

**Physician-Focused Payment Model Technical Advisory Committee  
Public Meeting Minutes**

**September 19, 2022  
8:46 a.m. – 4:12 p.m. EDT  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201**

**Attendance**

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

Paul N. Casale, MD, MPH, PTAC Chair (Vice President, Population Health, NewYork-Presbyterian, Weill Cornell Medicine and Columbia University)

Lauran Hardin, MSN, FAAN, PTAC Vice Chair (Vice President and Senior Advisor, National Healthcare & Housing Advisors, LLC)

Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)\*

Lawrence R. Kosinski, MD, MBA (Founder and Chief Medical Officer, SonarMD, Inc.)

Joshua M. Liao, MD, MSc (Associate Professor, Medicine and Director, Value and Systems Science Lab, University of Washington School of Medicine)

Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)

Terry L. Mills Jr., MD, MMM (Senior Vice President and Chief Medical Officer, CommunityCare)

Soujanya Pulluru, MD (Vice President, Clinical Operations, Walmart Health Omnichannel Care, Walmart, Inc.)

Angelo Sinopoli, MD (Chief Network Officer, UpStream)

Bruce Steinwald, MBA (President, Bruce Steinwald Consulting)

Jennifer L. Wiler, MD, MBA (Chief Quality Officer Denver Metro, UCHHealth and Professor of Emergency Medicine, University of Colorado School of Medicine)

**Department of Health and Human Services (HHS) Guest Speaker**

Chiquita Brooks-LaSure, MPP (Administrator of the Centers for Medicare & Medicaid Services [CMS])\*\*

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

Lisa Shats, PTAC Designated Federal Officer\*

Audrey McDowell

Steven Sheingold, PhD

***\*Via Webex Webinar***

***\*\*Pre-Recorded Remarks***

## List of Speakers and Handouts

### 1. Presentation: Payment Issues Related to Population-Based Total Cost of Care (TCOC) Models

Joshua Liao, MD, MSc, Preliminary Comments Development Team (PCDT) Lead

#### Handouts

- Agenda
- Population-Based TCOC PCDT Slides
- Second Supplement to the Environmental Scan

### 2. Listening Session 1: Vision for Developing Successful Population-Based TCOC Models

Mark Miller, PhD, Executive Vice President, Health Care, Arnold Ventures\*

J. Michael McWilliams, MD, PhD, Warren Alpert Foundation Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School\*

Michael E. Chernew, PhD, Leonard D. Schaeffer Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Director, Healthcare Markets and Regulation Lab, Harvard Medical School\*

#### Handouts

- Listening Session Day 1 Slides
- Listening Session Day 1 Presenters' Biographies
- Listening Session Day 1 Discussion Guide

### 3. Listening Session 2: Payment Model Features Contributing to Successful Population-Based TCOC Models

Kristen Krzyzewski, MBA, Chief Strategy & Program Development Officer, LTC ACO\*

Jeff Micklos, JD, Executive Director, Health Care Transformation Task Force\*

Clare Wirth, Director, Value-Based Care Research, Advisory Board\*

#### Handouts

- Listening Session Day 1 Slides
- Listening Session Day 1 Presenters' Biographies
- Listening Session Day 1 Discussion Guide

### 4. Panel Discussion on Operational Considerations and Financial Incentives Related to Successful Implementing of Population-Based TCOC Models

Alice Chen, PhD, MBA, Associate Professor of Public Policy, USC Sol Price School of Public Policy, University of Southern California (Academic/Policy Research Perspective)\*

Maryellen E. Guinan, JD, Policy Manager, America's Essential Hospitals (Provider Perspective)\*

Kathleen Holt, MBA, JD, Associate Director, Center for Medicare Advocacy (Patient Advocacy Perspective)\*

Gregory P. Poulsen, MBA, Senior Vice President, Policy, Intermountain Healthcare (Payer Perspective)\*

Katie Wunderlich, MPP, Executive Director, Maryland Health Services Cost Review Commission (State Government Perspective)\*

## Handouts

- Roundtable Panelists' Biographies
- Panel Discussion Guide

### *\*Via Webex Webinar*

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available on the ASPE PTAC website located at: <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>].

The [ASPE PTAC website](#) also includes copies of the presentation slides and other handouts and a video recording of the September 19 PTAC public meeting.

### **Welcome and Overview: Discussion on Payment Considerations and Financial Incentives Related to Population-Based Total Cost of Care (TCOC) Models Day 1**

Paul Casale, PTAC Chair, welcomed members of the public to the September 19-20 public meeting. He explained that the Committee has been exploring themes that have emerged from proposals submitted to PTAC from the public. Chair Casale noted that PTAC launched a series of three public meetings in March 2022 on population-based TCOC models to support the goal of the Center for Medicare and Medicaid Innovation (CMMI; the Innovation Center) of having all Medicare beneficiaries with Parts A and B in a care relationship with accountability for quality and TCOC by 2030.

Chair Casale introduced pre-recorded remarks by Administrator Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services (CMS).

Administrator Brooks-LaSure highlighted CMS's priorities related to equity and innovation, emphasizing that CMS is dedicated to advancing health equity, expanding access to affordable health care, and improving health outcomes. She indicated that as the largest purchaser of health care in the U.S., Medicare can serve as a vehicle for care transformation through which CMS can align equity with care delivery and payment models. The Administrator explained that CMS is driving high-quality, person-centered care that advances equity by accelerating participation in value-based care models that reward efficient spending and improved health care outcomes. She noted that the COVID-19 public health emergency (PHE) highlighted the value of Alternative Payment Models (APMs); for example, many Accountable Care Organizations (ACOs) invested in telehealth services, care managers, and community health workers (CHWs) to provide critical support to communities during the pandemic. This shift underscored the importance of providing care that addresses patients' unique circumstances outside of traditional health care settings.

The Administrator stated that CMS is working to enhance the transition to value-based care so that all Medicare fee-for-service (FFS) beneficiaries are in a care relationship with accountability for quality and TCOC. She indicated that when value-based care programs are not aligned, it can be complex and counterproductive for providers who provide care to patients across multiple payers. She added that misaligned programs can also create confusion for Medicare beneficiaries who would benefit from coordinated efforts to address health and social needs. The Administrator highlighted a recent [CMS publication in Health Affairs](#) that discusses the agency's progress on value-based care.

Administrator Brooks-LaSure stated that a key element of the strategy behind the goal of having every Medicare beneficiary in an accountable care relationship by 2030 focuses on aligning and coordinating the care models in traditional Medicare and Medicare Advantage (MA). She noted that the Center for Medicare is working with CMMI to align accountable care initiatives and use the Innovation Center's authority to test innovative payment and care delivery models that could be scaled into the Medicare Shared Savings Program (MSSP). She also stated that the Center for Clinical Standards and Quality (CCSQ) and CMMI are working together to help primary care and specialty clinicians who are part of the Quality Payment Program (QPP) to achieve high-quality care.

The Administrator highlighted how CMMI's strategy refresh is driving care transformation, including focusing on equity and person-centered care. She noted that CMMI will be engaging with providers who have not previously participated in value-based care initiatives and ensuring that the eligibility criteria and application processes do not exclude or disincentivize providers who care for specific populations, including those in rural and underserved communities. The Administrator discussed how CMS is engaging stakeholders so that beneficiaries and providers better understand care models and can provide input on their implementation.

Administrator Brooks-LaSure stated that PTAC's public meeting on TCOC is of particular interest to CMS and CMMI, and she looks forward to robust discussions among Committee members, subject matter experts (SMEs), and public stakeholders.

Chair Casale thanked Administrator Brooks-LaSure for her remarks. He explained that PTAC's March 2022 public meeting examined key definitions, issues, and opportunities for developing and implementing population-based TCOC models, and the June public meeting discussed how care within population-based models can promote a more high-touch, patient-centered health care system. Chair Casale indicated that the two-day September meeting agenda focuses on payment methodologies and design features that can best incentivize those care delivery practices. He noted that the meeting will include discussions of:

- The broad vision for developing successful population-based TCOC models;
- Important payment model design features and financial incentives;
- How to encourage clinical integration between primary and specialty care providers;
- Which performance metrics can best encourage value-based transformation;
- How to promote equity and address health-related social needs (HRSNs); and
- Transitional steps toward improving participation, provider accountability, and outcomes in population-based models.

Chair Casale referred audience members to [background documents](#) intended to summarize important issues and prior research related to these topics. He indicated that the September 20 public meeting would begin with opening remarks from Elizabeth (Liz) Fowler, Deputy Administrator of CMS and the Director of CMMI, followed by presentations by SMEs and a public comment period. He noted that both days of the public meeting will include time for the Committee members to discuss their comments and recommendations that will be included in a report to the Secretary of Health and Human Services (HHS).

