
14 Medicare supplemental plan. And that is 41
15 percent of people who are in Medicare
16 fee-for-service. That is -- and there are
17 another 18 percent that have retiree benefit
18 supplemental plan, another 10 percent that are
19 dual eligibles. These payer sources are very,
20 very different.
21 And Medicare's supplemental plan is
22 extraordinarily different, because if we improve
23 the ACOs and they're billing for more Part B and
24 physician office visits and physician services,
25 which overall saves money, you're actually

1 hurting a Medicare supplemental plan, because
2 they don't achieve the savings because they pay
3 it out in Part B.
4 And the Part A savings reduce
5 hospitalization, ED[75] visits, et cetera, actually
6 go to Medicare. And then secondly, the Medicare
7 supplemental plans have the real opportunity to
8 dive deep into the consumer. So I'll talk a
9 little bit more about that in a minute.
10 First, back to the beneficiary. I
11 think where we have forgotten is what's
12 meaningful for the beneficiary. So to try and
13 keep this simple, to understand, I call them my
14 five Cs.
15 The first is cost. We talk about
16 total cost of care. But how many of you are
17 actually measuring the total cost of care to the
18 beneficiary, their family, and their caregivers?
19 Right now, caregivers provide about
20 $600 billion annually on out-of-pocket expenses
21 that are unpaid and unreimbursed. About 21
22 percent of the cost, and it's about $7,000 on
23 average by a caregiver, about 21 percent of that
24 is on home renovations.

75 Emergency department

1 So that if you want somebody not to
2 fall, you've got to build in safety bars, you've
3 got to have safety maneuvers, you've got to have
4 monitoring systems, you have to have wide enough
5 doorways, you've got to accommodate wheelchairs,
6 walkers, et cetera.
7 So 21 percent of the expenditure are
8 home renovations. Seventeen percent are medical
9 costs. Six out of 10 caregivers say that they
10 are actually being asked to do medical services
11 and procedures that they've not been trained to
12 do.
13 And it's not just in the out-of-pocket
14 expenses, but it's also time. There was one
15 study out there that says right now, your average
16 Medicare beneficiary spends about three weeks
17 going to and from in medical visits. That's 20.7
18 contact days, and about 11 percent of Medicare
19 beneficiaries spend 50 days or more in contact
20 with health care.
21 So what are you doing to make the time
22 efficient? Because what happens is anywhere from
23 12 to 30 percent of caregivers are either cutting
24 back on work or leaving their jobs in order to
25 provide that care. Where are you in the ACO and

1 in the beneficiary services thinking about the
2 time and money?
3 And finally, it's resources. About 28
4 percent of Medicare beneficiaries are solo agers.
5 So the amount of services you need for a solo
6 ager are very different than the ones I have just
7 described who are paying out-of-pocket as a
8 caregiver.
9 But what about hearing loss? Did you
10 know that about two-thirds of all people 70 and
11 older actually have significant hearing loss, and
12 yet it's not paid for by Medicare?
13 But more importantly, 49 percent of
14 people who have a lot of trouble hearing, do not
15 have a primary source of care. How are you going
16 to engage someone if they don't know how to
17 communicate?
18 How many of you are bringing into your
19 virtual visits, captioning, speech to text? How
20 many of you are using speech to text in the
21 office so you make it convenient, and you make it
22 easy for someone to communicate?
23 Then that second C is convenience. I
24 just told you how many hours it takes. Right
25 now, on average, a Medicare beneficiary has to

1 wait an hour -- a month, in order to get an
2 appointment. One out of six Medicare
3 beneficiaries is told to go to an urgent care
4 center because they can't get an appointment.
5 If you're going to bring in all this
6 technology, are you going to do it as a single
7 platform, turnkey operation? We know that
8 through AARP studies, about two-thirds of
9 Medicare older adults in, you know, that are 65
10 and older, say that technology and all the
11 services you are providing are not designed for
12 them.
13 We know that in ACOs and health care
14 systems, they're designed around the workflow,
15 the physician. Where are you designed around the
16 workflow of the patient?
17 Think about the capacity and
18 capability, not only of the primary care, but the
19 capacity and capability of the patient and their
20 family.
21 The third C is for choice. I think
22 this is way undervalued in this whole picture.
23 Why do you think 21 percent of people stay in
24 Medicare supplemental in fee-for-service Medicare
25 of the total Medicare beneficiaries?

1 Because they want the freedom of
2 choice. They want a doctor they trust. They
3 want a doctor who looks like me, not necessarily
4 that's assigned. They want a specialist that
5 will meet their specific needs.
6 And how about the ones that spend some
7 time in their home, that they go visit their
8 children, you know, are you taking into account
9 that maybe they are going to be getting care from
10 multiple sources? And don't underestimate how
11 important that choice is connected to having
12 trust.
13 The fourth is coordination effort, you
14 know, it's been recognized. I'm going to dive
15 into that a little bit deeper when I talk about
16 opportunity for success.
17 But think about the coordination, not
18 only of medical care services, but that
19 caregivers are spending about 13 hours a month
20 just managing insurance, appointments, just the
21 administrative cost of trying to take care of
22 themselves.
23 What are you doing to reduce that
24 time? And you bring those values, the
25 beneficiaries will come.

1 And finally, lastly, compassion. If
2 you don't build in time for touch, time to hold
3 someone's hand, time to help them through crises
4 in life, there's a study out there that AARP has
5 identified one in two older adult -- I mean, in
6 the last two years, one in two older adults have
7 gone through a significant transition, whether
8 it's health issues, retirement, issues with
9 children moving out, loss of a spouse.
10 If you don't take these pieces into
11 account, you will not allow your primary care and
12 your specialist to do their best job.
13 So and then finally, and you know,
14 that may sound daunting, and we can't possibly
15 think about the beneficiary, but this is where
16 can we work with our Medicare supplemental plans
17 for example?
18 So in -- at my time at AARP, we worked
19 very closely with our Medicare supplemental plan
20 and did care coordination for the high-risk and
21 most complicated patients.
22 We found that disease management
23 didn't really work, but if you did whole-person
24 care as Mark alluded to, we had a reduction of
25 hospitalization, reduction of ED visits,

1 reduction of falls.
2 And we have a positive ROI[76] that could
3 range anywhere from two to one, to three to one,
4 and then the most complex patients as high as
5 seven to nine to one positive ROI.
6 So that opportunity exists, but you
7 have to understand how to do consumer engagement.
8 And what was really unique is it didn't matter
9 who their physician was, this was a direct to
10 consumer, to coordinate their care so that they
11 could operate with a physician.
12 So if we did a fall prevention program
13 about 40 percent of all of the -- I'm sorry,
14 about 40 percent of the people we called about
15 opportunities to prevent falls called their
16 doctors, and about 6 percent actually had their
17 medications changed.
18 If they were on a high-risk
19 medication, 60 percent called their physician and
20 15 percent actually had their medications
21 changed.
22 So let's not forget about the lever of
23 use to the beneficiary, and let's not forget
24 about using existing models like Medicare

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76 Return on investment

1 supplemental plans which are 40 percent of fee-
2 for-service as an opportunity to help align the
3 payment, the payment structure, and the outcomes
4 that you want.
5 DR. MILLS: Thank you so much, Dr.
6 Yeh. I appreciate all those great introductory
7 comments from each of you. In interest of
8 ensuring balance across different perspectives
9 and questions, we'll encourage panelists to keep
10 each response to just a few minutes. We've
11 prepared some questions we think will kind of
12 crystallize all the rich strains of input we've
13 heard.
14 Question one is, what would you say
15 are the most important factors that affect
16 participation in an accountable care relationship
17 at the provider level or in different kinds of
18 geographic areas?
19 And a follow-up to that is, what are
20 the most important strategies to increase that
21 participation?
22 We'll start with Dr. Calcagno and then
23 Chernew and then Babaria.
24 MR. CALCAGNO: Great, thanks. To me I
25 simplify it this way, change is hard. Right? If

1 you look up behavioral economics, status quo
2 bias, people don’t like change. So I really boil
3 it down to, are providers willing to participate,
4 are thinking, am I going to be better off
5 tomorrow than I am today?
6 And then the question really is, well
7 what's that mean, is it financially better off,
8 is it my work flows easier, do I have more
9 administrative burden, or probably most
10 importantly, can I actually care for my patient
11 the way I want to?
12 So when you boil it all down and start
13 talking to clinicians, from our experience you
14 can really say it falls in a couple categories
15 which I have touched on before, right?
16 There is limited resources and lack of
17 infrastructure in small practices, small provider
18 groups.
19 The work we all talked about and do is
20 not easy, it does require a significant
21 infrastructure, so how do we support that?
22 Two, independent physicians are
23 entrepreneurs and by definition they are looking
24 to balance risk and reward. Now it may be
25 different for employed positions, but the

1 independent physician is definitely trying to
2 balance that equation.
3 And three, as I've alluded to, risk
4 models don't really do a great job capturing real
5 risk, frailty, access, social economic, et
6 cetera.
7 I firmly believe that you can overcome
8 this through better clinical integration. As I
9 mentioned Advocate Physician Partners, 4,500
10 docs. But what I didn't say is about a third of
11 our practices are less than three physicians.
12 Several are solo practitioners. But yet they
13 participate in these programs because we provide
14 them the infrastructure, we provide them the
15 financial backing, et cetera.
16 Two, I think you have to be flexible
17 in your model design by being across six states
18 and different markets. South side of Chicago,
19 very different issues than downtown Charlotte.
20 And so being able to approach physicians there,
21 or a rural doctor, et cetera, you need to be able
22 to approach them where it makes sense to them.
23 Again, I already mentioned the
24 application risk adjustment, not just the
25 financials but even some of the quality metrics.

