Listening Session 3: *How to Maximize Participation of Beneficiaries in Accountable Care and Improve the Sustainability of Effective PB-TCOC Models*

Presenters:

Subject Matter Experts

- **David Muhlestein, PhD, JD** – Chief Executive Officer, Simple Healthcare
- **Sanjay K. Shetty, MD, MBA** – President, CenterWell, Humana
- **Sean Cavanaugh, MPH** – Chief Policy Officer, Aledade
- **Karl Koenig, MD, MS** – Executive Director of the Musculoskeletal Institute, Division Chief of Orthopaedic Surgery, and Associate Professor of Surgery and Perioperative Care, Dell Medical School, The University of Texas at Austin

Listening Session 3: ***How to Maximize Participation of Beneficiaries in Accountable Care and Improve the Sustainability of Effective PB-TCOC Models***

David Muhlestein, PhD, JD

Chief Executive Officer,
Simple Healthcare

Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation

David Muhlestein, PhD JD

Founder & CEO, *Simple Healthcare*

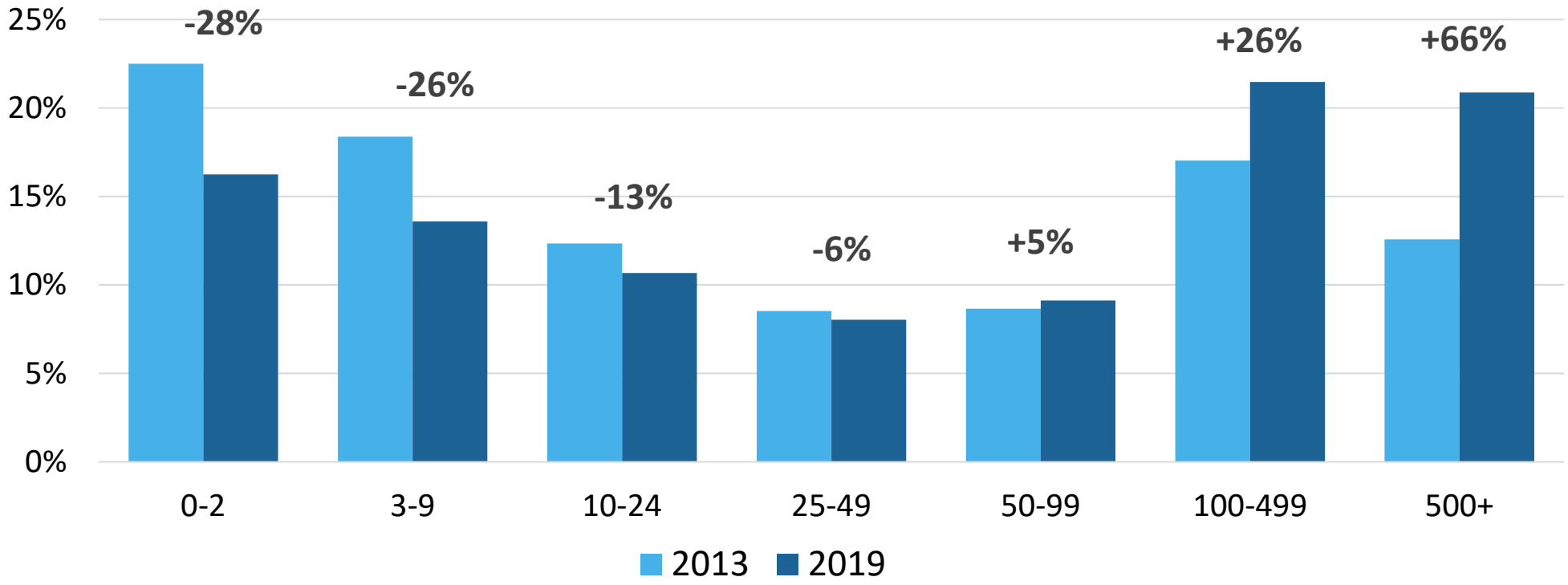
Visiting Policy Fellow, *Margolis Institute for Health Policy at Duke University*

Adjunct Assistant Professor, *The Ohio State University College of Public Health*

March 4, 2025

simple healthcare

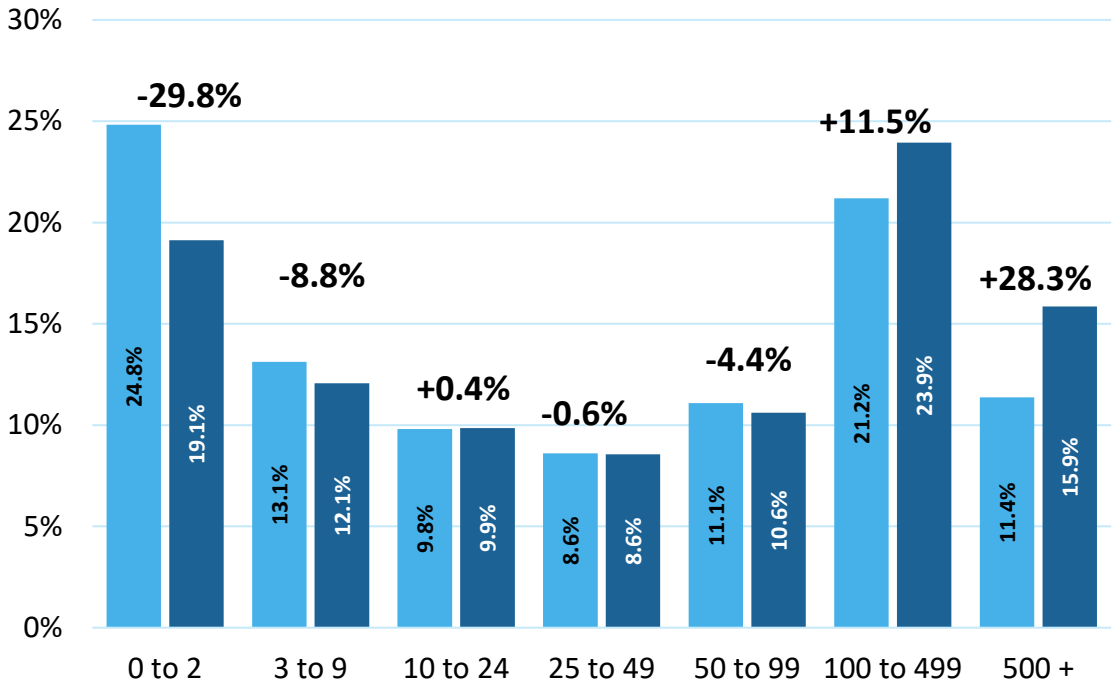
Proportion of Physicians by Group Size



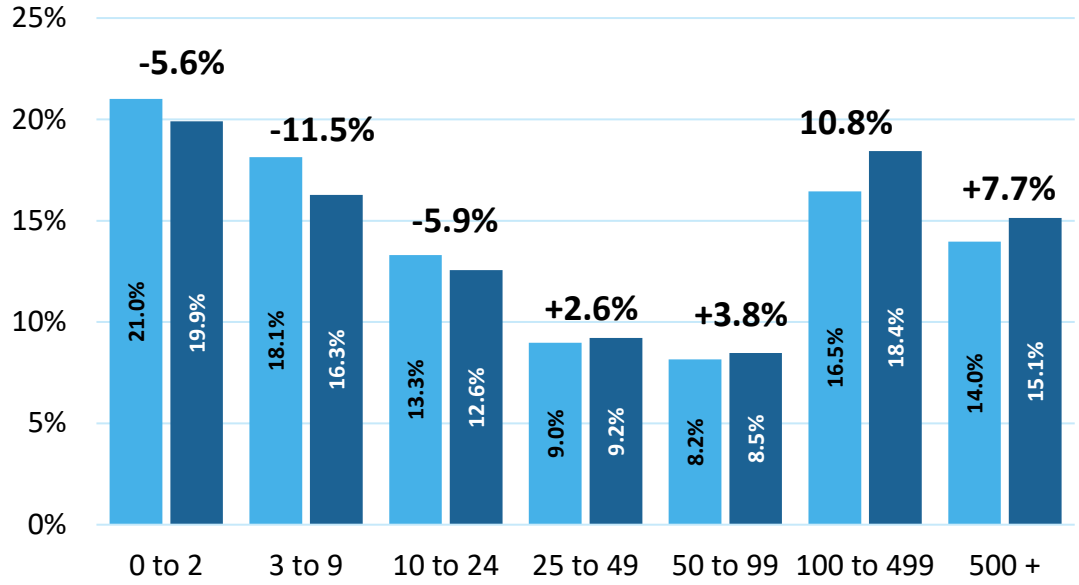
Source: Author's Analysis of Medicare Physician Compare Data