Chair Casale reminded stakeholders that PTAC accepts proposals for physician-focused payment models (PFPMs) from the public on a rolling basis. He noted that PTAC offers two proposal submission tracks, allowing flexibility depending on the level of detail that is available regarding the details of payment methodology relevant to the proposed PFPM. He referred stakeholders to the [ASPE PTAC website](#) for more information on how to submit a proposal.

Chair Casale invited Committee members to introduce themselves and their experience with population-based TCOC models. Each Committee member provided a brief introduction and then Chair Casale introduced Joshua Liao, the September population-based TCOC Preliminary Comments Development Team (PCDT) Lead, who presented the PCDT's findings from the [background materials](#).

### **Presentation: Payment Issues Related to Population-Based TCOC Models**

Dr. Liao indicated that the five additional members who served on the PCDT were Chair Casale, Lawrence Kosinski, Walter Lin, Terry (Lee) Mills, and Soujanya Pulluru. He explained that the September theme-based discussion will focus on payment issues and methodology considerations with the objective of exploring options to incentivize care delivery innovations and encourage specialty integration in population-based TCOC models. Dr. Liao noted that PTAC has deliberated on 28 PFPM proposals to-date, many of which have sought to reduce TCOC and raised issues regarding the role of specialty integration. H

Dr. Liao presented a diagram illustrating desired payment features, care delivery features, and vision of population-based TCOC models, as well as a list of enabling factors that may facilitate these desired features. He emphasized the importance of aligning model design features with the goal of TCOC models and recognized that a variety of methodologies can be used to achieve these goals.

Dr. Liao presented opportunities and challenges on a spectrum of payment methodologies that could be used in population-based TCOC models ranging from prospective capitation to FFS with shared savings and losses. Dr. Liao emphasized that individual opportunities and challenges may be relevant in different ways across different payment methodologies. He suggested that it is important to surface opportunities and challenges and consider how they manifest across the spectrum of different payment methods. He also noted that these opportunities and challenges may be characterized as more conceptual or operational, or in some cases, both.

Dr. Liao presented a series of tables highlighting examples of population-based and episode-based payment methodologies along with their associated opportunities and challenges. He explained two reasons for highlighting episode-based payment methodologies: 1) one of the objectives of the theme-based discussion is to address specialty integration, and episode-based models have been more successful at engaging specialists; and 2) many episode-based models have sought to address TCOC, including proposals deliberated on by PTAC. Dr. Liao suggested that understanding the role of episode-based models can be addressed as part of the Committee's broader objective of focusing attention on specialist integration in population-based models.

Dr. Liao presented a list of population-based TCOC model design considerations, noting the ones the PCDT believes are most relevant to the theme-based discussion are denoted by an asterisk.

Dr. Liao presented a series of slides featuring model design considerations associated with participation incentives; up-front resources and infrastructure; level of financial accountability; attribution; benchmarks; risk adjustment; and selection and performance metrics.

Finally, Dr. Liao presented areas for discussion during the September public meeting, emphasizing that these issues are critical to incentivizing innovations within TCOC models and addressing the issue of specialty integration.

Chair Casale invited Committee members to ask questions about Dr. Liao's presentation.

- Angelo Sinopoli asked how practices fund these initial care delivery investments at the outset. He noted that over time, practices will ideally generate shared savings, but the initial investments are significant. He asked about what model features can help practices ramp up quickly and remain successful in the model. Dr. Sinopoli suggested that there will need to be an effort to organize the broader community (e.g., community-based organizations [CBOs], state agencies), which can impact model performance beyond what primary care practices are able to achieve. He advised against a Preferred Provider Organization (PPO) risk structure in which the network takes on the risk while the providers continue to be paid FFS and do not lead to the incentives necessary for achieving the goals of population-based TCOC models.
- Bruce Steinwald asked whether population-based TCOC models should be multi-payer or focus specifically on Medicare.
  - Dr. Liao stated that he believes these models should be multi-payer. He noted the importance of aligning payment approaches so that clinicians and organizations can focus on care transformation without the complexity of multiple payment structures, regulations, and performance metrics.
  - Dr. Pulluru suggested that population-based TCOC models should be multi-payer but suggested that Medicare can play a role in data sharing, which is fundamental to a successful multi-payer TCOC model.
- Chair Casale remarked that the slide illustrating opportunities and challenges along the spectrum of payment models highlights important tensions inherent in moving toward population-based TCOC models. He emphasized the importance of access to actionable data in addressing challenges related to these tensions.
- Dr. Mills highlighted the need to consider trade-offs between different approaches to attribution, benchmarking, and risk adjustment in population-based models. He noted that it is a necessary condition to provide contemporaneous, actionable data and how this relates to the desire for a precise and accurate model.

### **Listening Session 1: Vision for Developing Successful Population-Based TCOC Models**

- Mark Miller, PhD, Executive Vice President, Health Care, Arnold Ventures
- J. Michael McWilliams, MD, PhD, Warren Alpert Foundation Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School
- Michael E. Chernew, PhD, Leonard D. Schaeffer Professor of Health Care Policy, Department of Health Care Policy, Harvard Medical School; Director, Healthcare Markets and Regulation Lab, Harvard Medical School

Chair Casale moderated the listening session with three SMEs on their vision for developing successful population-based TCOC models. He noted that full biographies and presentations can be found on the [ASPE PTAC website](#).

Mark Miller delivered a presentation titled “Population-Based Total Cost of Care Payment Models.”

- Dr. Miller introduced himself and Arnold Ventures, a philanthropy funding research, policy development, technical assistance, communication, and education. He shared that the opinions expressed in his presentation are his own, but also reflect those of Arnold Ventures.
- Dr. Miller shared that his work on constraining unnecessary utilization includes the need to:
  - Increase the share of spending and enrollees in population-based models.
  - Offer providers financial incentives to contain costs and provide high-quality care.

- Dr. Miller noted that identifying low-quality care and sharing that information with providers can be an important step to help them perform in capitated payment models.
    - Reduce FFS payment for low-value care and make FFS less profitable.
    - Align beneficiary and system incentives to seek high-value, high-quality care.
  - Dr. Miller described Arnold Venture’s research and policy principles regarding moving toward population-based payment:
    - Emphasize the shift toward population-based payment models by de-emphasizing the role of episode-based payment models.
      - Episode-based payment models are fragmenting. They reflect issues with FFS in some ways and dilute incentives to contain cost and quality.
    - Reduce the number of model tracks and direct providers toward population-based initiatives and two-sided risk.
      - Providing some limited number tracks can accommodate the factors relevant to different types of providers, for example, by providing low-risk tracks for smaller organizations, with the goal of ultimately moving more providers toward two-sided risk.
    - Strengthen and simplify incentives for model participation, including by providing financial support and technical assistance to help providers develop care delivery systems.
    - Consider making models mandatory.
    - Continue to make remaining in FFS less appealing to providers by developing greater payment differentiation between FFS and population-based models and allowing greater flexibility for providers in population-based models.
    - Improve performance benchmarks.
      - Improving benchmarks is necessary to address the ratchet effect, address rural issues, and address the benefits of developing regional adjustments.
      - Moving toward an administrative benchmark could allow for increased predictability, stability, and equity.
    - Improve risk adjustment systems.
      - Limit profits from upcoding.
      - Include factors that are less subject to manipulation and more dependent on reinsurance to address variation and risk across different models.
    - Move majority of primary care to capitated per-member per-month (PMPM) payments.
      - Primary care providers (PCPs) should play a greater role in helping patients navigate the health care system, which could be best achieved through PMPM reimbursement.

Michael McWilliams gave a presentation titled “Population-Based Payment Models: Promise, Progress, and Design.”

- Dr. McWilliams disclosed that he is a Senior Advisor to CMMI, on the board of directors at the Institute for Accountable Care, and a consultant to RTI International, BlueCross BlueShield North Carolina, and Abt Associates. He noted that he would be presenting as a Harvard professor, and his comments do not represent the view of CMMI and/or CMS.
- Dr. McWilliams presented on the realistic and unrealistic expectations of TCOC payment models, noting that TCOC payment models can control spending growth, discourage overutilization, smooth revenue during demand shocks, and offer providers more flexibility to select the right services for patients, but that they cannot make preventive care and health improvement profitable or universally improve quality through pay-for-performance.