1 We internally do some quality metric risk
2 adjustments as well.
3 And then again, I know I've said it
4 multiple times, but don't change the rules mid-
5 participation, right? I think Michael spoke
6 about that as well. That drives my clinicians
7 crazy. Hey, what you're doing, you did well,
8 we're not going to do it that way anymore.
9 And then from a beneficiary
10 perspective, I'm glad to hear you talk about that
11 Charlotte, I really there is a huge opportunity
12 for beneficiary engagement. Enhanced benefits be
13 it access, be it reducing their out-of-pocket
14 costs, be it helping them navigate their disease
15 states, et cetera.
16 There is a lack of awareness, there's
17 a lack of education. So helping them understand
18 why these are good for them. And then taking a
19 playbook out of some other models out there,
20 there is no reason we can't tailor some of these
21 plans to high-risk patients. To get them excited
22 and engaged to what they're doing.
23 And then lastly, I'll just add, if you
24 think about what the other payers do, they
25 require primary care selection. They have a very

1 much more defined network, which I know is not
2 always popular for people to say micro or narrow
3 network, et cetera, but it improves coordination.
4 And then they do offer supplemental
5 benefits. Our MA plans, the number one thing
6 that drives them in the Chicago market is if
7 there's a rich dental plan.
8 So I do think there are ways to incent
9 beneficiaries. Thank you.
10 DR. MILLS: Dr. Chernew?
11 DR. CHERNEW: Great, thank you. I'm
12 going to talk about five quick things, but I'm
13 not going to say much about them. One I said I
14 in my remarks, benchmarks have to be set well so
15 you're not going to lose when you model this
16 long-term.
17 Two, Don mentioned this, so I'll just
18 say it, risk, how much downside risk you are
19 imposing is a big deal for organizations. I
20 actually think the evidence suggests you can
21 succeed without downside risk, and so I would be
22 very wary of imposing a lot of downside risk
23 because you believe it's necessary for success.
24 I actually don't think it is.
25 I think I said a version of this in

1 remarks as well, it needs to be simple. It needs
2 to be simple in two ways. It needs to be
3 administratively simple. I think admin will kill
4 a lot of groups, it's just, who wants to spend
5 their time doing admin to participate. You really
6 have to simplify that part.
7 And then simplifying the choice. Now
8 remember, people are not choosing, I want to be,
9 and I want to be out. There's one thing. It's
10 like sending someone to the grocery store with
11 5,000 different versions of ketchup and saying
12 which ketchup do you want. It is a really hard
13 choice to participate if there's so many things
14 you have to weigh off and know what they are. So
15 you really need to simplify the set of models to
16 get people in.
17 And then the last thing about
18 participation that I'm going to say is, and no
19 one said this so it might be out of scope is, you
20 need a certain scale to succeed. And if Medicare
21 Advantage becomes 90 percent of the market,
22 you're not going to get a lot of people in. So,
23 you really need to think about how this plays
24 with the Medicare Advantage world. And if that's
25 out of scope, sorry.

1 Last thing I'll say about beneficiary
2 engagement and benefits and stuff, and I'm glad
3 an ocean away from Charlotte when I say this, I'm
4 a fan of aspects of beneficiary engagement, but I
5 think it's often said, without understanding the
6 full environment, I'm not saying Charlotte didn't
7 understand the full environment of what's going
8 on, people have a bunch of supplement benefits
9 that are, say for example, in the fee-for-service
10 world. You need to figure out how you're going
11 to coordinate different groups of people doing
12 different types of things in different ways.
13 And I worry that our desire to let the
14 ACO manage this is actually admirable, but it is
15 actually much more complex than you think because
16 now you're coordinating with what the benefit,
17 supplemental benefits are. And remember, the
18 main thing was, just make it simple to join,
19 right? Beneficiaries do need all the things
20 Charlotte spoke about, but they don't need
21 everybody to give it to them, right?
22 And so you need to figure out how
23 you're going to do that because the coordination
24 across these groups, and I feel the same way
25 about multi-payer coordination. If you want, Mark

1 mentioned Medicare Advantage plans doing this
2 underneath, which I think is a good idea, but the
3 Medicare Advantage plans, if they're using prior
4 auth and prior auth is saving money and that
5 money is then captured as a bonus to the groups
6 that they're sub-capitating, it becomes quite
7 complicated to figure out how it works.
8 So someone else on the call can
9 explain to me how to coordinate that.
10 I would simply end by saying, keep it
11 simple. Don't take the money away if they
12 succeed. Don't give them too much risk and then
13 you'll do okay. And be humble at what you can
14 accomplish. I'm done with my rant.
15 (Laughter.)
16 DR. MILLS: Excellent. Dr. McClellan
17 and Dr. Yeh, any brief comments on participation?
18 DR. YEH: Mark, do you want to go
19 ahead or, okay. So, first of all, Michael, you
20 said it correctly, simplicity, it can be done.
21 I'd also like to say, stop playing everything and
22 laying it on the providers, that there are ways
23 to engage the beneficiary directly.
24 Thirdly, we have not at all talked
25 about the opportunity with Medicare supplemental

1 plans that people choose so that they can see any
2 provider that they want. There's real
3 opportunity, but here's the problem, with
4 Medicare supplemental plans, if we do all these
5 quality improvement programs, if we do care
6 coordination, they are actually counted as
7 administrative expense and not medical expense.
8 So there isn't the incentive to bring
9 in where 40 percent of Medicare beneficiaries
10 purchase the Medicare supplemental plan, you
11 can't bring that payer in because all of these
12 efforts to improve quality and outcome and
13 coordination of care counts as an administrative
14 expense.
15 That's just one example of where we
16 could align. And let's understand who this lever
17 is that we have yet to use. And I can say, we
18 made it simple. We had over 30,000 beneficiaries
19 that we could demonstrate the longer they were in
20 the program, the fewer hospitalization, the fewer
21 ED visits, the fewer falls. But those were all
22 savings to Part A and not to the Medicare
23 supplemental plan.
24 So what can we do to bring that payer
25 in to work with the ACOs, to work with the

1 clinicians, and to work with the beneficiaries
2 because it can succeed? We modeled it in markets,
3 we scaled it across two states, we converted it
4 to telephonic, and we continued to have the same
5 results, including 44 percent less likelihood to
6 move out of the home into a long-term facility.
7 We're not tapping into this.

8 DR. MCCLELLAN: And quickly, Charlotte
9 and I in one way or another have been working
10 for, I don't know, a decade or so on how to get
11 you Medigap better integrated with traditional
12 Medicare and the shift to whole-person care
13 arrangements. That was an important issue.

14 Now as you see, like, you know, the
15 majority may be headed toward the vast majority
16 of beneficiaries being in Medicare Advantage
17 because they can get more generous benefits and
18 more coordinate, more generous benefits going
19 along with those networks, which traditional
20 Medicare doesn't do, at least not in the same
21 way. And that's the kind of choices, as Charlotte
22 said, that people want.

23 If people are left on traditional
24 Medicare at this point, generally are people who
25 have these supplemental coverage plans, or are

1 there for some other special reason. And that is
2 a key part of the future now. It's no longer
3 something you can just think about down the road.
4 And also on getting these additional
5 benefits and affordability to work, we need to
6 give ACOs, and these accountable providers, more
7 help across the whole spectrum of benefits.
8 You're seeing this play out over the next couple
9 of months in the Part D benefit redesign that's
10 happening, which is making the benefit much more
11 generous, which is great, but it means that the
12 prescribers, and the Part D plans, are bearing a
13 lot more risk than they used to.
14 That is so much easier to do in a MA
15 plan where you got transparency and visibility
16 into the whole beneficiary's care experience.
17 You can take stuff, like while using drugs it
18 might be costly, to get costs down, downstream.
19 You can have a more ability to influence what
20 would be an otherwise more generous benefit.
21 And that's showing up in the bids that
22 CMS got this year in the need for this special
23 demo. So that's something that may not be easy,
24 but I think can be addressed, and maybe even go
25 further.