Primary care and Specialist Consolidation

Primary Care Physicians



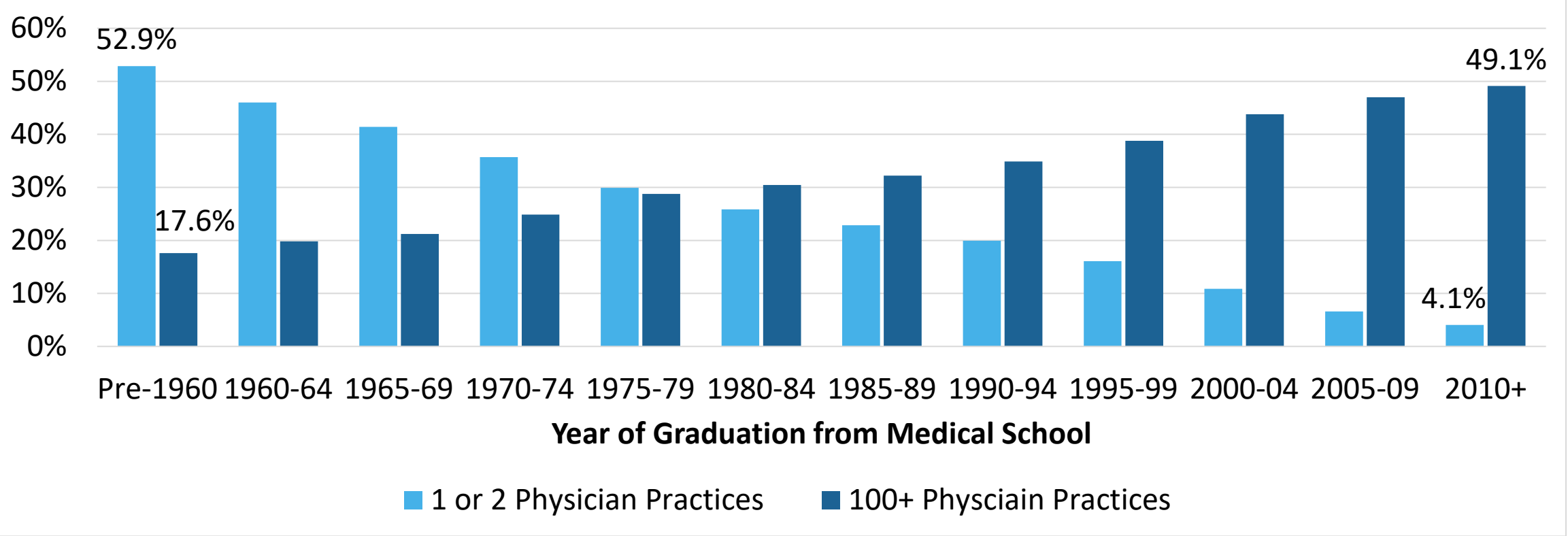
Specialists



June 2013 ■ December 2015

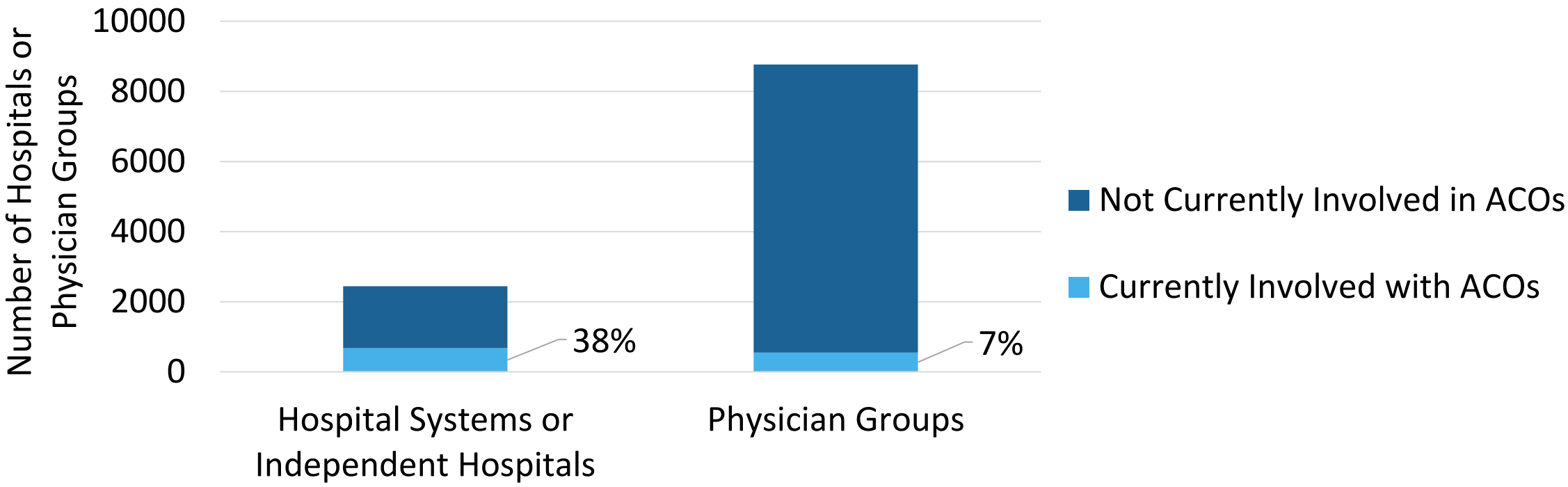
See Muhlestein, David B., and Nathan J. Smith. "Physician Consolidation: Rapid Movement From Small To Large Group Practices, 2013-15." *Health Affairs* 35, no. 9 (September 2016): 1638–42. https://doi.org/10.1377/hlthaff.2016.0130.

Proportion of Physicians in Small and Large Group Sizes by Year of Graduation from Medical School, 2018



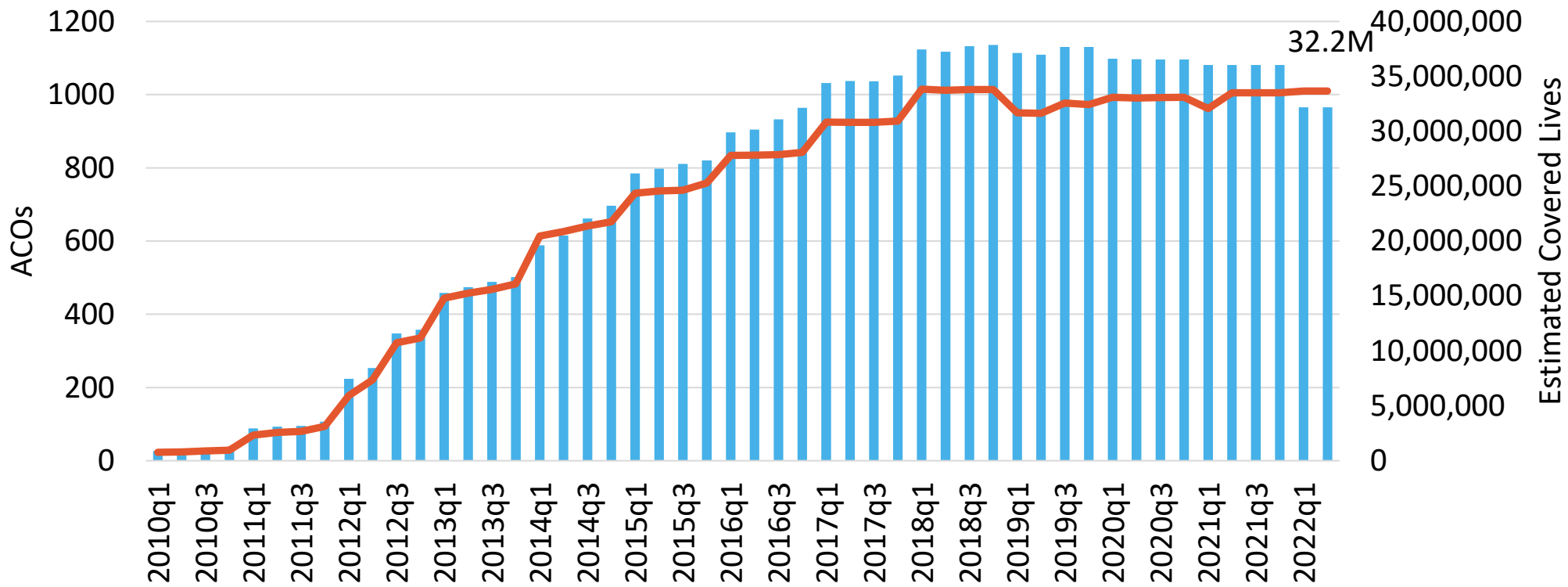
See Muhlestein, David, Lia Winfield. "Preparing a New Generation of Physicians for a New Kind of Health Care." NEJM Catalyst, February 28, 2018. https://catalyst.nejm.org/preparing-new-generation-physicians-new-health-care/.

Market Potential for Accountable Care Organizations



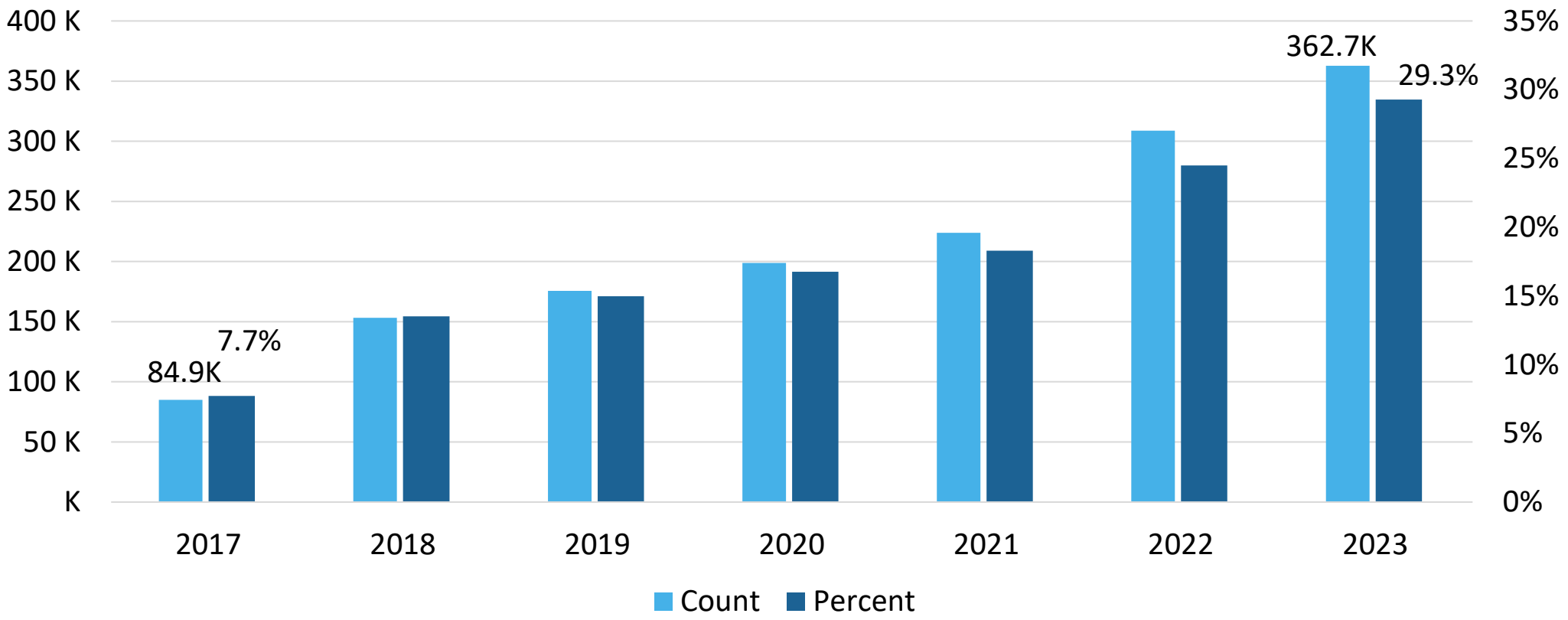
See Muhlestein, David, Tianna Tu, and Carrie H. Colla. "Accountable Care Organizations Are Increasingly Led by Physician Groups Rather Than Hospital Systems." *American Journal of Managed Care* 26, no. 5 (May 2020). https://www.ajmc.com/journals/issue/2020/2020-vol26-n5/accountable-care-organizations-are-increasingly-led-by-physician-groups-rather-than-hospital-systems.