- Dr. McWilliams noted that decoupling revenue from service selection is a precondition for care delivery transformation because it removes FFS incentives and allows providers greater freedom to choose the right services for patients.
- Dr. McWilliams reiterated that TCOC payment models do not necessarily make preventive care or health improvement profitable. He clarified that while healthier populations need less care, population health improvements are costly and can induce some types of utilization.
- Dr. McWilliams noted that the evidence on pay-for-performance is not encouraging. He explained that it can be very difficult to establish strong incentives to improve quality without creating waste, potential for manipulation, or situations where providers simply “teach to the test” rather than focus on quality broadly. He suggested that quality will largely be determined by intrinsic physician motivation and extrinsic competitive pressures, so future payment models should largely be focused on TCOC and population-based payments rather than pay-for-performance components.
- Dr. McWilliams presented existing evidence on the savings and quality improvements in ACO programs.
  - Dr. McWilliams noted that ACO programs have induced behavioral changes that lower spending, but associated savings have been small. The fact that savings are limited is likely due to these programs having weak incentives. He suggested that stronger incentives can increase savings. He clarified that savings have been driven primarily by waste reduction and less by integration, coordination, and prevention.
  - Dr. McWilliams stated that selective participation in ACO programs by ACOs with already low spending has likely resulted in overstated program savings compared to benchmarks. He noted that subsidies to the ACO programs have likely negated much of the ACO program’s true savings.
  - Dr. McWilliams noted that evidence for ACO quality improvement is limited partially by data constraints, but that this evidence has shown relatively small and scattered improvements. The exception is with patient experience measures, which show improvements, but the improvements are not clearly attributable to the pay for performance incentives. He provided findings from his team that showed overall care ratings were entirely concentrated among high-risk patients, suggesting a potential effect of high-risk case management, rather than pay-for-performance incentives.
- Dr. McWilliams offered several design considerations for population-based payment models.
  - Dr. McWilliams suggested that population-based models should include a multi-track structure to accommodate lower-risk options for smaller organizations.
  - Dr. McWilliams noted that the benefits of downside risk tend to be overstated, as ACOs facing losses in voluntary models will exit, limiting its impact.
  - Dr. McWilliams emphasized that, while prospective TCOC payments can be desirable to participants, they are not necessary to establish incentives. He suggested that a model based on FFS with year-end reconciliation can offer advantages in terms of transaction costs.
  - Dr. McWilliams suggested that risk adjustment needs to address the trade-off between predictive accuracy and the need to support broader goals, such as additional support for historically marginalized populations. He offered potential solutions, such as omitting some indicators from the model or setting payment above current spending for certain groups. He noted that the risk adjustment system will also need to be adjusted to mitigate coding incentives, which could compromise predictive accuracy, but is an acceptable trade-off.



- Dr. McWilliams offered that primary care capitation payments are an important method to increase primary care spending and make the best use of primary care as a way to reduce waste and improve quality.
- Dr. McWilliams noted that the current benchmarking methodology, based on observed or realized FFS spending, serves as an internal benchmark that can create ratchet effects and weaken ACO participation incentives. He advocated for external, administratively-set benchmarks to decouple benchmarks from observed spending.
- Dr. McWilliams noted that group-level incentives can help to pool risk and encourage organizations to do what individual clinicians cannot do on their own. He suggested that reducing the risk at the group level and moving it to the clinician level defeats that purpose. The primary ways to change clinician behavior include shifting internal compensation from FFS toward salary and offering non-financial incentives. Dr. McWilliams explained that clinicians have a limited incentive to improve their own performance if the reward is determined largely by the performance of their peers.
- Dr. McWilliams noted that the ACO Realizing Equity, Access, and Community Health (REACH) model and its associated health equity benchmark adjustment is a promising development. Similarly, proposed changes in the physician fee schedule for the MSSP offer progress.

Michael Chernew gave a presentation titled “Incentives vs Cash Flow in Population-Based Payment Models.”

- Dr. Chernew introduced himself and clarified that he would be speaking in his role as a Harvard professor, and his views do not represent those of MedPAC or any other organizations he is a member of.
- Dr. Chernew described the levels of entities involved in health care system payment. He noted that funds from Medicare, an employer, or individual premiums are often funneled through a carrier, such as an MA plan or ACO. The funds then move through a health system to a medical group or hospital, and then down to the provider. He clarified that some steps can be skipped and that incentives can vary by step.
  - Dr. Chernew described that in ACOs, the goal was to move past insurance carriers and other conveners directly to a delivery system. In the FFS world, the money goes directly from the payer to a medical group or individual provider.
  - Dr. Chernew emphasized that incentives and payments can vary by step in the chain between funders and providers. He noted that population-based payments could go from Medicare to the insurance carrier or ACO, and the delivery systems could be paid in various ways via FFS. He emphasized that many different versions of compensation can happen at every level as funds flow through the health care system.
- Dr. Chernew noted that while non-financial incentives can vary by level of the health care system, the tools used to implement these incentives vary by program.
  - In FFS, there are patient cost sharing initiatives that can be dampened by the incentives of supplemental coverage. ACOs use incentives to manage care more efficiently by providing education, information, and financial bonuses; reducing administrative hurdles; making investments in care infrastructure; and allowing flexible network design. MA plans additionally use incentives such as network design, prior authorization, benefit design, and APMs.
- Dr. Chernew clarified the differences between cash flow and incentives, noting that incentives refer to how profits are affected by utilization and are typically holistic, affecting finances over a longer period of time. As a result, an ACO paying FFS throughout the year with year-end reconciliation can produce incentives similar to capitation. He emphasized that it is important not to get distracted by

the potential drawbacks of short-term FFS incentives, because the ultimate incentives of year-end reconciliation can matter more than the FFS transactions. In ACOs, cash flow provided by FFS can provide the regular funding needed to facilitate daily operation and avoid the need for ACOs to have complex contracting mechanisms across unaffiliated providers; however, because the incentives end up being the same, the FFS foundation is irrelevant.

- Dr. Chernew described how the different possible relationships between organizations at higher and lower levels of the health care system can impact care delivery but are not central to incentives. Dr. Chernew emphasized an important difference between MA plans and ACOs. MA plans manage care for a set of beneficiaries that enroll in the plan, which gives them leverage with providers. ACOs are either providers or must recruit providers to gain patients, which gives providers leverage over the contracting ACOs. In either case, the provider controls the patient, and the ACO needs to recognize that.

Chair Casale invited Committee members to ask questions of the presenters.

- Chair Casale asked the presenters to explain their visions for structuring payment methodology in population-based TCOC models.
  - Dr. Miller suggested that beneficiaries should select either a PCP or a physician who is their primary contact (e.g., a patient with congestive heart failure might select a cardiologist), to enable the primary contact physician to help steer the patient to high-value care.
  - Dr. McWilliams agreed with Dr. Miller and suggested that offering beneficiaries a cut of shared savings could offer tangible evidence of the benefits of a new payment system and facilitate beneficiary movement to more efficient providers. He also noted that it will be important to structure APMs and ACOs in a way that recognizes the increasing role of MA versus traditional Medicare. Assuming traditional Medicare continues to be viable, Dr. McWilliams asserted that a valuable methodology could be a foundational, multi-track, ACO-like payment system coupled with a limited number of episodes and bundles. He emphasized the importance of a multi-track system with different entry points to accommodate more providers. He also suggested avoiding the addition of new services to the FFS fee schedule, allowing flexibility to innovate in care delivery and disincentivizing FFS, while encouraging providers to move into value-based programs.
  - Dr. Chernew referred individuals to the MedPAC chapter on the foundational ACO model. He suggested that CMMI needs to move away from a “test and diffuse” mentality of model development, emphasizing that moving toward a single foundational, population-based model with a limited number of episodes will enable care transformation and effective evaluation. He also highlighted the importance of developing administrative benchmarks, noting that administrative benchmarks can provide budgets and responsibility for managing economic and clinical outcomes without ratcheting money away from successful providers. Dr. Chernew finished by discussing the inherent threat of MA to APMs, suggesting that payments to MA should be cut to support development of successful APMs.
- Chair Casale asked the presenters to describe the type of payment model design features and financial incentives they feel are most important to developing successful TCOC models. He also asked the presenters to describe evidence associated with the effectiveness of these approaches.
  - Dr. McWilliams noted that benchmark reform is the most important step to develop effective TCOC models. He discussed how eliminating benchmark ratchet effects would increase provider incentives to decrease costs and participate in models. He also noted that future models should be open to increasing savings rates to increase participation,

highlighting that Medicare may be better able to control spending through administrative, externally set benchmarking rather than partial savings.