1 And think about drug payment models,
2 to Mike’s point, that aren’t just, well let’s
3 just assume that any new drug coming on the
4 market is going to face a lot of prior auth, is
5 going to have to set a high price since the
6 volume is not going to be very big. It will be
7 10 years before we get the volume way up and the
8 price way down. Can’t get there faster if you’re
9 implementing all of these alternative payment
10 approaches.
11 So very important steps for getting
12 beneficiary engagement, starting with
13 affordability in the traditional Medicare program
14 from here on out.
15 DR. BABARIA: I think I got –
16 CO-CHAIR HARDIN: Yes, go ahead, Dr.
17 Babaria.
18 DR. BABARIA: -- skipped over.
19 CO-CHAIR HARDIN: I was just going to
20 say I think you were prepared to comment.
21 DR. BABARIA: No problem. So one, I
22 know this is out of scope, but to piggyback off
23 of Michael.
24 You know, in addition to really
25 thinking about what's, how is this carried

1 through MA I do think, you know, Medicaid is that
2 other piece. Because at some point if we want
3 this to be the norm for all health care payment,
4 and not an alternative model, we can get there so
5 much further if we figure out the Medicaid piece
6 and then commercial can follow, right?
7 You hit a tipping point across most
8 markets and most states if you can figure out a
9 way to do that. So thinking about where the
10 synergies are at the federal level would be
11 really helpful.
12 And then I think some of our practical
13 implementation experience at the state level is
14 really, even if the models are different, you
15 know, there is a lot you can really simplify and
16 standardize when it comes to which quality
17 measures, what the reporting looks like across
18 different models. And we have a lot of self-
19 imposed wounds that we had inflicted because we
20 have a lot of directed payment programs that flow
21 about $5 billion annually to mostly large health
22 systems and hospital systems.
23 And we had designed those in the silo,
24 and they were actually sort of adding
25 administrative burden. The measures were similar

1 but not exactly the same as all of the value-
2 based payment work happening in managed care, and
3 in our ACOs.
4 And so we, over the last three years,
5 have done tremendous cleanup. And have almost 99
6 percent alignment now over measures at least.
7 And have tried to simplify the administration as
8 much as possible. And we're really seeing the
9 dividends of that payoff where even if people are
10 participating in different programs, different
11 models, those synergies are very clear.
12 DR. MILLS: Wonderful, thank you for
13 that. We're going to turn now to incentives.
14 And the question is, what factors do you think
15 are most powerfully affecting primary care and
16 specialty, and/or specialty providers incentives
17 to participate in ACOs or other types of APMs?
18 And what would you think would be the
19 most important model desire priorities for given
20 that insight to what incentives are working and
21 impacting what would be the design priorities to
22 try to increase participation of different kinds
23 of providers in total cost care models over the
24 next five and a half years?
25 Sorry, let's start with Dr. McClellan,

1 then Calcagno, then Chernew, then you and
2 Babaria.
3 DR. MCCLELLAN: Great, well thanks
4 very much. I do think this is one of the big
5 challenges ahead. And I want to congratulate CMS
6 and PTAC for some focused increasing attention to
7 these issues in recent years.
8 CMMI has a whole strategy on steps for
9 this. And I know it's been a focus for all of
10 our interactions with PTAC. So hopefully some
11 real synergy opportunities for action there.
12 As I mentioned briefly in my remarks,
13 and reflected in a lot of our work, specialty
14 care is complex. And I do think you want to keep
15 it simple, to Mike's point, but we haven't, we've
16 kept it kind of too simple from the standpoint of
17 really getting specialists engaged in these
18 models.
19 One way that I think more help is
20 needed is in providing some models. Not
21 necessarily requirements, but just make it
22 easier. Especially for the smaller practices.
23 The physician-led ACOs to engage specialists more
24 effectively.
25 It's true that there is no one-size-

1 fits-all on how you want to compensate
2 specialists who are working with primary care
3 providers, but it’s also true that if you’re a
4 primary care ACO and you’re not Don’s size, and
5 I’m going to come back to the big ones in a
6 second, you have a pretty tough time engaging
7 with specialists. You’re not a big enough share
8 of the market to get the specialists to pay
9 attention to actually engaging in a, forming a
10 contract with you that works out those shared
11 savings and new steps for collaboration. And you
12 also don’t have the bandwidth to come up with
13 what those terms might look like.
14 CMS has done some interesting things
15 recently with their shadow bundles and stuff like
16 that to try to provide at least some templates
17 that can be used. Now give California some credit
18 on this. We’re looking at what California has
19 done around specialty engagement and some of the
20 work that we’re doing in the North Carolina state
21 transformation collaborative.
22 So some models that make this easier,
23 and this would be a great area for a rapid
24 learning test within an overall model. So, you
25 know, four providers who are in ACOs and want to

1 work more with specialists, if there is a
2 critical enough mass in the market of
3 specialists.
4 And there are a growing number of
5 specialists that are doing this in MA and see
6 Larry Kosinski there too. Sonar is a great
7 example of a model that is, you know, GI
8 collaboration on chronic management of conditions
9 that can't be sustained under current, easily
10 under current specialty payment mechanisms for
11 colonoscopies and doing procedures.
12 So there are some models that can
13 work. I think they can be piloted and implemented
14 more widely. I think collaboration between
15 groups like AGS[77] have been working on this.
16 ACC[78], orthopedic groups, AAOS[79]. There is some
17 good models out there.
18 And MA needs this too. The network
19 models there have implemented things like sub-
20 capitation arrangements and the like. But they're
21 still hurting, I think, for meaningful
22 performance measures. You know, getting to, for
23 example, standard functional status measures for

77 American Geriatrics Society
78 American College of Cardiology
79 American Academy of Orthopaedic Surgeons

1 people with back pain or lower extremity disease
2 or standard measures of outcomes and quality of
3 life for patients with inflammatory bowel
4 disease. These are not that hard to do now,
5 they're good standards out there, they just
6 haven't been built into the models.
7 For the hospital base and larger
8 systems, I really appreciate what Don is doing,
9 but got to say, there are a lot of hospital-based
10 systems out there that aren't yet fully on board
11 or engaged. They may have MSSP programs running
12 to help manage their medical patients, but not
13 necessarily fully engaging their specialty
14 groups, which are still accountable for turning
15 over procedures and getting those beds cleared
16 and used as rapidly as possible while getting by
17 in the shared savings model. There I think you
18 may need some more steps in the mandatory way.
19 You know, CMS is moving towards
20 mandatory bundles for the short-term episodes.
21 If you really want to get more of the payments
22 linked to coordination, not just for the primary
23 care doctors but for the specialists, and link to
24 things like tracking functional status over time,
25 I'm not sure voluntary is enough for these larger

1 integrated systems.

2 And by the way, there are a lot of
3 large systems that are not integrated like Don's
4 but are more consolidated. And I do think
5 there's some good ways to support more
6 independent primary care practices and specialist
7 practices to get that infrastructure. You don't
8 have to have ownership, necessarily, in order to
9 achieve these goals.

10 And conversely, what we have seen is a
11 lot of evidence that these larger systems don't
12 do as well in the ACO models and do have higher
13 prices.

14 DR. MILLS: Great. Dr. Calcagno.

15 MR. CALCAGNO: So, you know, a lot of
16 what I want to talk about is really what we've
17 already touched on. So a couple key things.

18 I think Michael said it, a portfolio
19 synergistic models. I think if you really want
20 participants, that's where you have to start. I
21 can go through a litany of examples where these
22 models competing with each other have actually
23 caused fragmentation across the work we're doing.
24 So I'd start there.