ACOs and Covered Lives Over Time, 2010 to 2022



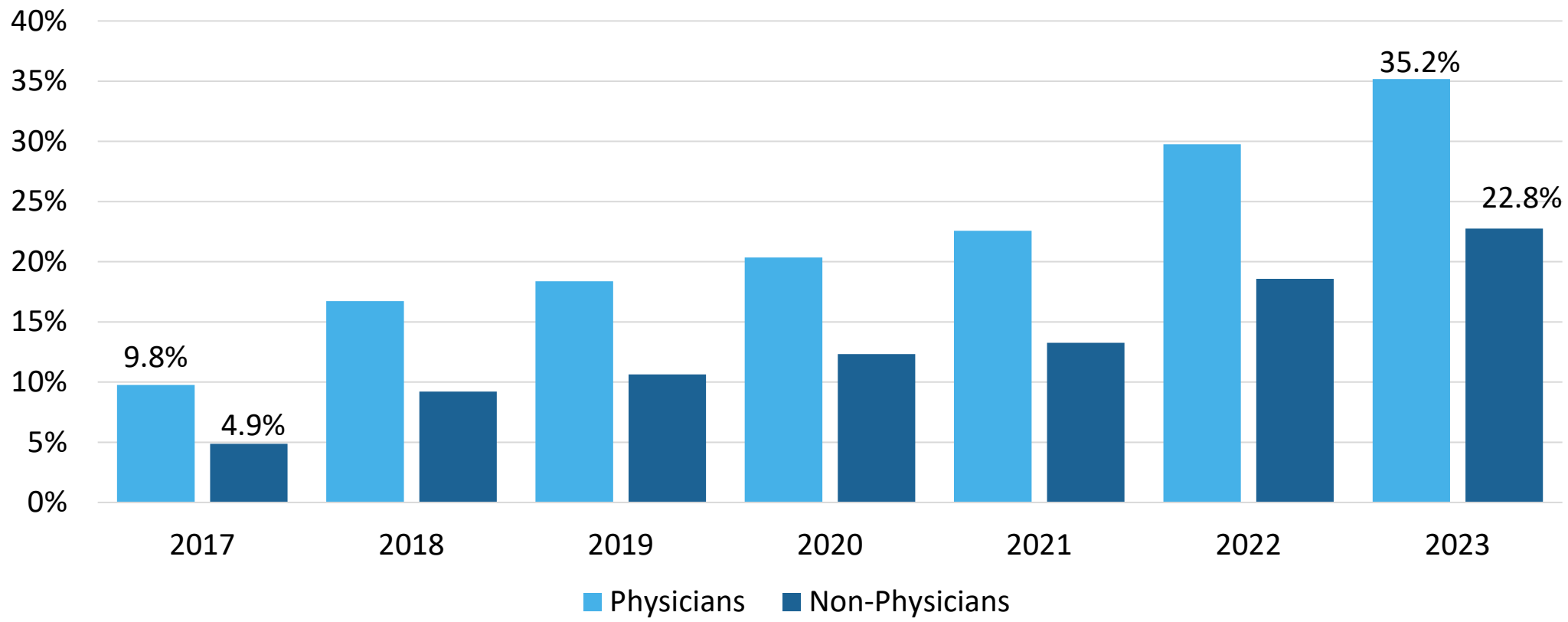
See Muhlestein, David, Robert S. Saunders, Kate de Lisle, William K. Bleser, and Mark B. McClellan. "Growth Of Value-Based Care And Accountable Care Organizations In 2022." Health Affairs Forefront, December 2, 2022. https://doi.org/10.1377/forefront.20221130.22253.

Advanced Alternative Payment Model (AAPM) Qualified Participants Over Time



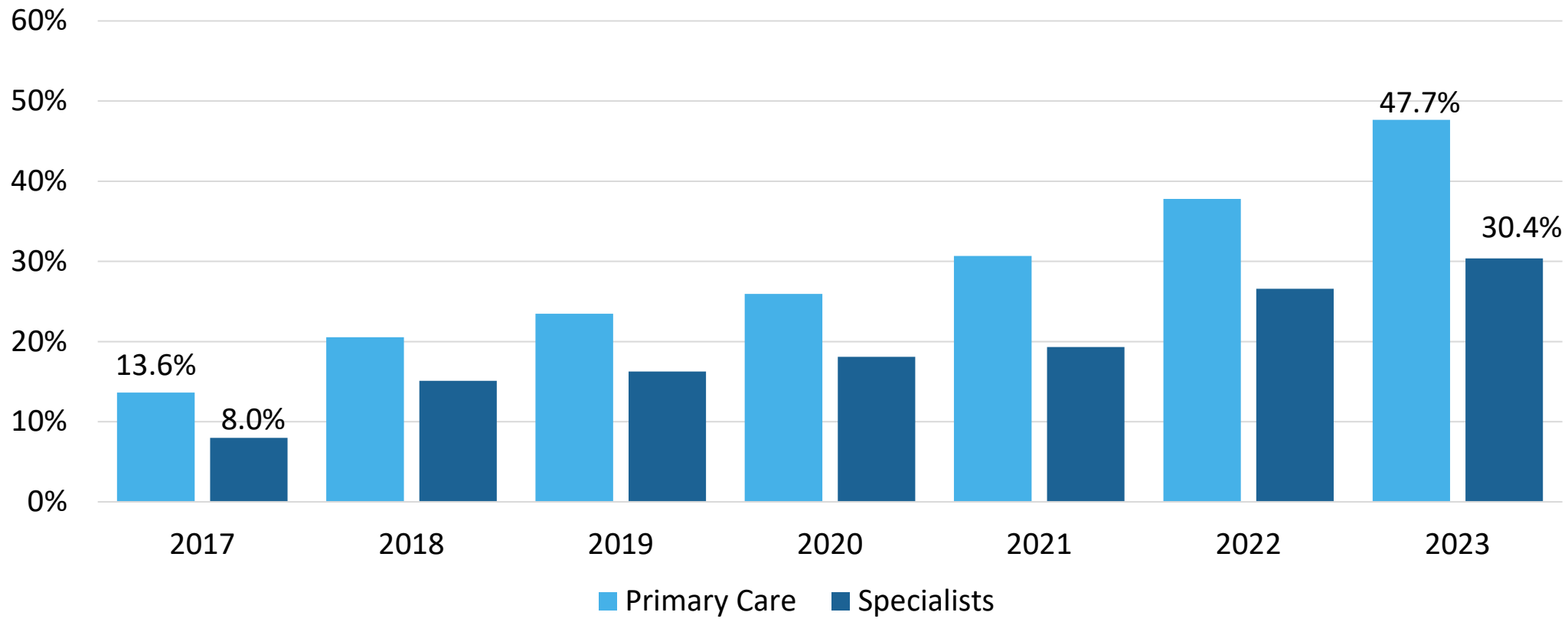
See Muhlestein, David. "Assessing Provider Adoption Of Medicare Advanced Alternative Payment Models." *Health Affairs Forefront*, December 16, 2024. https://doi.org/10.1377/forefront.20241212.507239.

Percent of Physicians and Non-Physicians that are AAPM Qualified Participants over Time



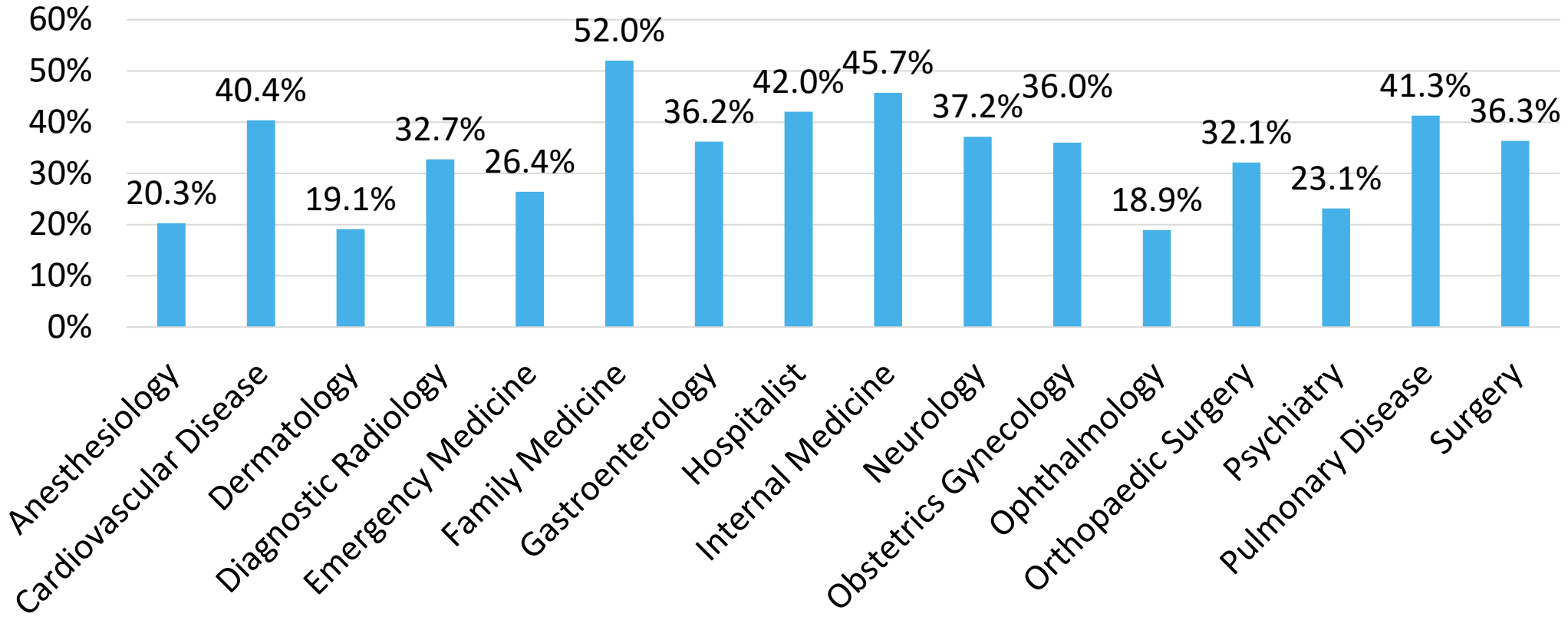
See Muhlestein, David. "Assessing Provider Adoption Of Medicare Advanced Alternative Payment Models." *Health Affairs Forefront*, December 16, 2024. https://doi.org/10.1377/forefront.20241212.507239.