- Dr. Chernew stated that the three most important features for developing successful TCOC models are benchmarks, risk adjustment, and attribution. He also highlighted the importance of attribution, noting that APMs have less clarity on patient attribution and enrollment than MA. He suggested that all three issues need to be resolved to develop effective models that reward high-value care and discourage low-value care. He noted that additional work would need to be done to incorporate episode-based payment models to ensure that savings and population-based risk are distributed to the right organizations. Dr. Chernew emphasized that additional conversations needed on voluntary versus mandatory model participation, noting that both have their benefits and trade-offs; voluntary models can be constrained by having limited options to encourage provider participation, and mandatory or heavily incentivized models can offer additional design flexibility, but not all providers can succeed in a mandated model.
- Dr. Miller agreed with the importance of using administrative benchmarks and moving toward mandatory models as ways to move away from FFS. He also noted that even if models function as FFS systems with year-end reconciliation, they should offer providers some certainty and cash flow.
- Chair Casale asked the presenters to discuss their thoughts on the most important interim steps needed to increase provider participation in value-based care models, help providers assume greater financial risk, and encourage provider investments in care delivery transformation.
  - Dr. Chernew highlighted the importance of establishing certainty and stability in payment models to encourage provider participation. He suggested that models should allow providers to prosper in a controlled way, rather than ratcheting down and reducing the potential for providers to succeed. He noted that allowing providers to profit from improving efficiency, while controlling top-line spending growth to a sustainable rate, can benefit both providers and payers, and sustain providers through a future where FFS payments do not increase at rates favorable to them.
  - Dr. McWilliams agreed that interim steps need to be explicitly linked to long-term solutions. He highlighted promising actions taken in the ACO REACH model to set higher benchmarks for providers caring for underserved populations and the benefit of the proposed MSSP rule to create an external benchmark. He emphasized the importance of making benchmark modifications to create opportunities for sustainable growth and incentives that work over time; considering the best approach to primary care capitation and risk adjustment; mitigating coding incentives, including beneficiaries in savings; and achieving multi-payer alignment in developing payment models.
- Chair Casale asked the presenters to review additional insights related to developing effective payment methodologies for population-based models.
  - Dr. Chernew discussed how future efforts in payment reform will need to consider how to redesign the MA system. He noted that, while MA plans can offer significant value, the program is currently larger than intended and must be redesigned with new benchmarks to gain efficiencies and improve value.
- Mr. Steinwald asked the presenters to describe their thoughts on the continuing role of FFS in payment models.
  - Dr. Chernew suggested that the FFS system should be reformed, and that it will continue to be necessary as a background for determining savings related to use of APMs.
  - Dr. Miller noted that he agreed with Dr. Chernew's comments and emphasized that FFS should be made unattractive and less profitable for providers than a value-based system.

- Dr. McWilliams noted that it is important to distinguish between FFS as a payment system and FFS to track payments toward risk-bearing organizations. He also commented that it may make sense for both FFS payment and TCOC payment to exist and be used for different services. He clarified that even when some providers are being reimbursed through FFS, incentives can still be transferred to the rest of the market if there is a competitive market that demands efficiency from FFS providers.
- Dr. Kosinski asked how to make FFS unappealing and transition specialist compensation away from FFS, particularly in specialties similar to gastroenterology where a vast majority of provider revenue comes from a single elective procedure.
  - Dr. Miller noted that innovation within an accountable care model can allow for flexibility within the FFS payment structure. While revenue may flow through the model through FFS, reallocation can allow for flexibility to adjust incentives and make compensation attractive to and supportive of providers.
  - Dr. McWilliams observed that there could be several methods to adjust incentives to support specialist providers, including through offering non-financial incentives to reduce spending among salaried physicians; developing subcontracting agreements that reward reductions in low-value procedures; and making care management fees to affiliated providers and unaffiliated referrals. He noted that some markets are competitive enough that ACOs can refer to more efficient, higher-quality providers, but emphasized that a foundational population-based payment model can adapt to allow incentives to flow through both financial and non-financial means to specialists.
  - Dr. Chernew emphasized that the reform of the FFS system and associated fee schedule and codes is an important step, in addition to developing an overarching system that can manage care, referrals, compensation, employment, bonuses, and quality payments.
- Dr. Pulluru inquired how to change attribution models in order to encourage independent attribution given the increasing restrictions associated with MA “pay-viders” and capitated plans.
  - Dr. Chernew noted that one of the most important steps is to reform primary care payments, because FFS does not adequately incentivize primary care practitioners because of the significant administrative burden placed on independent providers.
  - Dr. McWilliams noted that the concern that increasing numbers of PCPs may be working with MA pay-viders has not been rigorously studied and suggested that the issue stems from an imbalance in primary care payment between MA and traditional Medicare. He offered two possible solutions: reducing MA payments, and providing global, capitated payments for primary care within TCOC models.
  - Dr. Miller added that it is important to consider the impact of managed care FFS and MA on Alternative Payment Models, noting that overpaying for and subsidizing MA can lead some organizations looking to recruit patients and providers away from other organizations.
- Jennifer Wiler asked the presenters whether their model recommendations would be voluntary, mandatory, or heavily incentivized.
  - Dr. Chernew noted that the approach to encouraging participation would differ by track and organization size, with large organizations being heavily incentivized to incorporate two-sided risk, and small organizations being able to participate in less-heavily incentivized programs similar to MSSP Classic.
  - Dr. McWilliams agreed with Dr. Chernew, noting that model participation incentives should be considered on a spectrum, with different levels of participation incentivization depending on the type of provider.

- Dr. Miller noted that he leans toward heavily incentivized and even potentially mandatory participation in models. He suggested that mandatory participation could help facilitate research on models.

## **Listening Session 2: Payment Model Features Contributing to Successful Population-Based TCOC Models**

- Kristen Krzyzewski, MBA, Chief Strategy & Program Development Officer, LTC ACO
- Jeff Micklos, JD, Executive Director, Health Care Transformation Task Force
- Clare Wirth, Director, Value-Based Care Research, Advisory Board

Lauran Hardin, PTAC Vice Chair, moderated the listening session with three SMEs on payment model features contributing to successful population-based TCOC models. She noted that full biographies and presentations can be found on the [ASPE PTAC website](#).

Kristen Krzyzewski gave a presentation titled “Payment Model Features Contributing to Successful Population-Based Total Cost of Care Models.”

- Ms. Krzyzewski introduced LTC ACO, an enhanced track MSSP ACO that serves approximately 20,000 beneficiaries residing in 39 states with over 1,800 participating providers.
- Ms. Krzyzewski shared that the LTC ACO program earned the highest gross savings per beneficiary in 2019 and 2021. Despite the negative impacts of the COVID-19 PHE on LTC ACO’s patient population, LTC ACO has been able to improve in quality, earning the highest quality shared adjusted rate of 75 percent in 2021.
- Ms. Krzyzewski noted that the LTC ACO population is a unique, high-cost, high-needs population.
- Ms. Krzyzewski emphasized that the long-stay nursing facility resident population presents an opportunity for value-based care, considering its high-cost, high-risk, low MA penetration, and low value-based program participation. She noted that as Medicaid increases the use of home- and community-based services (HCBS) to lower costs, the nursing facility population will become increasingly older, higher-risk, and higher-cost, and require increased care coordination.
- Ms. Krzyzewski shared that the LTC ACO, to become successful, has had to address several challenges associated with rules governing MSSP model broadly:
  - Providers typically provide services under more than one Tax Identification Number (TIN), making it difficult to isolate their specific patient population. Ms. Krzyzewski suggested that better approaches to identifying relevant patients using both National Provider Identifiers (NPIs) and TINs could help with attributing the correct populations to providers and avoid penalizing providers inappropriately.
  - The requirement that there is a physician visit for attribution to be made in the MSSP program is a challenge because the bulk of primary care is provided by nurse practitioners (NPs) and physician assistants (PAs). Ms. Krzyzewski recommended that future models follow ACO REACH’s flexible attribution methodology and eliminate the required physician visit for attribution.
  - The minimum participation levels of 5,000 beneficiaries in the MSSP are a challenge for smaller, more fragmented long-term care providers. Ms. Krzyzewski suggested developing lower participation thresholds for MSSP ACOs serving high-needs populations.
  - It is a challenge that benchmark development does not currently consider and adjust for differences in population cost and risk relative to average populations. Ms. Krzyzewski shared that the LTC ACO supports moving toward administrative benchmarks.
  - It is a challenge that quality measures were not designed for the long-term care population.

- The COVID-19 episode methodology presented a challenge, as it did not exclude the bulk of COVID-19 costs for the long-term care population, penalizing long-term care providers compared to others.
- Ms. Krzyzewski emphasized the importance of continuing the use of telehealth for care coordination. She also underscored the importance of continuing data sharing.
- Ms. Krzyzewski discussed key drivers of participation in LTC ACO. She noted that because LTC ACO assumes the downside risk of the MSSP Enhanced Track, even providers who are typically very risk averse are willing to join the program. Ms. Krzyzewski also emphasized the importance of the five percent Medicare Access and Children’s Health Insurance Plan (CHIP) Reauthorization Act (MACRA) bonus for encouraging provider participation, noting that its potential withdrawal would likely discourage provider participation.
- Ms. Krzyzewski underscored the importance of value-based care for the long-term care Medicare population, encouraging the Committee to support policy recommendations to increase uptake among long-term care providers.

Jeff Micklos gave a presentation titled “Patients, Payers, Providers, and Purchasers Partnering to Promote Value.”