25 I'll end on what Mark talked about on

1 predictability and certainty. Again, most of our
2 independent physicians are entrepreneurs. They
3 basically want to be able to balance risk and
4 reward. And if a stroke of a pen can change the
5 model significantly, that's not going to be
6 exciting for them to participate.
7 And I know I've mentioned it multiple
8 times, but real risk adjusts I'll call it. A lot
9 of clinicians on the call today. And I know when
10 I talk to my physicians, both employed and
11 independent, they don't just see a hypertensive
12 patient, right? They see a polychronic patient
13 because that same patient has diabetes and also
14 has CKD[80], et cetera.
15 It doesn't speak to their SDOH
16 factors, their health disparity, their lack of
17 access, their frailty, et cetera. So real risk
18 adjustment that makes sense to the clinician.
19 And that goes, I think to the theme, I
20 think Michael started it, but several people have
21 said it, simplify. A lot of these programs are
22 way over engineered. And as a result, it's not
23 that doctors couldn't make sense of them, the
24 doctors aren't going to spend the time to make

80 Chronic kidney disease

1 sense of them. Something that should just
2 naturally make sense to the clinician would be
3 very helpful.
4 And I might add two other things that
5 I haven't heard spoken about a lot. One, I'll
6 call it eliminating the burden. When you look
7 at, again, I'll use my network, so again, 15
8 networks who looked across all our contracts, we
9 have 107 different quality measures. And even if
10 I looked at one single network, it's a very, very
11 large number.
12 One of the ones that really matter,
13 how can we standardize, how can we simplify.
14 Clinicians don't want to just check a box to say,
15 hey, they thought about this or did that. What
16 are the real things that they're are going to
17 improve our participation.
18 And then again, it's been said several
19 times, but don't punish success. When we're
20 successful in BPCIA, we're successful in REACH,
21 next thing we know the rules have changed.
22 You saw a massive exodus from BPCIA
23 when the rules changed. So we can't do that
24 because that goes back to the certainty
25 principle. And you also can't continue to reduce

1 targets when you've had continued success, so how
2 do you get around that ratcheting effect.
3 So bottom line I think at the end of
4 the day is, how do you balance all these things?
5 I think embedded bundles would make a lot of
6 sense. Again, that idea of synergistic models in
7 a portfolio. But then you also have to balance
8 that with what support and resources are you
9 providing?
10 You know, we are fortunate, as Mark
11 pointed out being a large system, we are able to
12 capture some economies of scale and whatnot. But
13 we still sometimes turn to Medicare Journey and
14 others that have access to data and have applied
15 bundles and things like that. Is there a way to
16 make that more accessible for folks that really
17 are smaller practices, smaller networks, et
18 cetera? Thank you.
19 DR. MILLS: Excellent. Thank you for
20 that, Don. Dr. Chernew.
21 DR. CHERNEW: So first I think we can
22 all probably agree that mandatory will really
23 help you with participation. So I won't dwell on
24 that.
25 My other piece of advice would be that

1 just design good models, and don't design so many
2 of the models that people are confused about
3 which ones to participate in. I'm less worried
4 about small practice, because I think if you
5 design good models you will get conveners and
6 other organizations that will enable small
7 practices to participate in ways that will allow
8 them to leverage things that being small they
9 wouldn't otherwise be able to do.
10 And then my third point, and I did
11 have a third point, was beware of episodes. So I
12 like episodes, I understand, but you really need
13 to think through what money is it, what do you
14 want to have happen where you're going to save
15 money and approve quality?
16 So one thing is, you want there just
17 to be fewer types of episodes. You want a
18 population health in a way that you don't need as
19 many hospital admissions, or whatever that is. I
20 completely understand.
21 And that money I think we're going to
22 agree, in many cases goes to the primary care
23 doctor. Some chronic conditions, you know, you
24 might want to go to a specialist who's managing a
25 patient, you know, nephrologist, or someone like

1 that. And I can understand that.
2 But a lot of the money from the ACO
3 savings, or the savings overall, is coming from
4 post-acute care. And so you need to be careful
5 if, who is going to get the money if you keep
6 someone out of a nursing home or you do some
7 other type of more efficient post-acute care. Is
8 that money go to a specialist because you have
9 now put in an episode where the specialist
10 controls that saving, or is that savings going to
11 go to the primary care doctor?
12 And if you put in a lot of episodes,
13 or you're not careful about what episodes you put
14 in, you will be giving all that money, you know,
15 my view is post-acute care is the ATM for ACOs.
16 And if you give that money to the specialist,
17 because you built a lot of episodes, you're
18 giving a lot of the money that I think the
19 population-based, primary care-based systems
20 would have been counting on to make their
21 savings, and they would be syphoned away to some
22 potential specialist who now controls it because
23 of the design of the episode.
24 So while again I'm not anti-episode, I
25 actually think there is a number of ways you can

1 like, in fact, I like the TEAM model because they
2 have really scaled back and thought about that, I
3 think a bit more you can debate TEAMS separately.
4 But I don't think trying to find a model that
5 fits everybody to engage them is going to be
6 helpful if those models span savings that
7 otherwise go to the organizations that are
8 bearing population risk.
9 DR. MILLS: Great. Okay, Dr. Babaria,
10 Dr. Yeh, last comments on that topic?
11 DR. BABARIA: I definitely ditto the
12 keeping it simple and really supporting stability
13 because that is really needed on the risk
14 stratification front. In our state Medicare
15 program for similar reasons, existing risk
16 stratification models and risk predictive models
17 are very utilization and cost-based and weren't
18 meeting our needs, especially around social
19 drivers of health and underutilization, so we are
20 building our own state-wide transparent algorithm
21 to do that predictive risk modeling that is more
22 clinically informed. So happy to follow-up or
23 provide info if that is helpful to anyone.
24 DR. YEH: And then I just want to add
25 in, because I haven't heard it spoken of, is a

1 lot of what we've describe tend to be elective in
2 planned care. But remember, about two-thirds of
3 care happens after hours, it's not Monday to
4 Friday.
5 So if really want to get participation
6 from the primary care and specialist we have to
7 be including the emergency departments, the
8 urgent care, et cetera, that provide that safety
9 net after hours which is good for the
10 beneficiaries and may help reduce the burden of
11 care on your clinician participants.
12 And with geriatric emergency
13 departments now growing, that can improve both
14 the outcomes, sorry Michael, but may reduce some
15 of the post-acute care needs in actually keeping
16 people into the home, and that kind of follow-up
17 care. I don't think we're tapping into that
18 lever as well to help the ACOs be more
19 successful.
20 DR. MILLS: Outstanding. Thank you
21 for that. We're going to stay on the theme of
22 incentives, but actually turn our attention to
23 beneficiaries.
24 And what kinds of incentive do you
25 think are most important encouraging beneficiary

1 participation of different, in the different
2 kinds of fee-for-service beneficiaries who are
3 not currently in the countable care relationship?
4 And I suppose as you've highlighted,
5 as we've got both MA and Med Supp and standard
6 fee-for-service, how do we align beneficiary
7 incentives to try to get the best outcome there?
8 We'll start with Dr. Yeh and Dr.
9 Barbaria and Dr. Calcagno.
10 DR. YEH: Well I guess I would start
11 with, we're not measuring the beneficiary
12 experience, if you will. One is, are we actually
13 measuring the total cost of care that the
14 beneficiary is spending on their out-of-pocket
15 expenses? If we really want them to participate,
16 it's just like if supplemental benefits and MA,
17 we should be allowing those kinds of supplemental
18 benefits to reduce their total cost of care.
19 Number two, time is money. And if you
20 can demonstrate that you are reducing and
21 coordinating and making the time convenient for
22 the beneficiary, their families, and their
23 caregivers, people will appreciate that. Make it
24 simple for them as well and think about the
25 workflow of their life, not just the workflow of

1 the practice, of the practitioners, they're
2 important.
3 Thirdly is to, what we found more
4 important than anything else that brought people
5 in was creating that coordination of care, making
6 it easy to navigate all the fragmentation. And
7 can you bring in the services that beneficiaries
8 care about? I haven't heard us talk about DME[81],
9 supplies. You know, all this out-of-pocket
10 expense where you've got to buy your own
11 dressings, you got to buy, you know, your own
12 supplies, your own walkers, et cetera. Not
13 everything is covered. And what are we doing to
14 make it easy so that you can live every day
15 simply at home?
16 And finally, creating the kind of
17 technology that is easy, turnkey, platform based.
18 Right now what beneficiaries face is you have a
19 different app for your blood pressure, one for
20 your pulse ox, one for your respiratory rate, one
21 for your temperature, one for your activity
22 tracker. So the more we can make it convenient
23 and simple for the beneficiaries, they will come.
24 That's why they buy their Apple

81 Durable medical equipment

1 devices. It’s why they use their smartphone.
2 Because they want it to work in their lives.
3 DR. MILLS: Dr. Barbaria.
4 DR. BABARIA: Yes. So over as a part
5 of our transformation to Medicaid, we have
6 actually set up a number of Medicaid member
7 listening sessions. But the state level that
8 meets directly with our executive team on a
9 quarterly basis, as well as at the regional level
10 via all of our managed care plans, and I think
11 this goes back to, what's in it for the member.
12 And the refrain we consistently hear,
13 right, members don’t care, you know, am I in a
14 ACO, am I in a MA plan? In fact, I would say I
15 think general perception is being in those things
16 limits choice and limits access and not the
17 converse.
18 And what they really care about is,
19 can I get an appointment when I need it, do I
20 have long wait times? Is my provider someone
21 that relates to me, speaks my language, that I
22 trust, and have that relationship with? And are
23 my health care needs and preferences being
24 honored and met?
25 And we have very, you know, we have

1 lots of members who are in ACO and manage care
2 plans who are having those needs met, and others
3 who are equally not having those needs met. And
4 I think really looking at what will incentivize
5 and drive them in is, essentially at the end of
6 the day how well those needs are being met, along
7 with the education and sort of word of mouth, you
8 know, for those entities that have been able to
9 achieve those goals.
10 DR. YEH: But we're not measuring that
11 on a consistent basis. So you cannot improve it
12 if you're not measuring and tracking.
13 DR. BABARIA: Yeah. And we, you know,
14 we have our sort of CAHPS surveys that are very
15 poorly responded to. We collect them in English
16 and Spanish which leaves out about, I think 17
17 threshold languages in the State of California
18 and are inadequate. But the more we can march
19 towards patient-reported outcome measures and
20 universal member experience, the closer we will
21 get there.
22 DR. MILLS: Agreed. Dr. Chernew and
23 then doctor, sorry, Dr. Calcagno first and then
24 brief comments from Dr. Chernew and Dr.
25 McClellan.