Percent of Primary Care Physicians and Specialist Physicians that are AAPM Qualified Participants over time



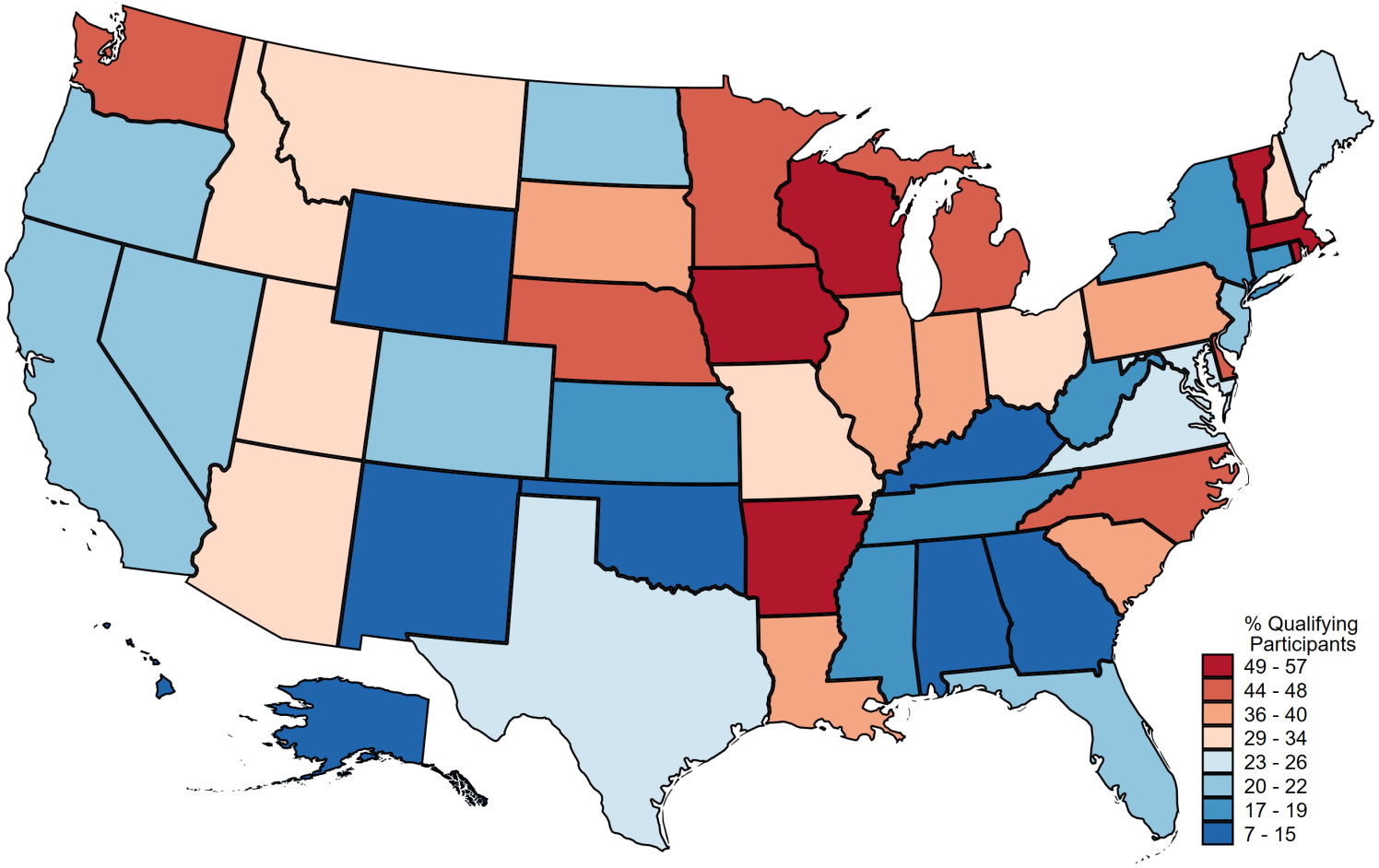
See Muhlestein, David. "Assessing Provider Adoption Of Medicare Advanced Alternative Payment Models." *Health Affairs Forefront*, December 16, 2024. https://doi.org/10.1377/forefront.20241212.507239.

Percent of Physicians who are AAPM Qualifying Participants by Specialty, 2023

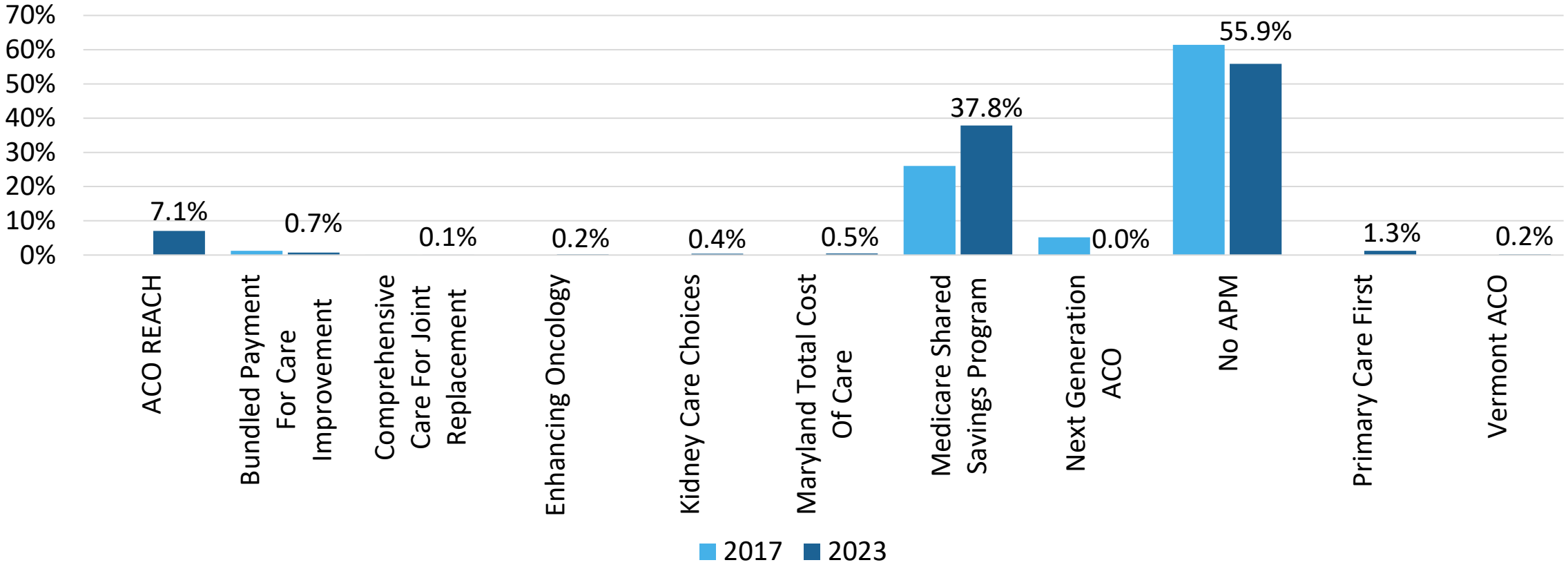


See Muhlestein, David. "Assessing Provider Adoption Of Medicare Advanced Alternative Payment Models." *Health Affairs Forefront*, December 16, 2024. https://doi.org/10.1377/forefront.20241212.507239.

Percent of Providers who are AAPM Qualifying Participants by State



Percent of Providers Participating in Various Models



See Muhlestein, David. "Assessing Provider Adoption Of Medicare Advanced Alternative Payment Models." *Health Affairs Forefront*, December 16, 2024. https://doi.org/10.1377/forefront.20241212.507239.

Recommendations

1. Develop incentives for primary care providers to join existing AAPMs
2. Design new specialty-specific AAPMs for specialist providers that are currently unlikely to be QPs
3. Create clear strategies for non-physicians to adopt AAPMs
4. Revise the approach to model overlap by creating a hierarchy of models
5. Study regional differences in AAPM adoption and Identify market-level strategies to further adoption

Listening Session 3: ***How to Maximize Participation of Beneficiaries in Accountable Care and Improve the Sustainability of Effective PB-TCOC Models***

Sanjay K. Shetty, MD, MBA

President, CenterWell,
Humana

Maximizing Participation in Accountable Care and Improving the Sustainability of Effective PB-TCOC Models

Sanjay Shetty, MD, MBA

President, CenterWell

March 4, 2025

Humana

CenterWell

Dr. Sanjay K. Shetty joined Humana in March 2023 as President, CenterWell. In this role, Dr. Shetty is responsible for leading strategy, growth, and business operations across the Company's health care services businesses, including Pharmacy, Provider Services, and Home Solutions. He also leads the Humana Military segment, which partners with the Department of Defense to administer the TRICARE health program for active-duty military members, retirees and their families. He is a member of the Management Team, which sets the firm's strategic direction.