- Mr. Micklos introduced the Health Care Transformation Task Force (HCTTF), an industry consortium that was created in 2015 to support providers, payers, purchasers, and patients committed to moving toward value-based transformation.
- Mr. Micklos explained that the HCTTF began in 2015 with the goal of having 75 percent of payer and provider members participating in value-based payment by 2020. While HCTTF members have not yet met this goal, HCTTF members have more than doubled their participation in value-based care since 2015.
  - Mr. Micklos noted that cultural commitment and practical buy-in are foundational to initiating participation in value-based care. He highlighted how HCTTF offers its members resources and tools for conducting readiness assessments, partnership evaluations, and internal benchmarking analysis, noting that organizations need to know their own and their potential partners’ capabilities and limitations before enrolling in payment models.
- Mr. Micklos described HCTTF members’ participation in accountable care models, noting that member organizations span the continuum from low-risk, on-ramp models to two-sided, full-risk capitated global budget models. He noted that most member organizations are currently participating in moderate risk models, with two-sided risk on TCOC, capitation on a limited cost of care, or capitation on limited cost of care with one-sided risk on TCOC.
  - Mr. Micklos suggested that HCTTF members are interested in pursuing and supporting additional full-risk models in the Medicare program.
- Mr. Micklos highlighted several key on-ramps and transformation supports to encourage participation in value-based programs.
  - Mr. Micklos explained member interest in the MSSP ACO Investment Program, noting that members feel up-front payments would help limit barriers to entry, such as infrastructure start-up costs, for new participants. He noted that the program’s payment terms offer providers the ability to adapt to value-based programs before repayment.
  - Mr. Micklos noted that at-risk care management payments build provider capacity to serve individual patients and move away from a sole FFS revenue focus.
  - Mr. Micklos shared that the effectiveness of private partnership arrangements can vary by form of arrangement, whether it is direct contracting, joint venture, or a clinically

integrated network. He emphasized that understanding and communication between partners is critical at the beginning of the model.

- Mr. Micklos emphasized that ongoing participation protections and incentives need to be properly calibrated and regularly revisited. He noted the importance of ensuring that incentives flow through to individual providers, so that they can experience the benefit of value-based care. Mr. Micklos also commented on the importance of eliminating the ratcheting effect, which happens with current benchmarks to encourage sustained provider participation. He approved of the move toward administrative benchmarks in Medicare. He noted that all payers need to offer a variety of risk arrangements to support providers participation at a variety of risk levels before they can progress to incentivizing advanced risk arrangement adoption and employing tools such as reinsurance and stop-loss protections.
  - Mr. Micklos noted that retroactive benchmarking adjustments in Medicare models have led to the departure of a large number of organizations, most recently due to a retroactive benchmarking change in the Bundled Payments for Care Improvement (BPCI) Advanced Model.
- Mr. Micklos underscored the challenge of specialist engagement in accountable care arrangements for many performance-based providers. He noted that the HCTTF supported MSSP's proposed rule to adjust MACRA's Advanced APM bonus program, suggesting that current bonus calculations and rules about qualifying practitioners often discourage ACOs from engaging with specialists due to concern with affecting their advanced APM bonus payments. Mr. Micklos asserted that, given the uncertain future of episode-based payment models, future models should offer specialist engagement strategies that are desirable across all model types.
- Mr. Micklos noted that the current proliferation of APMs has made it difficult to manage patient attribution, measure model impacts, and appropriately credit providers for cost and quality improvements. He suggested that future models should incorporate nested clinical episode models within ACOs to account for the overlap between ACOs and clinical episode models. Mr. Micklos noted that the HCTTF recommends that CMS pursue a hierarchical model alignment strategy that sets a consistent and predictable beneficiary attribution policy and shows preference to higher-risk arrangements.
- Mr. Micklos emphasized the need for multi-payer alignment and greater consistency across models to increase model adoption. He suggested that success will require a shared vision of multi-payer alignment. He clarified that APM alignment can maintain competitive differentiation, but should align across quality measurement, risk adjustment, and patient attribution methodologies.

Clare Wirth gave a presentation titled "Value-Based Care's Path Forward: Commercial Risk."

- Ms. Wirth noted that commercial risk may likely decide the future of value-based care and suggested that commercial risk can take either of two possible scenarios:
  - An industry-wide reimbursement standard in which both Medicare and commercial plans align, with commercial payers following Medicare's lead in developing programs based on population-based payment and increasing risk.
  - A split in risk between the commercial sector and Medicare, in which the commercial sector structures payment approaches around bundles and episodes, while public programs continue to move forward with population-wide, risk-based contracting. Ms. Wirth noted that this path forward would require all industry stakeholders to operate in a hybrid world with split incentives.

- Ms. Wirth suggested that each potential scenario has its own trade-offs for how commercial players might achieve savings and efficiencies, noting that each potential path would present unique roadblocks and require participants to give up certain revenue streams.
- Ms. Wirth noted that, because commercial payers, providers, and other support participants are designing their own models, there have been many different types of experimental models and varying levels of success and pathways forward.
  - Ms. Wirth asserted that because CMS is a central governing body, it has had more consistency moving toward population-based risk even while experimenting and redesigning models.
  - Ms. Wirth noted that successful commercial models have required a heavy emphasis on up-front investment and compromising with partners.
  - Ms. Wirth emphasized that commercial models also need to be appealing to employers and employees.
- Ms. Wirth discussed how the differences between Medicare and commercial populations lead to different risk prevention strategies in primary care, utilization, and consumer engagement. For example, given the younger, healthier commercial population, commercial risk focuses on keeping people healthy, preventing them from overusing care, directing them to cost-effective treatment options, and offering consumers lower costs and provider options. Medicare has a far greater emphasis on primary care utilization, chronic care management, managing multiple chronic conditions across multiple specialists and primary care, and offering consumers consistent clinicians.
- Ms. Wirth noted that, given the unique concerns associated with commercial populations, both commercial risk options have their own trade-offs and advantages. She noted that it is not necessarily clear which option will generate the most savings for the commercial sector, and emphasized that the path toward value-based care is an adaptive one, requiring organizational changes and commitment to reach ultimate goals.
  - Ms. Wirth discussed how the distinct approach to commercial risk with a focus on creating bundles and episodes to drive savings in high-spend target areas is tailored to a commercial population's needs, but will require managing many different pieces and potentially split provider focus.
  - Ms. Wirth discussed how following the public sector to focus on population-based models will be more feasible for providers on a daily administrative basis but will be more difficult for employers to justify.

Vice Chair Hardin invited Committee members to ask questions of the presenters.

- Vice Chair Hardin asked presenters to discuss their thoughts on the most important payment model design features and financial incentives used to develop successful TCOC models and associated evidence on their effectiveness.
  - Mr. Micklos advocated for increased investment in primary care to facilitate the move to TCOC models. He noted that additional risk tracks and on-ramps can facilitate increased participation in value-based programs and emphasized that transparency and clarity in model design surrounding payment, performance evaluation, and access to appropriate data are primary concerns of HCTTF members in the development of successful TCOC models. Mr. Micklos asserted the necessity of developing mitigation strategies regarding retroactive Medicare benchmark adjustments, given the negative financial consequences these adjustments can have on providers.



- Ms. Wirth suggested that PCPs and their associated care teams, including nurse care managers, integrated behavioral health providers, and pharmacists, can serve as the anchors of population health management. She noted that there can also be significant opportunities for collaboration with specialty care providers but clarified that it will be important to develop consistent metrics and processes to ensure that specialists refer well-managed patients back to primary care and that patients receive the correct treatment.
- Ms. Krzyzewski emphasized that the benchmark is the primary concern for providers choosing to participate in LTC ACO, asserting that a sufficiently generous benchmark is necessary to maintain and build provider participation. She mentioned that the draft physician fee schedule included in the proposed rule was very encouraging to LTC ACO providers and others serving complex populations. Ms. Krzyzewski noted that the current benchmark ratchet proposed for 2024 would substantially reduce LTC ACO's benchmark and eliminate the associated incentives for provider participation. She clarified that, while the proposed prior savings adjustments, minimization of the negative regional adjustment cap, and the offset to ACOs serving highly complex or high-risk populations are a good start, payments need to be risk-adjusted to better serve providers of complex, high-cost populations. Ms. Krzyzewski also highlighted that the potential expiration of the five percent bonus on Part B billing will likely interfere with efforts at provider recruitment. She concluded by highlighting the importance of widening the gap between incentives for participating in value-based care and disincentives for using FFS in order to drive performance and participation in value-based care programs.
- Vice Chair Hardin asked the presenters what payment methodology features are most important for managing the relationship between primary care and specialty care providers when designing population-based models.
  - Ms. Krzyzewski clarified that the bulk of LTC ACO's patients are primarily seen by PCPs, noting that increased investment in primary care, through capitation, is used to encourage provider participation in the model.
  - Mr. Micklos stated that the HCTTF agreed with Ms. Krzyzewski's assertion of the importance of the advanced APM bonus payment. He highlighted how, if the program is not extended by Congress, many providers will not continue to participate in population-based models. Mr. Micklos emphasized that accountable entities need to be able to reward network providers in a timely manner, noting that the two-year lag period is a major challenge in enticing new providers. He offered that timely reconciliations of shared savings could be helpful for engaging providers in models, including specialist participation in clinical episode models. He noted that HCTTF members have shared how health system-led ACOs have increased the ability to manage both clinical episode and ACO models. He concluded by emphasizing the need for additional innovation in strategies to continue value-based care.
  - Ms. Wirth discussed the Advisory Board's research from interviews with provider organizations, hospitals, hospices, health systems, and medical groups on engaging specialists in value-based care, noting that many interviewees were still focused on primary care and were unclear on how to engage specialists in value-based care. Despite this, the Advisory Board identified three main areas to engage specialists: reducing low-value referrals by keeping more patients in primary care and maximizing primary care access and capacity; expanding reimbursement and incentives for utilizing e-consults with specialists; and developing guidelines to refer well-managed patients back to primary care.