1 MR. CALCAGNO: I think it’s as simple
2 as this, beneficiaries, A, don’t understand what
3 an ACO is, B, quite honestly, they don’t really
4 care until the point that they need it, and then
5 C, all the coordination we do is really behind
6 the scenes so it’s transparent.
7 And my proof point on this is, my
8 father was recently diagnosed with cancer, and he
9 didn’t care, he’s on Med Supp, didn’t really care
10 until all this happened, right. And now he has
11 an oncology nurse navigator. She is essentially
12 coordinating everything he needs upfront. He is
13 super excited about that. Right? He loves that.
14 So think about that as a model for the
15 ACO. How do we make sure that coordination is
16 front and centered for those that need it, and
17 then how do they understand it? Right?
18 There is a whole bunch of health care
19 literacy. You know, there is, particularly in my
20 father’s case, 80-year-old, not exactly
21 cognitively all there, right, so there's
22 challenges that you have to deal with. But I
23 think it all comes down to, are they seeing the
24 value of it.
25 They don’t necessarily have to

1 understand the stuff all the experts on this call
2 understand, but do they see the value, and can
3 the design make that value transparent to them?
4 DR. MCCLELLAN: And just to add maybe
5 a way to think about additional benefits and
6 traditional Medicare, you know, yeah in ACO, Don
7 and others could come up with some additional
8 hearing assistance or other benefits they could
9 just offer, but most the ways that additional
10 benefits get delivered in traditional Medicare is
11 through there's a billing code for it and, you
12 know, accounting for the copay and so forth, it's
13 something else that could be covered.
14 And CMS is trying to move in that
15 direction. You've seen some additional billing
16 codes for things like care coordination. Don,
17 I'm not sure how helpful the additional billing
18 codes are going to be for you all for that.
19 Telehealth, expanded services, remote monitoring.
20 Charlotte, digital technologies. That structure
21 helps.
22 I think what CM, the Center for
23 Medicare has not quite figured out yet is, well,
24 you know, we want to allow for more of this
25 billing to help organizations move in this

1 direction, but how do we combine that with the
2 overall big picture of simply put, we want to
3 help organizations get to, not just some
4 additional fee-for-service billing, but more
5 comprehensive total cost of care and beneficiary
6 management.
7 One way to do this, and this may sound
8 a little bit more complex, but it seems like
9 we're almost at the point with so much
10 alternative payment approaches and traditional
11 Medicare, they almost need two tiers for these
12 additional efforts.
13 So the kinds of concerns that people
14 have raised about telehealth, about covering
15 digital and so forth, mainly apply in the
16 unmanaged fee-for-service setting where a concern
17 is that there would be more billing. It's not,
18 there is nobody who is overall accountable for
19 those costs or is making sure that it's being
20 used in a way that makes sense.
21 So if Don wants to, if Don's plans
22 that are in substantial risk find these
23 additional coordination billing codes for primary
24 care docs, for that matter, specialty docs
25 useful, if they want to do more billing for

1 digital health, great, they're on the hook for
2 those services translating into better outcomes
3 and lower cost.
4 It'd be a nice clear signal that I
5 think is confusing some providers today is, well,
6 you know, I could take these little steps towards
7 care coordination but, you know, I'm not really
8 sure what the long-term models are going to be so
9 maybe I'll just stick here for a while. This
10 would more clearly reinforce that the goal is to
11 facilitate the fact that you can deliver more
12 flexible services and better benefits, maybe even
13 some copay forgiveness if the ACO wants to do it,
14 if we make it easier for plans and, sorry, for
15 providers to set up these models.
16 DR. MILLS: Wonderful. Last word, Dr.
17 Chernew.
18 DR. CHERNEW: So I'm largely where Don
19 is on that. I don't think you want to overwhelm
20 beneficiaries with joining an ACO or not joining
21 an ACO, a bunch of things that would be really
22 confusing for them.
23 The beneficiaries can choose their
24 doctors. If the doctor is in ACO, the doctor, I
25 think, will have an incentive to provide a good

1 job. I think you want to measure to make sure
2 they're not providing a bad job. I said
3 something about stenting.
4 I think that's the core thing that you
5 should worry about. And you should just not
6 spend as much time trying to figure out new ways
7 of engaging coordination and a whole bunch of
8 other things. Just make sure that the ACO has
9 the right incentives and they're doing the right
10 things in terms of costs and outcomes. And that
11 includes patient experiences in a whole bunch of
12 ways, I think that's the key thing.
13 I agree with Mark in the sense that
14 for services that are not going to be covered by
15 Med Supp, having a package that allows ACOs if
16 they want to offer those services I think is
17 valuable, but understand, a lot of the Medicare
18 Advantage benefits are financed with a pretty
19 generous Medicare Advantage payment model.
20 So don't think that you're paying
21 Medicare Advantage and ACOs the same amount, and
22 then you're going to get the same level of
23 benefits because they're financed on a very,
24 very, very, I don't know how much more time we
25 have, very different frame. And so, you really

1 need to think through how all of that will really
2 work and practice because you're not going to get
3 the same ACOs competing with Medicare Advantage
4 plans given the vast differences and the
5 mechanisms for how they're paid.
6 And I would just try and be a little
7 more cautious about what you think you can
8 accomplish by trying to build in a lot of
9 programs to try and get particular types of care
10 coordination and/or beneficiary engagement. Just
11 pay them a flexible amount, measure the amount of
12 beneficiary satisfaction, give them the
13 opportunity to provide things that they otherwise
14 might not be able to provide and call it a day
15 without worrying about complex codes in a bunch
16 of ways. And Mark and I will have to have a beer
17 over what to do with telehealth codes.
18 DR. MILLS: Outstanding. I'm going to
19 turn to our last question. We have about 10,
20 actually nine minutes left.
21 I want to turn to other markets,
22 perhaps inside the United States, perhaps outside
23 United States. What kinds of lessons can be
24 learned from other markets, and are there
25 examples of effective approaches you've seen in

1 other markets used to address challenges and
2 barriers affecting provider participation and
3 value-based care that might be relevant here?
4 So that’s a wide open, tell us what
5 you’d like us to know type of question starting
6 with Dr. Barbaria, Dr. Chernew, and Dr.
7 McClellan.
8 DR. BABARIA: I’m going to pass it on
9 my esteem colleagues on this panel, I don’t have
10 much to add to this question.
11 DR. CHERNEW: So if I’m esteemed, then
12 I’m not sure that I qualify, but assuming I do,
13 I’m going to answer because I think I was
14 supposed to be next.
15 So I’m here in Amsterdam. I was
16 talking to the Dutch health authority about what
17 they do, but understand a lot of their things are
18 mandatory, they have a very different system in a
19 range of ways.
20 It’s not like they had a fee-for-
21 service system they decided to put in value-based
22 models and then try to solve the problem we’re
23 trying to solve. They built systems that are just
24 fundamentally different for how they work. They
25 mandate insurance.

1 Here in the Netherlands, everybody
2 chooses their doctor. I think Don or someone
3 said that. So the attribution issues aren't
4 there. They don't quite impose the same amount
5 of risk in the same way. There is some version
6 of risk, they have the different insurance
7 system.
8 So this is a much longer question than
9 I'm prepared to answer, but it is not a question
10 like, maybe there is other places that do this,
11 but I think you would find the U.K. as well, they
12 have a completely different system in the NHS[82].
13 They didn't build a lot of models and then try to
14 get people into models the way we're thinking
15 about getting into models. They did do certain
16 similar things, but I don't think we have time to
17 get into the specifics, at least where I'm in, so
18 maybe someone else will know examples that are
19 more analogous to what we're trying to do.
20 DR. MCCLELLAN: Yes, I think the main
21 thing is, because this is hard, and don't worry,
22 we're not the Netherlands for better or worse, I
23 guess. What I have seen really starting to help
24 is this recognition that while there are

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1 differences across payers, there are common
2 themes.
3 A big one is, we started with this
4 stronger primary care. So I don’t know any
5 segment of the U.S. health insurance market where
6 there aren’t efforts underway to try to increase
7 advanced primary care, team-based care
8 capabilities and link those to some
9 accountability for coordinating care and managing
10 total cost. Yes, the specific areas that
11 Medicaid is going to focus on for that with moms
12 and kids are going to be different than Medicare
13 and polychronic patients can be different than
14 commercial where it’s more dealing with discrete
15 issues, and maybe more behavioral health and
16 other things like that.
17 But having these state transformation
18 collaboratives that CMMI has started to support
19 is a good way to help get people on the same
20 page. I wish it could go faster. And, you know,
21 I think here maybe it’s a structural issue with
22 CMS and CMS finding ways to work together better
23 across programs.
24 We’ve talked about how CMMI models go
25 into Center for Medicare programs. Well, if we