Dr. Shetty earned his undergraduate degree from Harvard College and his medical degree from Harvard Medical School, and he continues to be board certified in Diagnostic Radiology. He also has an MBA from The Wharton School at the University of Pennsylvania.

About CenterWell

CenterWell Senior Primary Care

- More than 340 primary care centers in 15 states
- Participate in PB-TCOC models with MA partners, as well as ACO Reach
- Unique care model allows more time with patients

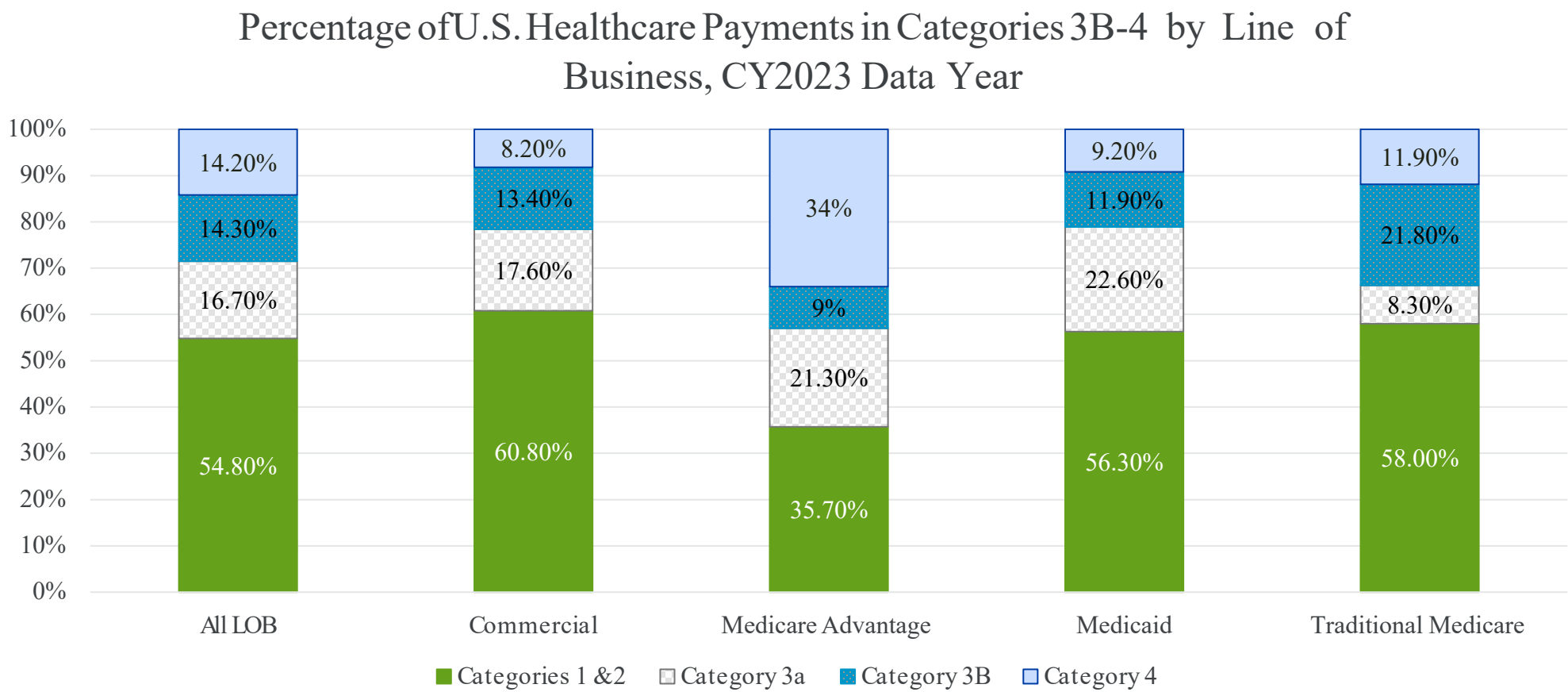
CenterWell Home Health

- Home-based care from approx. 350 locations across 37 states
- Nearly 8 million home visits
- Specialized clinical programs to meet patient needs

CenterWell Pharmacy

- Home delivery, retail, specialty and hospice pharmacy services
- Over 48 million prescriptions filled
- 2.5 million customers served

Medicare Advantage leads in participation in PB-TCOC models



Source: Health Care Payment Learning & Action Network, APM Measurement: Progress of Alternative Payment Models. 2024 Methodology and Results Report. November 14, 2024.

Medicare Advantage also accounts for significant participation in CMMI models

Beneficiaries and individuals included in CMS Innovation Center Models and Initiatives[1] (Estimate as of September 30, 2024)	
Totals[2]	**Total Beneficiaries and Individuals Impacted[3]**
Medicare FFS, including Medicare and Medicaid dually eligible enrollees	12,149,588
Medicare Advantage (MA), including Medicare and Medicaid dually eligible enrollees	19,970,422
Non-dually eligible Medicaid enrollees	1,724,185
Medicare Part D Prescription Drug Plan (PDP) and MAPDP beneficiaries, including Medicare and Medicaid dually eligible enrollees	21,849,161
Individuals with Private Insurance and Those Who Were Either Uninsured or Not Covered by Any of the Aforementioned Payers	1,642,858
Medicare and Medicaid dually eligible enrollees	10,793,456[4]
Estimated Total for All Beneficiaries and Individuals	57,327,214[5]

Source: Center for Medicare and Medicaid Innovation, 2024 Report to Congress, December 2024.

Success in PB-TCOCmodels requires significant investments in an array of capabilities

Infrastructure

- Population health management tools
- Sufficient staffing structure and panel management
- Effectiveness of electronic medical records

Engagement

- Process for managing collaboration and metrics
- Patient communication and outreach
- Willingness and ability to share data

Growth

- Established growth opportunity and strategy
- Physician's engagement with plan
- Clinic and physician growth capacity

Clinical operations

- Effective care coordination
- Increased PCP utilization among patient panel
- ER diversion plan
- Post-discharge care mgmt.

Performance

- Accurate and complete documentation process
- Internal financial and quality performance reporting to identify drivers of performance

Key Messages

- Support for Medicare Advantage is key to driving expanded participation in population-based total costs of care (PB-TCOC) models.
- Stability in MSSP and ACO REACH – including predictability in benchmarks – fosters confidence in providers as they evaluate the significant investments needed to perform well in these models.
- Payments based on completion of processes, rather than outcomes, weaken incentives for providers to commit to practice transformation and PB-TCOC models.

Humana

Listening Session 3: ***How to Maximize Participation of Beneficiaries in Accountable Care and Improve the Sustainability of Effective PB-TCOC Models***

Sean Cavanaugh, MPH

Chief Policy Officer,
Aledade

Listening Session 3:

How to maximize participation of beneficiaries in accountable care and improve the sustainability of effective PB-TCOC models

Sean Cavanaugh

March 3, 2025

Aledade

Policy Institute

Sean Cavanaugh

Chief Policy Officer, *Aledade Policy Institute*

- At Aledade since 2017 - recently launched the Aledade Policy Institute to build on our work
- 2014 - 2017: CMS
  - As Deputy Administrator & Director of the Center for Medicare, I was responsible for all A,B,C, D payment rules; and I oversaw the Medicare Shared Savings Program
  - As Deputy Director, Center for Medicare & Medicaid Innovation, I was responsible for the development, operations, and testing of new payment and service delivery models; and part of the team that developed the Pioneer ACO Model
- Prior to CMS, I worked in Congress, the Maryland hospital rate setting commission, and the NYC Mayor's Office

Aledade is the largest independent primary care network in the country, focused exclusively on value-based care

Serving 2.9+ million patients across 2,400+ practices in 2025

Map shows primary locations for 2025 partner practices

How to Expand Value-based Care

- Aledade has probably spoken to more physicians that have chosen NOT to participate in value-based care than any other organization in the country.
- Progress is stymied because the elements of VBC that attracted early adopters and innovators are not what will entice the remaining providers to make the leap from traditional fee-for-service payment models to value-based care.
- So….where do we go from here?

CMS Should Speak Directly to Providers

CMS should be clear with the provider community that it expects them to be in a value-based model. To date, the message has been about getting *beneficiaries* into accountable care, but *providers* are the ones who need to take action.

Use the CMS bully pulpit to market VBC to providers

They are the ones who need to make a change - not beneficiaries

Focus on a niche market

Early adopters are unsatisfied with the status quo and looking for a change

Emphasize solutions

Primary care physicians feel like FFS has failed them. VBC offers solutions - and has clear benefits for patients

Make MSSP the preferred & easy choice

Reduce burden, distinguish from MIPS, and make the AAPM incentive real by speeding up payment and linking to assigned beneficiaries

Define FFS as the Competition

Get the message across loud and clear

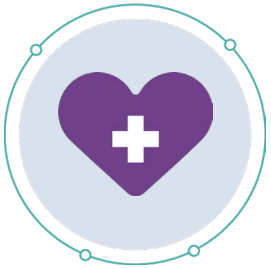
"FFS is bad for patients."