- Dr. Sinopoli asked Ms. Krzyzewski how LTC ACO approaches provider engagement, given its small numbers of patients per provider.
  - Ms. Krzyzewski acknowledged that LTC ACO has to make progress on provider engagement, noting that the provider population is at the beginning of its value-based care journey and needs to be led slowly through the process. She discussed how LTC ACO focuses on clearly discussing financial incentives with providers and communicating about the benefits of value-based care, using the five percent bonus to attract providers into their program. Ms. Krzyzewski shared that once providers are engaged, arming them with information through data sharing and monthly engagement has been critical to changing their behavior and supporting the development of best practices, particularly in areas such as medication management, palliative care, and advanced care planning.
- Vice Chair Hardin asked the presenters to discuss strategies for increasing provider participation, preparing providers to assume greater levels of financial risk, and encouraging investments in care delivery transformation.
  - Ms. Wirth noted that a sense of the inevitability of value-based care has been lost in the last several years, noting that future messages need to emphasize the necessity of transformation to providers. She suggested that transitioning hospitals toward value-based care will be critical to expanding provider participation and overall transformation.
  - Mr. Micklos agreed with Ms. Wirth and suggested that the lull in the transition to value-based care was further exacerbated by the COVID-19 pandemic. He noted that conversations with HCTTF members revealed that providers participating in more advanced risk-based arrangements had fewer cash flow concerns and were more resilient in the face of the pandemic. He suggested that participation in models could offer similar flexibility amid present inflation and workforce shortage concerns. Mr. Micklos suggested that additional techniques for physician engagement include offering PMPM management fees to help offer providers flexibility to think about practicing differently and conducting transparent peer-to-peer evaluation.
    - Ms. Wirth noted that conversations with providers immediately after the onset of the pandemic emphasized the importance of moving to value-based care, but that more recent conversations have highlighted the importance of hybrid models that offer providers more flexibility to utilize incentives without completely abandoning FFS.
  - Ms. Krzyzewski emphasized the importance of incentives for provider participation and highlighted that incentives need to make value-based care more attractive than FFS. She suggested that CMS and CMMI need to design programs that account for the needs of both traditional populations and complex, high-cost, high-need populations, emphasizing that some existing model nuances disadvantage providers of complex populations and need to be eliminated. She concluded by discussing how different alignment between the MSSP and other models creates confusion and suggested that future models should build on the chassis of MSSP to enhance participation and avoid disruption and confusion among providers.
    - Mr. Micklos agreed with Ms. Krzyzewski that future models should use MSSP as the platform for innovation and noted that this would help address provider reticence to participate out of fear that they will not be successful.
- Dr. Mills noted that the role of the commercial marketplace will be critical in deciding the future of value-based care and suggested that the hybrid environment with split incentives for commercial and public payers would lead to either failure or a complete fragmentation of the provider and hospital landscape. He asked Ms. Wirth for additional details on the timeline for value-based care

transformation in the commercial marketplace and requested additional details on key potential influences in determining the commercial marketplace's value-based care path.

- Ms. Wirth noted that, while the future of commercial risk is highly variable and unpredictable, she could imagine a timeline of five to 10 years for the establishment of value-based care transformation in the commercial marketplace. She discussed how, despite employer frustration with the cost of health care, employers will likely be reticent to make changes over the next couple of years in order to retain and attract employees. Ms. Wirth noted that national health plans like Cigna and UnitedHealth Group have shown interest in commercial risk and value-based care, which could potentially push the market toward value-based care. She emphasized that the impetus for value-based care is coming more from commercial payers than from providers, with the exception of progressive independent medical groups who want consistency across their different patient sectors.
- Dr. Lin asked Ms. Krzyzewski how LTC ACO providers achieved per beneficiary savings and asked for additional clarification on how LTC ACO enabled and encouraged savings among providers.
  - Ms. Krzyzewski emphasized the importance of data sharing and meeting with providers. She noted that, given the physician visit attribution requirement, LTC ACO spends a significant amount of its resources ensuring that providers meet the model requirements and work within the quality measurement system. LTC ACO offers comprehensive onboarding and orientation to providers, as well as resources for addressing issues such as palliative care, hospice care, advanced care planning, medication management, and preventing avoidable hospitalizations.
- Dr. Sinopoli asked Ms. Wirth and Mr. Micklos about the differences between the commercial market and the Medicare market, inquiring whether they feel it is realistic to expect that commercial and Medicare programs will move together along the path of value-based care.
  - Ms. Wirth commented that she felt the path toward value-based care will move differently in different markets depending on the balance of populations and the level of partnership between plans and providers. She noted that plans and providers will need to partner together to determine the compromises they can make in different patient populations. Ms. Wirth suggested that either commercial plans move toward the Medicare model of focusing on additional preventive care or move away from Medicare to focus on core bundles tailored to different populations.
  - Mr. Micklos noted that certain areas, like behavioral health integration, will have increased overlap between commercial and Medicare programs. He offered that greater payer readiness on the commercial side and increased participation in MA will help advance value-based care. He also emphasized that overall, the commercial and Medicare populations are different and will evolve differently due to their unique focuses.

#### **Panel Discussion on Operational Considerations and Financial Incentives Related to Successful Implementing of Population-Based TCOC Models**

- Alice Chen, PhD, MBA, Associate Professor of Public Policy, USC Sol Price School of Public Policy, University of Southern California (Academic/Policy Research Perspective)
- Maryellen E. Guinan, JD, Policy Manager, America's Essential Hospitals (Provider Perspective)
- Kathleen Holt, MBA, JD, Associate Director, Center for Medicare Advocacy (Patient Advocacy Perspective)

- Gregory P. Poulsen, MBA, Senior Vice President, Policy, Intermountain Healthcare (Payer Perspective)
- Katie Wunderlich, MPP, Executive Director, Maryland Health Services Cost Review Commission (State Government Perspective)

Chair Casale moderated the panel discussion of five SMEs representing different perspectives on operational considerations and financial incentives related to successful implementation of population-based TCOC models. He introduced each panelist, noting that full biographies can be found on the [ASPE PTAC website](#).

Chair Casale asked the panel to speak about effective strategies for incentivizing care delivery transformation that impacts outcomes, quality, and cost.

- Maryellen Guinan stated that her organization, America’s Essential Hospitals (AEH), is an association for safety-net hospitals dedicated to equitable, high-quality care. She noted that AEH hospitals provide a disproportionate share of care for the uninsured. Ms. Guinan indicated that AEH members understand the potential for value-based care to improve health and reduce the incidence and effects of chronic disease—which is particularly important for the population served by essential hospitals—and to lower system-wide health care costs. She emphasized that value-based payment models allowed organizations to better adapt to patient needs and circumstances during the COVID-19 pandemic. Ms. Guinan highlighted the importance of value-based payment models given their potential benefits to patients, providers, payers, and society. She emphasized that it is particularly important for providers that serve low-income, medically complex, underrepresented communities that may not have participated as robustly in the past to be included in discussions on these topics.
  - Ms. Guinan highlighted areas for improvement to the fragmented care currently provided under the FFS system. She stated that there is a benefit of having a multi-disciplinary team—including not only clinical team members but also social workers, CHWs, and others—to work toward efficient, equitable, and valuable care. She discussed the need to identify spending that could be avoided or reduced without harming patients, which is a complex issue that varies across patients, providers, and conditions, and changes over time as technology and other conditions change. Finally, Ms. Guinan emphasized the importance of having adequate funding to incentivize providers to drive value, such as transportation to and from appointments for outpatient care, and screening and referrals for social determinants of health (SDOH), which are high-value services that are resource-intensive and often conducted by CHWs, who currently lack adequate reimbursement structures.
- Kathleen Holt introduced herself and her organization, the Center for Medicare Advocacy, by explaining that it is a national nonprofit law firm dedicated to helping people access Medicare benefits and maintaining the Medicare program. Ms. Holt emphasized the importance of having providers engaged with a patient’s care throughout their lifespan in order to improve trust between patients and practitioners, provide data on patients’ baseline health, and prevent later costly health care interventions. She noted that many people either do not have access to or do not perceive they need health care between childhood and age 65, and when they reach age 65, tend to view providers as a potential source of threatening diagnoses. She explained that when individuals do not receive needed health care before they reach age 65, Medicare costs increase and can lead patients to feel disconnected from health care providers. To address disparities in trust and treatment, Ms. Holt suggested that new models should allow for more Medicare-covered care to occur in locations outside of traditional health care settings that are more convenient for

patients to access patients (with the exception of services that require a higher level of access to technology). She suggested that patient-centered care should include members of a patient's community, including counselors, social workers, faith leaders, advocates, family, and friends. Ms. Holt explained that achieving care plan success in the long term requires coordination between providers and the broader community health care implementation team who will assist each other and hold each other accountable.