1 got a good core structure in the Center for
2 Medicare, maybe what's needed is helping CM,
3 telling CMMI, hey, we need to refine this model,
4 it's not working very well, can we do a more
5 rapid evaluation within our existing programs.
6 And to Don’s earlier point, you know,
7 I wish it were so, but unfortunately having been
8 there, CMS doesn’t perfectly get everything
9 right. Right in the beginning. The models have
10 to change. That’s the way you learn more about
11 how benchmarks actually work and participation,
12 if it's a voluntary model.
13 But you can make that process more
14 expected and have processes built in to pilot
15 changes and engage around them. And that can be
16 extended to multi-payers too.
17 And just to, back to comments about
18 what they’re doing in California. It’s just kind
19 of a reminder that CMMI and CMCS, you know, the
20 state part of the Medicare program really needed
21 to be building some stronger ties.
22 So the state transformation
23 collaboratives are not an exception, or kind of a
24 rule, as states are thinking about their waiver

1 renewals and SPAs[83] and other steps that should
2 be, and the states are interesting in aligning,
3 they just have somewhat different populations and
4 priorities. But I think some real opportunities
5 for more synergies.
6 MR. CALCAGNO: And then I would just
7 add, if you think about just the Medicare
8 Advantage Market, the ACA, et cetera, they
9 require network adequacy, right? So again, I
10 know it's not high on folks' list to narrow
11 networks, but the more, when you look at our
12 other payers that are doing MA ACA plans, you
13 have to define the network upfront. And because
14 it's defined, you're able to better coordinate
15 across that network.
16 And I do, again, include hospitals,
17 primary care specialists and post-acute all have
18 to be in that network. There is definitely a
19 selection bias if you're a primary care-led ACO,
20 if you're a hospital-led ACO.
21 And just having everybody on the same
22 page, again, going back to that simplified
23 portfolio where we don't have competing models,
24 we don't have competing providers in the network,

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1 we have one network that can actually coordinate
2 together, that would be the big takeaway that I'd
3 have.
4 DR. MILLS: And Dr. Yeh.
5 DR. YEH: Thanks. So I just want to
6 add three things. One, I really want to
7 underscore when Don was talking about care
8 coordination, we found when we were using the
9 Medicare supplement and we signed a care manager
10 to these individuals, high-risk, high-cost.
11 We could reduce hospitalization, ED
12 visits, et cetera, because we had a trusted
13 relationship of someone who could navigate the
14 insurance, navigate the appointments, navigate
15 the medications, navigate the activities and
16 behavior changes that would have to come. And
17 they don't have to exist only in health care
18 system. There are continuing care organizations,
19 assisted living types of approaches that provide
20 that care coordination.
21 And what's valuable, and to know how
22 important it is, when they do a good job for the
23 parents, the children then sign up for those
24 programs. So that it can bring you back not only
25 cost savings and better outcomes, but it can help

1 also with the engagement side.

2 The second is, I want to underscore
3 what Michael and Don and Mark have said about not
4 making these changes. These care coordination
5 programs, at least in our experience and fee-for-
6 service Medicare, you don't begin to see those
7 returns until at least 12 months.

8 If we're looking for short-term gains,
9 you're not going to get it, you have to be in
10 this for the long haul and over time. Which is
11 really important. So I just wanted to share that
12 piece as well.

13 DR. MILLS: Okay, outstanding.

14 CO-CHAIR HARDIN: Palav, if you had a
15 comment?

16 DR. BABARIA: Yes, it was mostly
17 covered it, but I recognize we're coming up at
18 time. You know, I think what one of my esteem
19 colleagues on this panel said earlier is, you
20 know, reframing the question to be less about how
21 do we design a model and more about, how are we
22 going to make this the norm, right?

23 And I think everything that you have
24 heard from the panelist so far is really, when
25 that is the problem you're solving for you make

1 different decisions. And it really is about
2 scalability, bringing in those other payers,
3 connecting the dots with sort of non-Medicare
4 coverage to get to that tipping point. And so
5 really keeping that at the foundation of the
6 design I think will really help.
7 DR. MILLS: Excellent. Thank you for
8 that fantastic final word. It encapsulated it
9 all. Thank you so much for the five of you
10 joining us this afternoon. You're welcome to
11 stay and listen to the rest of the meeting.
12 On behalf of the Committee and the
13 wider audience, I'd like to thank each of you for
14 your time and your insights and your lifetime of
15 learning that you provided for us. There were
16 outstanding conversations. We do appreciate your
17 time.
18 At this point we're going to take a
19 short 10-minute break. And the Committee will
20 return at 3:20 Eastern, where we will reflect on
21 the day and start discussing potential comments
22 and recommendations for the report to the
23 Secretary. Thank you. We are in recess.
24 (Whereupon, the above-entitled matter
25 went off the record at 3:09 p.m. and resumed at

1 3:22 p.m.)

2 * **Committee Discussion**

3 CO-CHAIR HARDIN: Welcome back. As
4 you know, PTAC will issue a report to the
5 Secretary of HHS that will describe our key
6 findings from this public meeting on identifying
7 a pathway towards maximizing participation in
8 population-based total cost of care models.

9 We now have time for the Committee to
10 reflect on what we have learned from our sessions
11 today. We will hear from more experts tomorrow
12 but want to take the time to gather our thoughts
13 now before adjourning for the day.

14 Committee members, I'm going to ask
15 you to find the potential topics for deliberation
16 document. It's tucked in the left front pocket
17 of your binder. To indicate that you have a
18 comment, please flip your name tent or raise your
19 hand in Zoom.

20 I also just want to alert you, as we
21 have in the past, I'm going to go around the
22 circle to have everyone add in what were your key
23 takeaways from today that we for sure want to
24 capture for the report to the Secretary, or
25 remaining questions that you're hoping that we

1 get to tomorrow.

2 So would anyone like to start? Who

3 would like to start?

4 CO-CHAIR SINOPOLI: I'll start.

5 CO-CHAIR HARDIN: Angelo, please go

6 ahead.

7 CO-CHAIR SINOPOLI: First of all, I

8 thought it was a fantastic day. All of the

9 groups and the panels were just amazing. And

10 clearly had a lot of expertise and a lot of

11 experience.

12 Today was kind of a culmination of

13 things I think we've heard over the last couple

14 of years as we've talked about various things,

15 but it was nice to see it packaged in a

16 particular way that kind of drove where we think

17 we need to go.

18 Some major areas of focus that I heard

19 about, are again, are things that we've talked

20 about but just heard it in a different way. One

21 was data. And not just raw data, and maybe

22 having access to that raw data, but being given

23 that data in the way that actually provides the

24 information to the practices so that they

25 understand how to manage their patients, and also

1 understand how well they're doing.

2 The other thing that was talked about

3 today was measures. Simplifying measures,

4 developing fewer measures, and creating standard

5 definitions across Medicare, but also all payers.

6 Developing fewer models. Now there

7 are too many opportunities to participate and too

8 many different models and is there a way to

9 rationalize those models to fewer models? Heard

10 some comments around being aware of, being wary

11 of downside risk directly to physicians. And

12 although we've talked about that a lot, I think

13 there was some good cases made today about not

14 maybe giving direct positive rewards but not

15 moving the downside risk directly to the docks.

16 Also, paying attention to the

17 beneficiary needs. And are we measuring that,

18 and how are we incentivizing activities for the

19 beneficiaries to participate?