Emphasize that FFS is unsustainable

2024 PFS had across-the-board reduction in fees of 1.25%, reverberating across payers

Sharpen the contrast to FFS

CMS paid $1.3 billion in Shared Savings to ACOs in 2024



Tout the strong track record for physician-led ACOs

$294/beneficiary in shared savings revenue for predominantly primary care-run ACOs in 2023

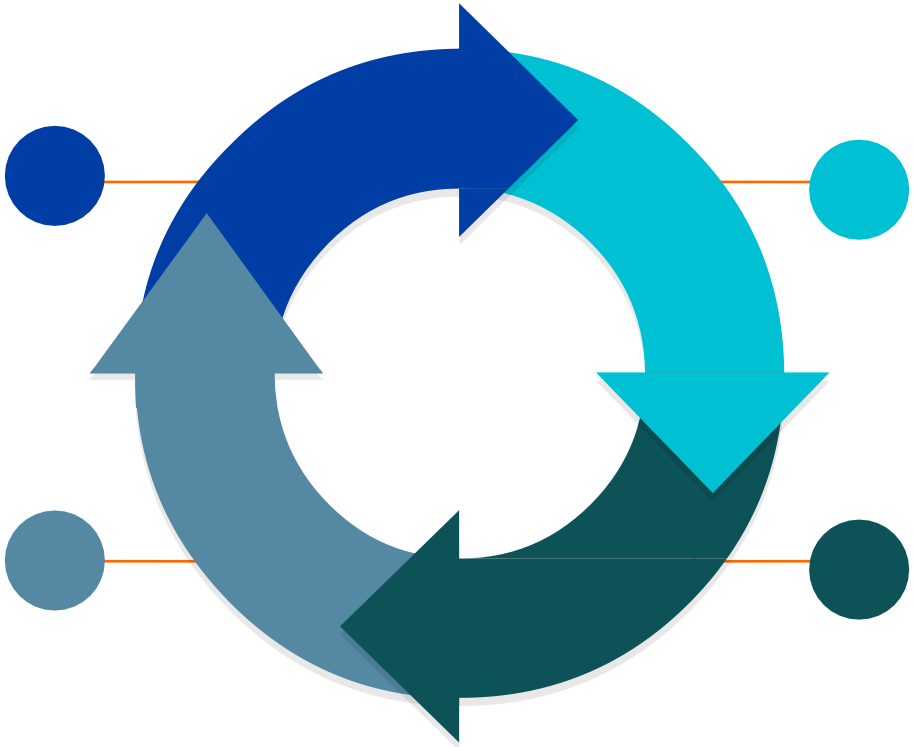
https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-continues-deliver-meaningful-savings-and-high-quality-health-care

Switch from Bells and Whistles to Proven Solutions

- While early adopters are willing to experiment, the mainstream market is looking for standard offerings
- CMS needs to affirm that MSSP is the permanent program and that CMMI accountable care models will be tested in the context of MSSP to spur growth in accountable care.
- Language around “innovation” does not attract them (post-pandemic, many of our practices told us they are wary of more change)
- Use MSSP, the flagship, proven ACO program, as the chassis to build further innovations and learnings on

Assemble the Whole Product

Address rebasing and ratchets, and delayed cash flow



Target variation in VBC contracts across payers

Harmonize quality metrics across payers

Provide standardization of agreements

Make Space for the simplifiers

Late adopters are not DIY-ers

- The mainstream late adopters do not want to spend time on technical implementation
- In the early years of MSSP, only 2-3% of ACOs worked with enablement companies
- In 2023, 29% of Medicare beneficiaries were in ACOs working with enablement companies and they generated 33% of Shared Savings
- Aledade alone supported ACOs with 10% of the Medicare beneficiaries and generated 16% of total Shared Savings

Aledade Policy Institute Recommendations

1. Fix the Accountable Care Prospective Trend (ACPT)
2. Simplify quality measurement and reporting to improve accuracy (no all payer reporting) and reduce burden
3. Ensure there are appropriate incentives to participate in AAPMs through extending the AAPM bonus and allowing more providers to receive it in a more timely fashion
4. Reduce burdens of participating in ACOs, through not requiring MIPS Promoting Interoperability reporting
5. Get rid of process measures such as medication adherence in MA Stars so that providers can focus on outcome measures that matter

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Karl Koenig, MD, MS

Executive Director of the Musculoskeletal Institute,
Division Chief of Orthopaedic Surgery, and Associate Professor of Surgery
and Perioperative Care, Dell Medical School,
The University of Texas at Austin

Implementing Population-Based Total Cost of Care Models

Physician-Focused Payment Model Technical Advisory Committee

Karl Koenig, MD, MS, FAAOS

March 4, 2025

Disclosures

- AAOS Healthcare Systems Committee Chair
- Peer Reviews with National Peer Review Corp
- No Device or Pharma Conflicts

Musculoskeletal diseases affect more than one out of every two persons in the United States age 18 and over, and nearly three out of four age 65 and over

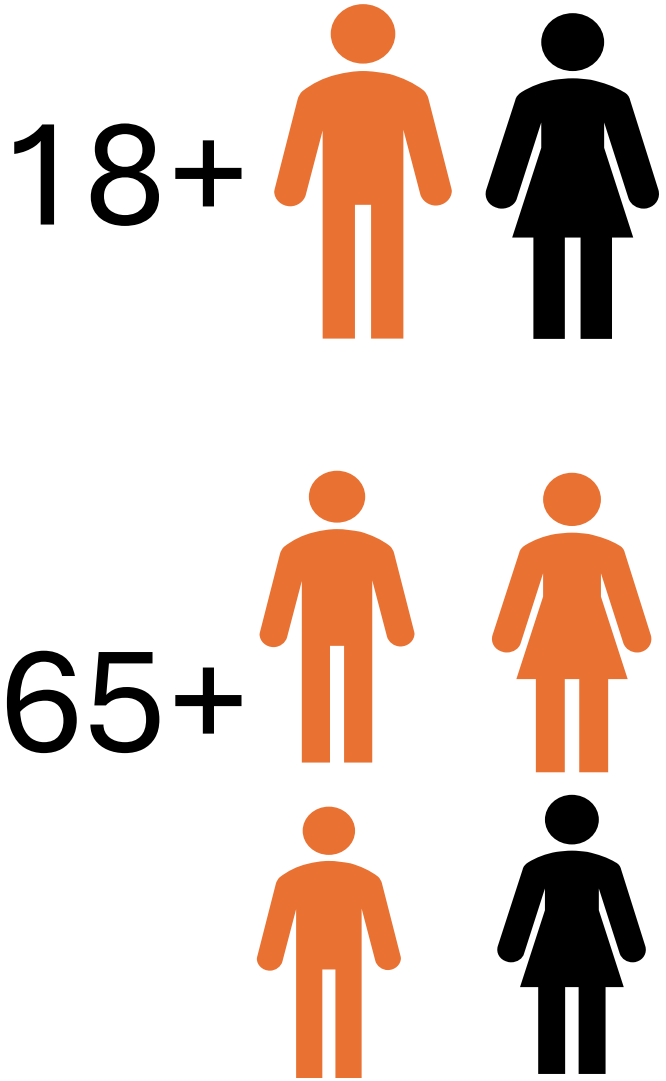
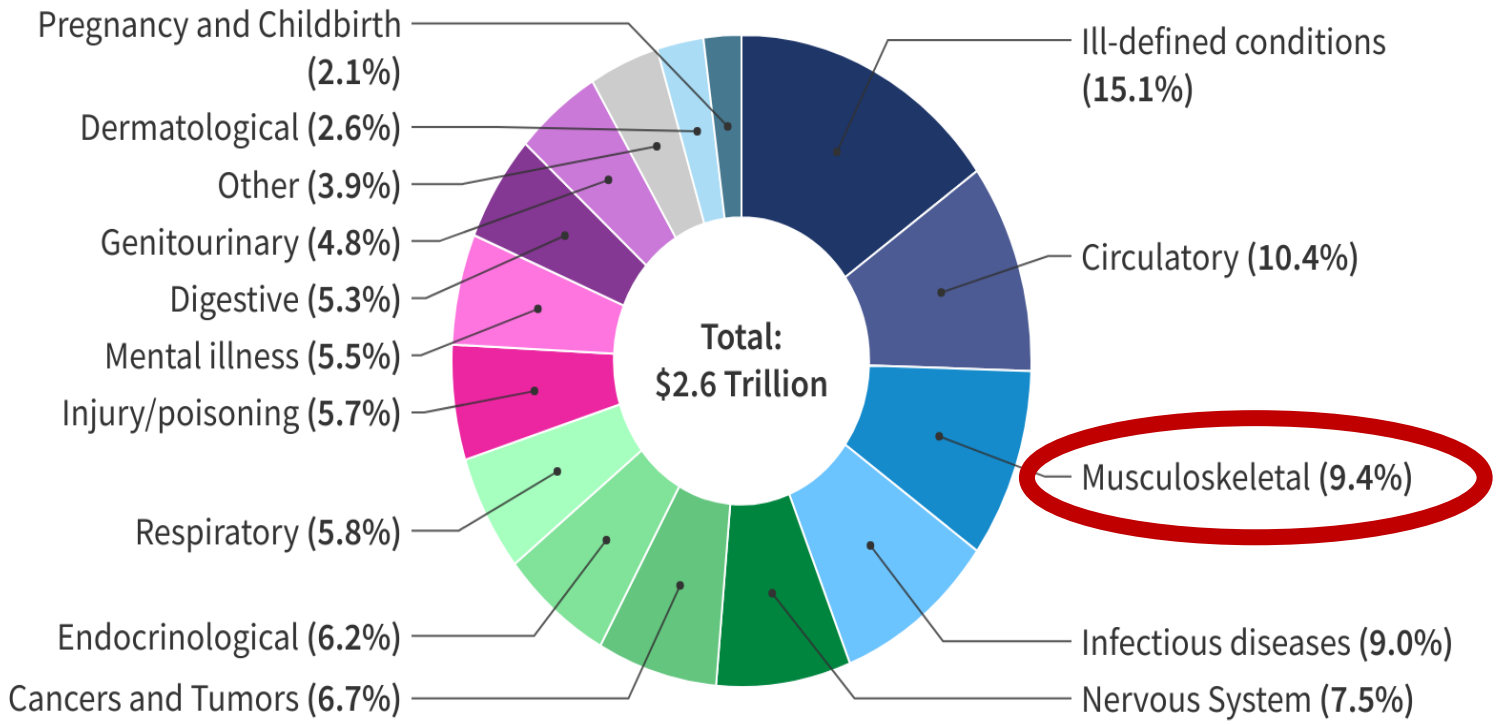


Figure 6

Distribution of Total Medical Services Expenditures, by Medical Condition, 2021



Note: "Other" includes residual codes, blood/blood-forming organs, perinatal, and congenital anomalies.