- Katie Wunderlich introduced herself and explained that her role in the panel, as the Executive Director of the Maryland Health Services Cost Review Commission, is to speak about the regulator's point of view. She noted that her organization sets hospital rates and is tasked with helping to develop and shape health care delivery reform and payment reform in Maryland. She described Maryland's TCOC Model, which sets global population-based budgets and requires population-based strategies to address chronic conditions and utilization. Ms. Wunderlich explained that Maryland physicians are on an FFS payment structure, and only engage them in value-based care arrangements through voluntary participation. Because Maryland physicians do not participate in national models, she noted that it is critical for the state to provide meaningful programs for specialists. She explained that providers are asked to identify interventions to improve cost and quality outcomes (e.g., interventions that address clinical care, quality improvement initiative redesign, and implementation of evidence-based protocols for discharge planning). Providers also consider interventions to improve beneficiary and caregiver engagement, for example, through shared decision-making or health literacy programs. She described interventions related to care coordination and care transitions across settings, which require robust interdisciplinary teams to select cost-efficient, high-quality care options. Ms. Wunderlich noted that as a regulator, she aims to structure programs that engage physicians and provide them with infrastructure to support the goals of value-based payment programs. She emphasized the importance of aligning value-based care models across payers to maximize physician efforts across their entire patient panel.
- Alice Chen introduced herself and stated her goal of providing an academic perspective to the discussion. She began by discussing ACOs, noting that the MSSP ACOs have generated savings, particularly physician-led MSSP ACOs. She indicated that Blue Cross Blue Shield commercial ACOs have also generated savings. Dr. Chen summarized the evidence by stating that while it is clear that ACOs can generate savings, these savings are low in magnitude, especially after taking into account bonuses that are awarded to providers by Medicare or other payers. She stated that the evidence indicates that quality of care remains unchanged under ACO models, although there is limited evidence showing that patient experience metrics may have improved in some cases. Dr. Chen discussed episode-based payments, noting that the Comprehensive Care for Joint Replacement (CJR) Model was a successful Medicare bundled payment model. Dr. Chen stated that her research shows spillover benefits from this program: providers participating in the CJR Model improved their patient care practices for MA, commercially insured, and FFS Medicare beneficiaries. She noted that evidence from commercial plans also suggests benefits of episode-based payments. Dr. Chen argued that while episode-based payments are effective in only a limited number of disease areas, they can coexist with broader population-based models such as ACOs. Finally, Dr. Chen discussed capitation, noting that MA saves an average of 10 percent relative to traditional Medicare and that capitated payments can be incorporated in ACO-like models. In summary, Dr. Chen stated that the research indicates that continuing to move toward population-based payment models with financial risk and accountability delegated to providers (who are best positioned to judge what is high- versus low-value) will be beneficial.
- Gregory Poulsen introduced himself and described his organization, Intermountain Health Care, as a large integrated health system that currently receives about half of its reimbursement in prepaid arrangements. Mr. Poulsen noted that Intermountain prefers prepaid to FFS arrangements, and

views them as a means of creating flexibility rather than risk, allowing the organization to provide better care. Specifically, Mr. Poulsen suggested that group prepayment is the most effective means to improve both quality and cost. He added that the limited benefits of ACOs demonstrated in research would be higher if incentives reached provider organizations, rather than just payer organizations (e.g., MA plans). Mr. Poulsen argued that the benefits of incentivizing provider organizations include the indirect incentives they experience to improve quality, since healthier people result in much lower costs. He explained that there are a few historical examples of organizations operating via capitated payments and achieving significant improvements in quality and cost, but that such successful organizations often become part of larger entities and lose the ability to achieve the same outcomes after they are absorbed. Mr. Poulsen noted that it is not useful to frame primary care as a distinct entity, as health care outcomes improve when a wider team is involved in patient care. Mr. Poulsen noted the importance of a multi-disciplinary approach and argued that changes in technology (e.g., telehealth) are blurring previous distinctions between specialties. He closed by emphasizing that both systems and culture are required components to address for provider accountability models to be successful, and that he expects that health care provider entities will be organized at a level to meet this need over time.

Chair Casale invited Committee members to ask questions of the panelists.

- Dr. Kosinski asked Dr. Chen to add more detail on how bundled payment models can exist inside ACOs.
  - Dr. Chen responded that the key questions about this topic include identifying when episode-based payments work, given that they do not work for all health conditions. The next question is then whether or not ACO providers have continued incentives to refer to episode-based providers, or alternatively, are the ACO and episode-based payments operating separately? Currently, when ACOs are also participating in episode-based payments, the episode-based payment is counted in the ACO spending, and the episode-based providers benefit from the payment and incentives associated with the bundle. Dr. Chen argued that, broadly, for people with multiple chronic conditions, ACOs are more appropriate than bundled payments because bundled payments would not provide incentives to coordinate across the different conditions. Dr. Chen called for more consideration into which episode-based payments should be included in ACO models and how precisely to incorporate payments across both models.
  - Dr. Kosinski followed up by asking for comment on nesting bundled payments within ACOs.
  - Dr. Chen responded that nesting bundled payments within ACOs could work well, noting that it is important for ACOs to have incentives to contract with efficient providers, and arguing that nesting episode-based payments into ACO payments would fit well within this goal.
- Dr. Wiler asked Ms. Wunderlich to comment on what unintended consequences she has noted in Maryland's TCOC Model, given that Maryland has one of the largest established TCOC pilots in the nation.
  - Ms. Wunderlich confirmed that Maryland's global budget model has operated since 2014, and hospitals in some parts of the state have been under global budgets since 2010. She noted that Maryland's work to monitor unintended consequences of the model includes use of all-payer quality programs (e.g., around readmissions and patient satisfaction). This is the foremost strategy for protecting patients against unintended consequences. In addition, providing cost-efficient care does not mean that care is withheld. Ms. Wunderlich added that, in addition, health systems that better manage chronic conditions reduce the need for high-cost, acute care services. Under a guaranteed population-based budget, Ms.

Wunderlich noted that a hospital is able to retain the savings when acute care is avoided. She then noted that, currently, her organization is working to ensure that savings that accrue to hospitals due to avoided acute care are used effectively to support patient access and to address chronic conditions and population health. Ms. Wunderlich stated that the time elapsed since 2014 is still relatively short, and that understanding is still developing about how to ensure that health care resources provided on a population-based reimbursement system are used to drive down costs and to maintain or improve quality and health outcomes.

- Dr. Pulluru asked Mr. Poulsen to comment on how Intermountain managed the transition to the level of capitated payment it currently has, and how it navigates models when payments are made retrospectively. She also asked for his recommendations on policies for payment methodologies.
  - Mr. Poulsen responded that, while it is essential for incentives to apply to provider organizations, this is distinct from applying incentives directly to providers. He emphasized that in either case, it is essential for the organization to focus on keeping patients healthy at a low cost. Mr. Poulsen stated that organizations have the capacity to achieve such outcomes (e.g., through key performance indicators, goal setting, and performance discussions). An organization receiving capitated payments may have key performance indicators organized around improving patient health and considering patients' lives holistically, whereas strategic conversations at organizations receiving FFS payments naturally revolve around increasing revenue and improving utilization metrics. In contrast, organizations receiving capitated payments seek to avoid expensive utilization such as surgeries and emergency room visits through primary care and care management. Mr. Poulsen stated that, in his opinion, it may not be useful to directly incentivize providers via payment models, but instead, it may be more useful for organizations to transform as a whole. He noted that organizations viewed as leaders in this space (e.g., Kaiser Permanente, Geisinger, and Intermountain) often have not directly incentivized providers to make changes.
- Vice Chair Hardin asked the panelists to comment on how they see payment shifting given the Administration's focus on equity and the recognition of the importance of CBOs.
  - Ms. Wunderlich noted that in Maryland, much of the outreach to communities happens through hospitals (e.g., initiatives that focus on long-standing health disparities such as maternal health and diabetes). She stated that there is an effort to improve connections to the community to improve health disparities. Ms. Wunderlich added that even as payment goes through hospitals for chronic disease management, there is an expectation that hospitals will meaningfully partner with CBOs. She described the example of a community vaccination program during COVID-19 that used funding from the global budget and required hospitals to work with several types of partner organizations to reach patients.
  - Mr. Poulsen added that the kind of coordination Ms. Wunderlich discussed can occur when individual organizations receive capitated payments, and argued that such capitated organizations have a strong documented record of reaching patients. He stated that identifying what is most relevant for each individual patient is beneficial both for patient care and to avoid large downstream clinical costs. Mr. Poulsen noted that Intermountain is currently focused on prenatal care, noting that immigrant and refugee populations have distinct preferences in this area. He explained that providing responsive services maximizes the chance of improving infant health and lowering costs. Mr. Poulsen added that the same principle applies to various health conditions, emphasizing that prepayment will improve equity, as well as cost and quality.