20 Heard again today some comments about

21 team-based care from several people and how

22 important that was and how maybe in the future we

23 could create a model that helps pay for team-

24 based care. And then also heard a lot of

25 discussion around benchmarking. And particularly

1 comments about avoid ratcheting. Which obviously
2 occurs today.
3 So those weren't all inclusive, but
4 those were things that quickly came to my mind at
5 the end of the day today, and so I thought those
6 were important things that needed to be
7 highlighted, so.
8 CO-CHAIR HARDIN: Thank you, Angelo.
9 I'd like to go to Larry and Josh next so we make
10 sure that we don't miss you since you're virtual.
11 Who would like to go first? Larry, you're off
12 mute. Please go ahead.
13 DR. KOSINSKI: All right, I'll go. I
14 was making my notes, but since you pushed up
15 earlier, I'll do it.
16 What I heard, we don't all hear the
17 same things I guess, but what I heard was we need
18 to coordinate the business success drivers with
19 the population health needs. And that applies to
20 the health system, it applies to the practice.
21 And it also applies to the beneficiary.
22 And we need to use simple methods with
23 actionable data to help us accomplish that. That
24 was my major, my major takeaway.
25 The second one is, we still have a

1 problem with the specialists. We can do bundles
2 and episodes, but we still have these big issues
3 lurking out there, what do we do with the
4 cognitive care model for specialists? And
5 they're the ones that are taking care of the most
6 complex costly patients that we have out there.
7 I jot down a lot of good sayings. I
8 love what Michael said it, you know, post-acute
9 care is the ATM for ACOs. I love that one. I
10 may make a slide out of that.
11 But, you know, we heard over and over
12 again, it's got to be actionable, it's got to be
13 simple, it's got to be implementable. And we're
14 in an era of hybrid models as well, and we've got
15 to utilize existing structures to try to help the
16 specialists become part of the solution.
17 I'm sure, I haven't had the chance to
18 go through my notes I have more, but that what
19 I've got right now.
20 CO-CHAIR HARDIN: That was great,
21 Larry, thanks. Josh, please go ahead.
22 DR. LIAO: Yes, thanks. I, a couple
23 key takeaways and a couple tension points that
24 I'd love to, you know, look forward to teasing
25 out maybe tomorrow or in future meetings.

1 The first is kind of predictability
2 and certainty. This sense of, you know, when
3 it's not predictable or you do everything right
4 and the outcome is unpredictable. I think that
5 being problematic, that was something that shone
6 through for me.
7 And the second, maybe more
8 importantly, was kind of this idea of rewarding
9 success generously. And I can see three kind of
10 subcomponents of that. One is model design. So
11 you heard ratchet, like one every 2.5 speakers.
12 So ratchet is a model design issue.
13 But there is another issue which is
14 just the size of incentive. I think Zeke said it
15 the most kind of directly, you know, one or two,
16 three percent versus 10, 20, 30 percent.
17 And then kind of like the impedance on
18 whatever side. Meaning, if you rely on conveners,
19 they play a very important role, but they suck up
20 a lot of that incentive, right? So even if you
21 increase the size, you only get that slice,
22 right?
23 So there is some model design. There
24 is just the money you pump in, and then there is
25 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.

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1 A couple tensions I don't know what to
2 do with, it's just me kind of putting it out
3 there for the Committee is, you know, I heard
4 kind of themes around, you know, we want
5 simplicity, we want fewer, we want rationale, and
6 yet I heard kind of ripples of another, what I
7 would call side of it, which is, but we need it
8 to be tailored, it needs to be like relevant, and
9 we need to give people a choice. And I find
10 those are sometimes not always directly aligned.
11 You know, you can create a clinical
12 integrated network. It can be large, it can
13 cover everybody, and then you will not have as
14 many options, right? So do you want simple,
15 streamline, rational, or do you want more options
16 that are smaller.
17 One more example than I'll stop. You
18 know, we talk about not having too many models.
19 And I tend to agree with having fewer rational
20 models, and yet I don't know which edge of the
21 blade we're on.
22 If you give more groups more types of
23 models with different parameters, does that
24 increase their participation?
25 And if you decide to cone it down to

1 two or three very large models, are we sure
2 that's going to increase participation, decrease
3 it, I don't know, it's an open question that I
4 don't know if anybody can answer. So we just
5 need to balance a few of those things that I
6 heard, I think.
7 CO-CHAIR HARDIN: So key, thank you,
8 Josh. Jay, please go ahead.
9 DR. FELDSTEIN: So in the theme of
10 keeping it simple, we hear over and over and over
11 again in every meeting, and for my tenure here,
12 we've got to pay primary care physicians and
13 providers more. Period. End of story.
14 All we're going to debate is how to
15 get them the money, and how much. And I think we
16 heard today it needs to be consequential. It
17 can't be a small bonus, it's not going to change
18 behavior, so we need to focus on that.
19 And then an area that I find very
20 interesting, and I will disagree with some of our
21 esteemed experts that we had this morning is, how
22 do we handle social determinants of health?
23 The panel this morning seem to feel,
24 well, if we really take care of health care
25 costs, we'll have more money to spend on social

1 determinants of health or spend it better. I'm
2 kind of on the other side of the chicken, egg
3 here, that I think if we spend more and figure
4 out how to pay more for social determinants of
5 health, we'll have less health care expenditures.
6 CO-CHAIR HARDIN: Excellent. Thank
7 you. Chinni, please go ahead.
8 DR. PULLURU: Fantastic day I thought.
9 Just lots of diverse opinions. And some
10 surprising ones.
11 So first I'd like to start with
12 something that threaded through the entire day
13 and that was democratizing and standardizing
14 data. Nothing new to us. We've heard this now
15 for years.
16 However, I think the thing that is
17 really important is that the, to ask that CMS
18 take the lead in that, and having data, the
19 ability to standardize and syndicate data not be
20 expensive. Because one person, two person, or
21 rural practices just can't afford that. And so I
22 think that just an important point.
23 The other thing that I found somewhat
24 surprising is they asked that incentives not
25 necessarily be passed down at the provider level.

1 And measurement, like quality measurement, be
2 done at the clinic level.
3 I'm not sure I agree with that
4 entirely, but I do appreciate that it's nuanced.
5 And that when you do translate incentives down to
6 the provider level, you have to be very careful.
7 And I think to ask for flexibility in the ACO to
8 do that is important.
9 So the last thing that was said in the
10 day, and I'll kind of, was simplicity,
11 flexibility. And things that enable the provider,
12 and not to forget the beneficiary. I thought
13 that was a really important point that came out
14 towards the end of the day, that beneficiary
15 adoption is important.
16 So let's look at the cost of the
17 beneficiary, let's look at what they're looking
18 at as well. Not leave them out of this sort of
19 realignment.
20 And then the last thing that, you
21 know, I found to be somewhat really important
22 that surfaced up is just the reminder that MA and
23 ACO are not comparable because they're funded
24 very differently.
25 And we often look at MA and say, gosh,

1 they're getting to all these things and look at
2 all their benefits, I wish we were able to just
3 do that. And I think that it's important to
4 remember, and be reminded of, consistently, that
5 the funding mechanism is different. So if we
6 can't fix the funding mechanism, then we have to
7 be cautious in comparing the two.
8 CO-CHAIR HARDIN: So helpful. Thank
9 you, Chinni. Jim, would you like to go next?
10 DR. WALTON: I'm going to just focus
11 on one part that has not been said, I think. And
12 I wanted to just amplify something that Larry
13 said. The physician provider enterprise must
14 succeed to match capacity to the population
15 health needs.
16 And there was a comment by one of our
17 speakers around the mismatch over the next 20
18 years, I suppose, between the capacity of the
19 provider community and the population demands –
20 needs, right, and also then, and also demand.
21 And then there was a discussion around the idea
22 that if we overpay and underpay at our own peril.
23 And so from a charting of our, let's
24 say the recommendations to the Secretary, it
25 seems to me that that might really be a part of

1 the front end of everything we're going to talk
2 about.
3 All the things we want to say is about
4 that because we, as the provider, representatives
5 of the provider community, are that particular,
6 that's our opportunity to have a voice into the
7 public conversation about the policy,
8 prioritization so that capacity doesn't, we don't
9 find ourselves 20 years from now, when I'm 87,
10 that we don't have enough capacity. And I've
11 chosen to live at a particular geography where
12 the capacity to get specialty care is now, is
13 limited to a telehealth visit because the
14 migration to the urban area.
15 You know, it is significant. And so I
16 thought I'd just elevate that and get that into
17 the discussion.
18 CO-CHAIR HARDIN: Thank you, Jim.
19 Lee, would you like to go next?
20 DR. MILLS: Love to. Similar to Jim,
21 I'm just going to focus on, I got so many pages
22 of notes it would take me hours to try to draw
23 pearls out of that.
24 But some key points that I certainly
25 heard. Of course data, ever present topic. I

1 did hear something almost even a little bit more
2 events we've heard is we need not just a data
3 utility infrastructure where the data is the
4 lifeblood moving through the system, but that the
5 models and the payer sponsoring value-based care,
6 the ACOs, the enabled companies, need to be more
7 proactive, more aggressive in doing analytics,
8 serving it to the doctors as actionable
9 intelligence.
10 Right now models typically say, we
11 make our data available, do with it what you
12 will. We're hearing, and I've experienced this
13 over 50 years, that is neither, it's not even
14 close to sufficient, right? That alone is a
15 barrier that would make most non-huge high-
16 revenue groups just pass.
17 Secondly, I think I heard, as clearly
18 as I had ever heard before, that complexity is
19 just out of control and out of hand. And that is
20 reflected multiple different ways. But
21 essentially, I heard from these experts,
22 essentially a please, stop releasing more models,
23 pick one, it will tweak, it will evolve, it will
24 adapt. It will get better. It will not be
25 perfect when you start, but just pick a couple of

1 horses and let's ride them, stop with the models.
2 Which I thought was interesting.
3 And then I appreciated the focus on
4 beneficiaries a little bit differently than what
5 we've had. And I heard two different things.
6 One was, I appreciated the attention,
7 the highlighting that we also, we often focus on
8 the fee-for-service versus MA dichotomy. You
9 know, when it's just flat Medicare, you pay your
10 20 percent, you see whoever you want, you don't
11 get any coordination, it's just open, open range.
12 And MA brings all these benefits and coordinates
13 it, and there is financing mechanisms to fix.
14 But this tweak in the middle that's 40
15 percent of fee-for-service have a Med Supp. That
16 they're paying much more out of pocket, but
17 actually they're not getting any of the
18 additional benefits, the coordination.
19 Those companies that want to
20 coordinate, if the fee-for-service beneficiary
21 has a Med Supp and they're in an ACO that
22 provides care management, that goes to cost base,
23 it's not medical cost. That was a really
24 interesting tweak I think is pretty important
25 that seems amenable to some policy changes.