Source: KFF analysis of BEA Health Care Satellite Account (Blended Account)

Peterson-KFF Health System Tracker

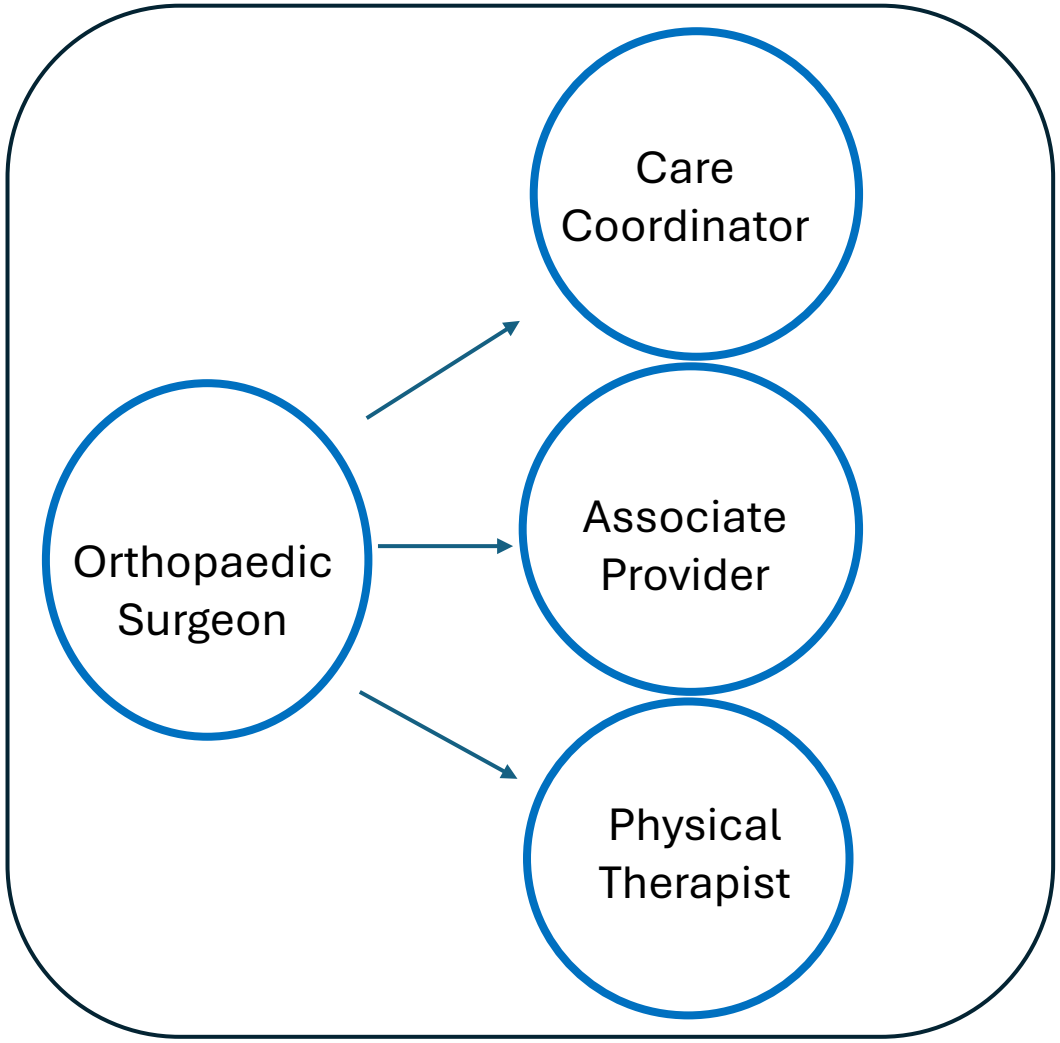
Source: www.ors.org

Specialty-ACO Interaction

- Value can be increased by either improving outcomes or decreasing costs
    - Primarily accomplished through incentivizing the use of effective, evidence-based treatments and allowing the patient and physician to partner in producing better health (rather than just addressing illness after it occurs)
- Mechanism for Specialty-ACO Interaction has not been worked out by current ACO plan
    - Since the ACO will be held accountable for musculoskeletal outcomes if they are utilizing condition-based payments, the ACO will either need to create their own teams to appropriately manage these conditions or set up systems to do so.
- A payment model that incentivizes collaborative high value care is going to be more effective than forcing ACOs to try and identify who is already providing high value care in their community.
    - Existing data from claims and inadequate risk adjustment algorithms make it virtually impossible for an ACO provider to identify and refer to high value specialists.

PCP leads from within the ACO, while the specialist manages the full episode of care within the condition-based bundle.

Single Payment to Specialist



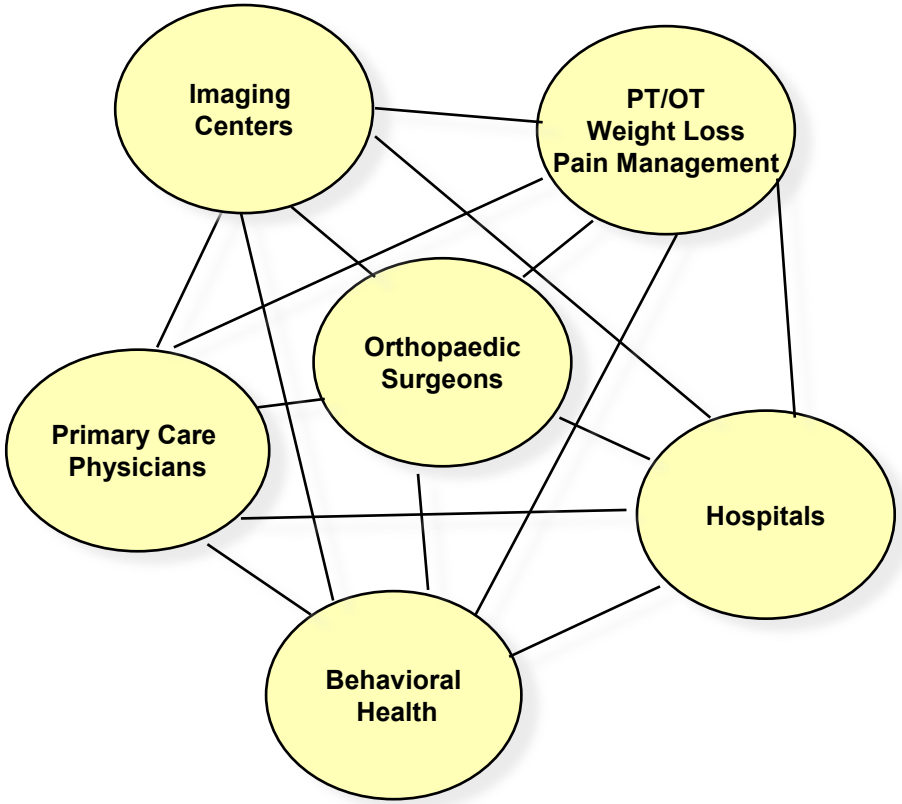
A bundled payment that covers the full care cycle for acute medical conditions or, the overall care for chronic conditions for a defined period (usually a year).

Why Condition-Based Payment Model for MSK Conditions?

- ACOs have matured at the primary care level, and many are improving quality through enhanced coordination. However, ACOs still face challenges when it comes to transformation around specialty care.
- Multiple stakeholders can spark the transformation toward high-value musculoskeletal care and should remain steadfast in motivating others to join forces. The model enacted must incentivize this change.
- Orthopaedic surgeons are required to lead these teams because we have the highest level of training and provide the full breadth of evidence-based treatment options for a given musculoskeletal condition.

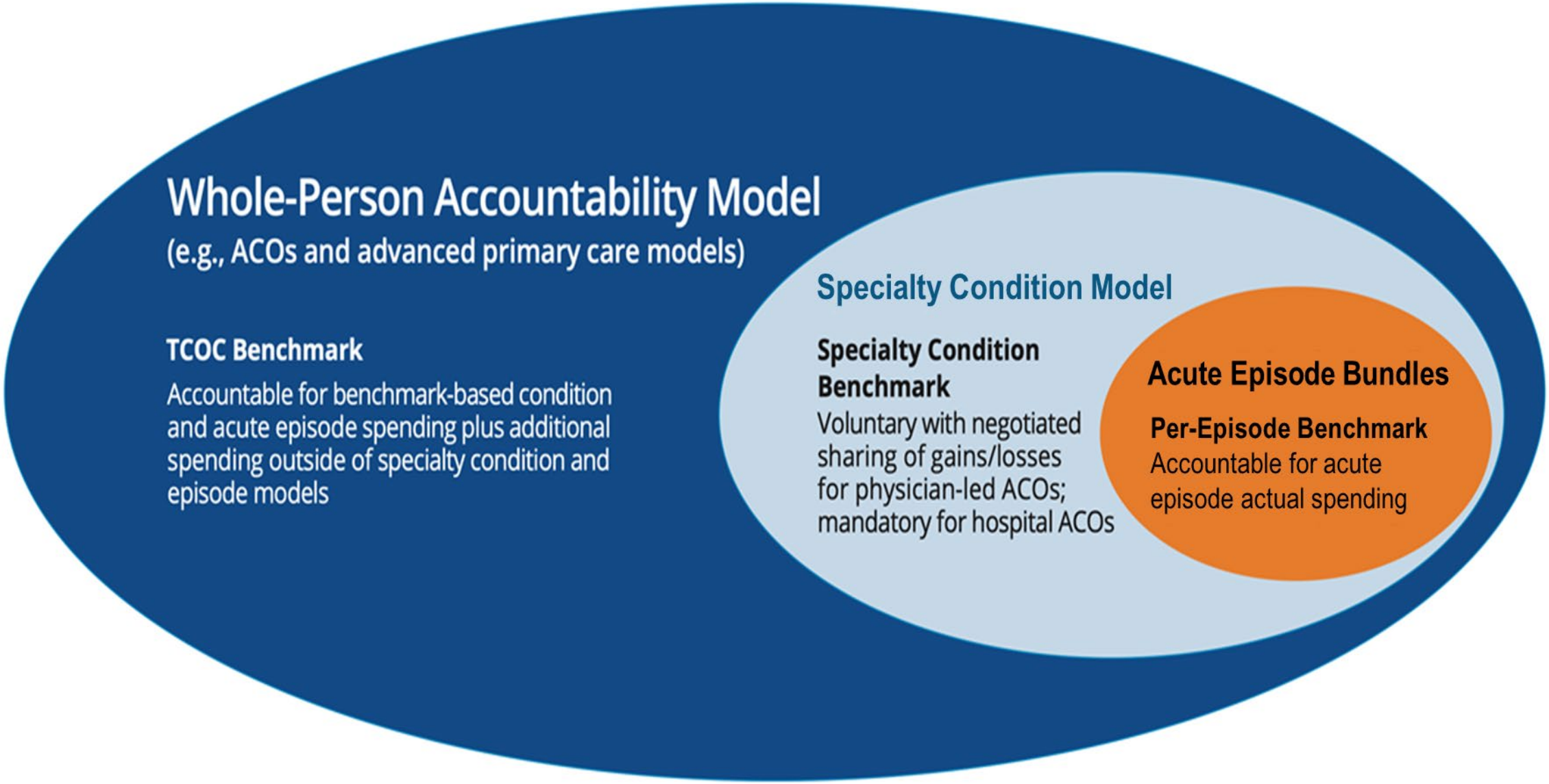
Shifting toward a more Patient-Centered Organization of Care Delivery and Services