1 And then lastly, I heard, and I’m not
2 sure how I feel about it yet, but I mean, I heard
3 somebody at the end say essentially that focusing
4 on beneficiary choice or beneficiary incentives
5 was the wrong question because beneficiaries
6 choose their physician. And if you build a
7 system that physicians are successful in and lets
8 them take better care of their patients, the
9 beneficiaries get what they want. They get the
10 access, they get the communication, they get the
11 coordination, and it all works out fine. And
12 that was interesting.
13 CO-CHAIR HARDIN: Thank you, Lee. And
14 Lindsay.
15 DR. BOTSFORD: Well I guess this goes
16 to, you can hear the same thing and take away
17 different things. So I think what I heard in the
18 conversation around beneficiaries is certainly a
19 call that we should look from the lens of the
20 beneficiary as we think about payment models and
21 where we need to be.
22 I heard conflicting things today as to
23 whether incentives makes sense and whether it
24 truly is sufficient to just get the doctor that
25 they want. So I think there is questions to be

1 answered around, how can savings be shared with
2 beneficiaries, what is it that beneficiaries want
3 and need. And probably some of those result in
4 why beneficiaries are making choices to get a
5 supp or go to MA or other choices being made.
6 So I know this is a conversation we're
7 already thinking about as a Committee, and
8 hearing multiple different panels touch on it
9 today I think just confirms we need to probe
10 more.
11 CO-CHAIR HARDIN: So helpful. Walter.
12 DR. LIN: Great day. Learned a lot.
13 And I look forward to another exciting day
14 tomorrow.
15 You know, just taking a step back,
16 right? So the theme of this two-day public
17 meeting is around, essentially identifying a
18 glide path toward the goal of achieving a hundred
19 percent beneficiary in accountable relationship
20 by 2023. And I think the very first panelists of
21 our very first panel called that, I guess big dot
22 goal into question, right?
23 So my big dot takeaway from this,
24 today's meeting was, perhaps there should be some
25 other definitions of success along this journey

1 to value-based care besides just a hundred
2 percent participation. But regardless though, I
3 think that's going to be one element. There
4 might be other elements that hopefully will come
5 out in our continued discussions. And even
6 perhaps tomorrow.
7 Along this journey though I thought
8 the panelists raised a lot of great points in
9 terms of what might be hindering some
10 beneficiaries and providers from participating in
11 total cost of care models. And just to kind of
12 highlight some of the things that have been
13 already mentioned.
14 Risk adjustment is one big issue,
15 right? I think one of our panelists put it very
16 bluntly and said, HCC is broken. And if we were
17 to redesign a risk adjustment system today, it
18 would not be using old fee-for-service claims
19 data. And there would be a much smarter way to
20 do that.
21 Looking at, for example, frailty. And
22 I heard that mentioned a couple of times. And
23 perhaps I'm sensitive to that because of our June
24 meeting, which a lot of our subject matter
25 experts talked about frailty and functional

1 status and cognitive status in helping with risk
2 adjustment.
3 But the other kind of similar thought
4 along those lines was, there is no way of moving
5 forward along this glide path without
6 reevaluating some fee-for-service codes. I
7 thought that was great to hear because that's
8 kind of been my own experience as well at bedside
9 and working with other clinicians who bill these
10 codes.
11 You know, I think Tim Ferris mentioned
12 that, gave the example that initial visit is 10
13 times the work of a follow-up visit, and yet it
14 pays just a little bit more. And there is some
15 other kind of examples on the way.
16 I'm glad to see CMS, CMMI moving in
17 that direction with codes like the advanced
18 primary care code that was discussed during the
19 CMS panel discussion. But I think that's going
20 to, those kinds of codes are going to help
21 lubricate some of these friction points that have
22 slowed glide path.
23 CO-CHAIR HARDIN: Thank you, Walter.
24 And Jen.
25 DR. WILER: So many wonderful points.

1 And really excellent day. I think the only other
2 comments I would add in is going back to the
3 phenomenal analysis that my colleagues in NORC
4 did reframing for us who are the population of
5 patients that we're talking about and what has
6 been the impact to date. And again, really, I
7 think rich data that's going to have a lot of
8 impact from the health policy and care delivery
9 perspective.
10 And I continue to be struck by the
11 fact that nearly 50 percent of all Medicare
12 beneficiaries are in Medicare Advantage plans
13 which as, juxtapose to those who are in
14 traditional Medicare, and yet there is only 30
15 percent or less of provider payments that are
16 being made in this APM space.
17 So back to the points made around a
18 goal of 100 percent accountable care
19 relationships by 2023, thinking about reframing
20 the goal may be important. And I like Dr.
21 Ferris' question around, who is responsible for
22 creating, or who's accountable for creating
23 capacity?
24 And the simple math that if a unit
25 cost is more than payment and participation is

1 voluntary, then we have a supply and demand
2 mismatch. So who is responsible for fixing that,
3 and for which population, regardless of,
4 ultimately then payment?
5 And I thought it was interesting that
6 Dr. Chen said as painful, I think I wrote this
7 down quite correctly as a quote. "As painful as
8 it was, it was good that CJR was mandatory."
9 Again, back to the comments that we've made
10 previously around voluntary versus involuntary
11 being a big dot mover.
12 And then two other subpoints that I
13 would make is this comment around a consideration
14 that risk adjustment benchmark goals should
15 consider some rate that is commensurate with
16 inflation in thinking about, you know, what is
17 total cost when we think at the 100,000-foot
18 view, what does success look like?
19 And then I also heard a comment around
20 maybe future risk adjustment methodologies being
21 more sophisticated using LLMs. And that sounded
22 to me like a real opportunity for industry
23 innovation for us to think better about how to
24 leverage big data to be more meaningful to create
25 benchmarks.

1 CO-CHAIR HARDIN: Thank you, Jen. And
2 I will ask, add just a couple of quick comments.
3 So as we look at all-payer models and
4 integration and heading towards total cost of
5 care, there were a couple of themes that stood
6 out to me. So one is a universal need to address
7 health equity in looking at payment rates, and
8 also upfront investments for building an
9 infrastructure to address the complexity on the
10 table.
11 The second is health-related social
12 needs and how universally amongst payment models
13 it's important to have a flow of how that's
14 addressed. And three key themes that are
15 emerging as part of that, one is nutrition, the
16 second is transportation, and the third is
17 housing.
18 And then the other key theme, as much
19 as we definitely have universal desire to have
20 primary care that we trust, the other theme of
21 longitudinal care management and that
22 relationship and the opportunity to engage
23 beneficiaries in a partnership to really
24 participate in their care and that importance of
25 having an integrator to bring everything

1 together.

2 * **Closing Remarks**

3 So we've had a fantastic day. I want
4 to acknowledge the PCDT group for the excellent
5 presentation that they began this meeting with,
6 as well as the research and articulation from
7 ASPE and NORC. And all of our panelists. We've
8 had excellent dialogue today.

9 I want to thank everyone for
10 participating. And also for all of you who are
11 listening in. We will be back tomorrow at 9:00
12 a.m. Eastern time.

13 Our two-day agenda will feature three
14 amazing listening sessions. Our first listening
15 session will focus on organizational structure,
16 payment, and financial incentives for supporting
17 accountable care relationships.

18 The second listening session will
19 focus on developing a balance portfolio of
20 performance measures for population-based total
21 cost of care models.

22 And the third listening session will
23 address challenges regarding data, benchmarking,
24 and risk adjustment. There will also be an
25 opportunity for public comment tomorrow afternoon

1 before the meeting is concluded with Committee
2 discussion.
3 We hope you will join us then. Thank
4 you. And the meeting is adjourned for the day.
5 * **Adjourn**
6 (Whereupon, the above-entitled matter
7 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

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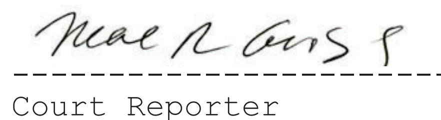

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