Traditional Approach to Care

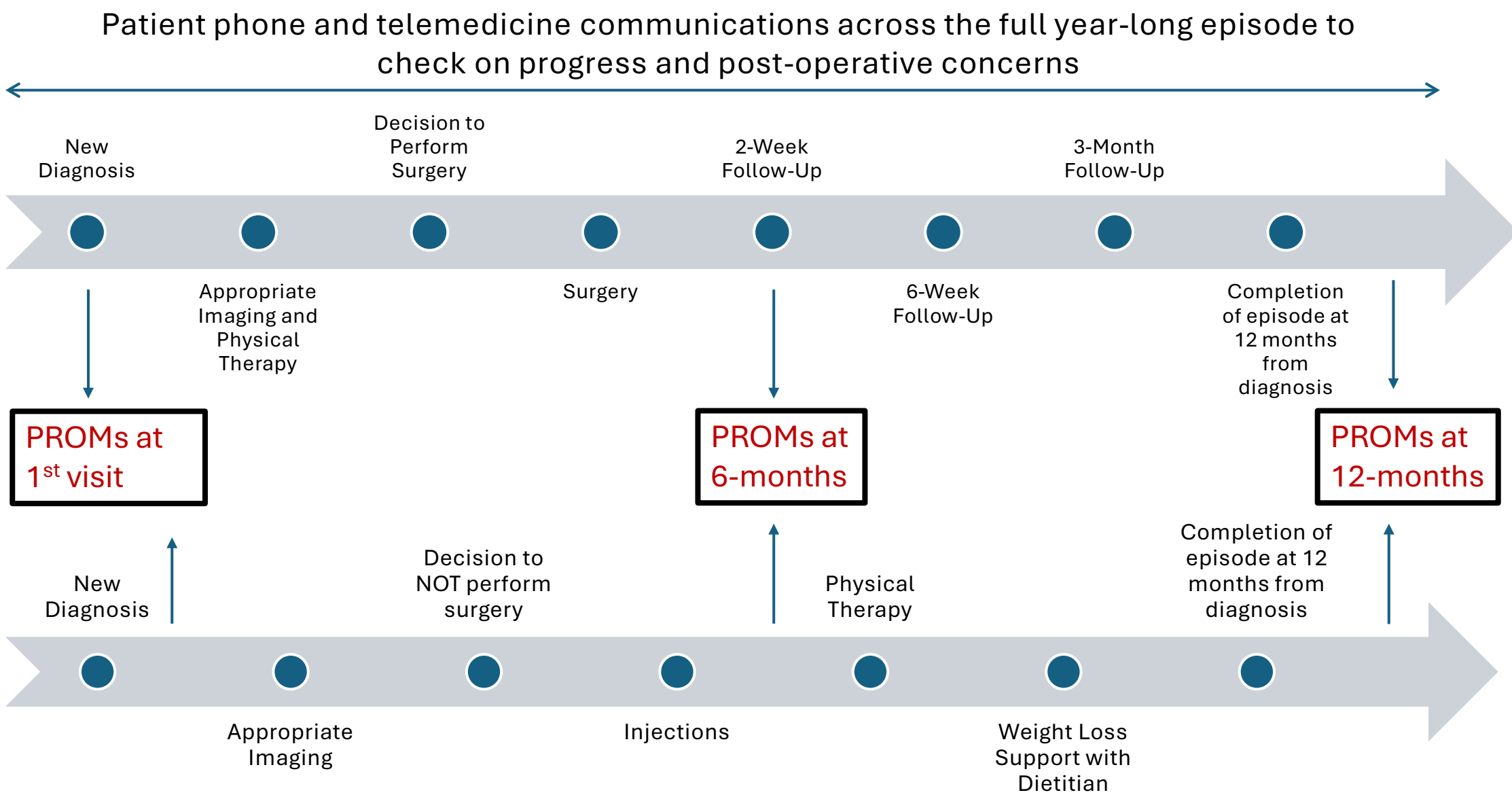


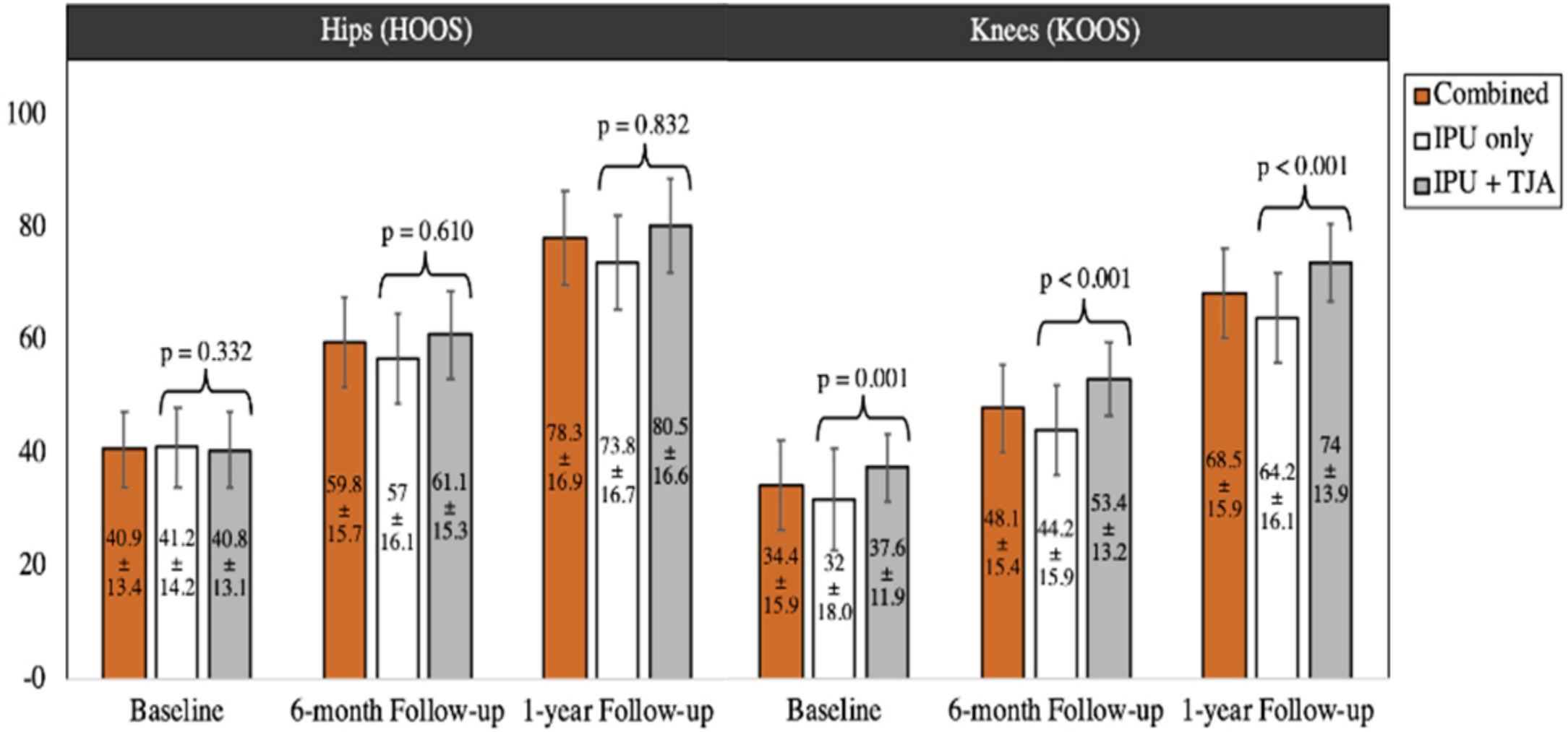
UT Health Austin Musculoskeletal Institute

Specialty-ACO Interaction: Payment Mechanism



Single Payment Model for Knee Osteoarthritis





Based on data from Oct 2017 – Oct 2019
The change in HOOS JR for patients with Hip OA and KOOS JR for patients with knee OA undergoing IPU care only, IPU care plus surgery and both groups combined; Total n=2496; Linked PROMS at 1-year (n=496)

The episode price should include historical per-patient annual spend on relevant services per the program specifications regarding included ICD-10s, CPTs, sites, types, provider, geographies, and business lines

Include surgical professional fee distributed across all patients as fraction the utilization rate $1000 fee, 15% utilization rate = $150 added to each per-member per-period payment	For the related-but-separate surgical bundle, there will exist a separate target price (less the surgical professional fee)	Apply withholds for episode completion/attribution & quality/measurement Balance provider-specific & multi-provider/regional utilization history	Include correction for under-utilization of relevant services (e.g., nutrition, mental health)	Begin with initial upside for 1-2 years Introduce downside years 2-3 and beyond Moving eventually toward risk-adjusted capitated payment

Questions?