- Ms. Guinan noted that a shared accountability structure that includes community partners warrants further discussion; currently, hospitals serve as conveners and, under recent policies, are accountable for screening and reporting. She suggested that future models should align with these existing requirements for screening and referral to CBOs. Ms. Guinan added that shared accountability with CBOs could occur through sharing data between medical and non-medical organizations.
- Dr. Chen added that the ACO REACH Model is addressing equity concerns by allowing higher spending for certain populations. She indicated that the precise amount of higher spending needed is an area that warrants further research.
- Chair Casale asked Ms. Wunderlich for additional information on Maryland’s bundled payment experiment.
  - Ms. Wunderlich clarified that the bundled payment experiment began in 2022 and that the goal was to craft a physician-directed model that could work within the constraints of Maryland’s global budget program. The bundled payment program began with episodes for gastroenterology, general surgery, orthopedics, neurosurgery, and cardiology, and the state is considering adding additional models.
- Chair Casale asked the panelists to speak about the best options for structuring payment methodologies for population-based models. He also asked for their perspectives on what strategies and interim steps can help providers transition to increased financial risk.
  - Dr. Chen noted that it is particularly challenging for smaller organizations to take on the infrastructure investments needed to succeed in advanced payment models, and suggested that models offer a track with lower-risk options for smaller practices to encourage participation. This could leave open the possibility of transitioning to higher levels of accountability in the future. Dr. Chen stated that benchmarking requires careful consideration. She suggested that using historical FFS spending to set benchmarks is a good starting point, but this raises questions about how to introduce incentives for savings. Dr. Chen cautioned that budget or benchmark reductions over time, if implemented, should happen gradually; reducing benchmarks abruptly can cause the organizations that had higher spending in previous years (and thus have the greatest potential to transform care) to exit the program. Finally, Dr. Chen commented on considerations for updating benchmarks each year. She explained that currently benchmarks are based on the previous year’s performance, and lowering budgets for those who reduce spending may create a perverse incentive. Dr. Chen summarized her recommendations: set initial benchmarks at levels that encourage high-spending providers to lower spending, but not to the extent that it discourages providers participation; and set benchmarks initially based on FFS spending, and then update benchmarks based on an administrative growth factor. She added that Maryland’s global budget model has a set growth rate, which provides a precedent for this approach.
  - Ms. Wunderlich noted that larger organizations are able to take on more risk than smaller practices. She added that to take on risk, providers must be able to analyze patient data, which requires infrastructure that larger organizations are more likely to have. Ms. Wunderlich noted that this pattern of challenges for smaller practices has been evident in Maryland’s program to provide non-claims-based payments for advanced primary care. She noted that for smaller PCPs, Maryland partners with care transformation organizations to help provide the infrastructure that practices need to better manage patients under a TCOC model. She added that options for payment methodologies can be more aggressive for larger organizations than smaller organizations.



- Mr. Poulsen discussed that the word “risk” has been used to describe prepayment (capitation) and noted the risk of FFS, as demonstrated by the dramatic changes in hospital care utilization during COVID-19 pandemic. Mr. Poulsen noted that this risk of FFS applies to health care providers, including hospitals, nursing homes, and physicians. Mr. Poulsen stated that it is important to discuss the benefits of prepayment models as they increase options for providing effective health care. He provided an example of a prepayment multi-payer model in rural areas that resulted in better community health outcomes at a lower cost. Mr. Poulsen added that FFS payment entails complex billing procedures that are expensive to implement, and there are also costs to providers of complying with fraud, abuse, and antitrust statutes, which Mr. Poulsen noted are in place to counter perverse incentives inherent in FFS. He suggested that streamlining these areas could potentially have substantial benefits and emphasized that individual providers and organizations that gain deep experience in prepayment prefer the model to FFS.
- Ms. Guinan noted that the question of supporting providers to take on more risk is a common topic in discussions between AEH and CMMI about how to define the safety-net, among which APM participation is limited. She added that the patients of these providers may be high-cost and likely to benefit from the care coordination incentivized by these models. She explained that while there is no current definition of an “essential hospital” for policy making, AEH believes that such a definition could help target model design, evaluation, implementation, and resources, and support the development of incentives that work for safety-net providers. In addition, Ms. Guinan stated that most current metrics do not adjust for social risk; having metrics that are equitable would be attractive to essential hospitals and the safety-net. She explained that certain models such as the Hospital Readmissions Reduction Program (HRRP) look at some measures of social risk, but there have not yet been measure-specific adjustments that account for these risk factors. Ms. Guinan added that social factors such as access to transportation and food security impact readmission rates. Ms. Guinan underlined the importance of enhancing social risk adjustment in models. She also noted that AEH is supportive of up-front funding for transformation, and that CMMI has proposed advancing payments in MSSP. However, Ms. Guinan stated that AEH does not support a distinction in model design between low-revenue and high-revenue ACOs, noting that high-revenue ACOs are often hospital-led, and that providing up-front funding would be beneficial to all providers. Finally, Ms. Guinan noted that she supports a glide path for taking on risk, and that many AEH members (that are not small providers) have slim or negative margins, making it important to allow them to continue to take on one-sided risk for a short additional time.
- Ms. Holt discussed how models that include financial risk for providers may have unintended impacts on patient access. She noted that Medicare providers are typically not required to accept all Medicare-covered patients, and stated that in response to new models, more providers are declining to serve high-need, high-cost patients due to the negative financial impact. In addition, some providers accept high-need patients, but do not provide patients with all needed care. Ms. Holt added that data cannot measure care that is not provided. She raised the question of whether one model is sufficient to allow equal access to health care to all patients, especially high-need, high-cost patients. She asked for consideration of how high-need patients, such as those living with chronic conditions, will be able to access care, and called for a goal of every Medicare patient having equal access to care in the development of new models.
- Chair Casale asked for panelists’ suggestions on how to engage specialists in new models.

- Mr. Poulsen discussed incentives to serve the most vulnerable, potentially challenging patients. He argued that under FFS payments, the consequence of not seeing a particular patient is that, in the short term, the provider misses a small reimbursement, and in the longer term, the patient may require intensive care accompanied by high reimbursement. In contrast, Mr. Poulsen stated that prepayment creates incentives to avoid the need for acute care and argued that prepayment models have the potential to provide access to care to the most vulnerable patients. Mr. Poulsen discussed three models for coordinating between primary care and specialty care. Under the first, the model the PCP serves as a gatekeeper, which Mr. Poulsen stated is widely opposed. Second, there is a model of combining prepayment for primary care with bundled payments for specialty care, which involves the challenge of defining bundles for specialty care. Mr. Poulsen stated that bundles for diseases rather than treatments may be more effective and could avoid, for example, incentives to perform unnecessary surgeries. The third model is to develop integrated care teams that include both primary and specialty care physicians making decisions together. Mr. Poulsen felt that this third model leads to better outcomes. Mr. Poulsen described mental health and primary care integration as a key example of this approach, describing Intermountain's experience with mental health specialists helping PCPs make diagnoses and, in some cases, providing treatment immediately, explaining that this is preferable to referring a patient to a mental health provider who may not have availability for many months. Mr. Poulsen noted that such integration is easier to accomplish under a prepayment model rather than FFS payments.
- Dr. Sinopoli asked Mr. Poulsen about the proportion of physicians working with Intermountain who are independent and how the organization engages independent physicians.
  - Mr. Poulsen indicated that about half of Intermountain physicians are employed and the other half are affiliated, both in primary care and secondary care. He added that some physicians prefer to be independent, and some do not, and Intermountain accommodates both. In either case, Mr. Poulsen explained that Intermountain requires physicians to work in teams and abide by requirements for collaborating with colleagues. This includes participating in data sharing with all physician colleagues who see shared patients. He noted that teamwork among physicians does not require employment, but does require coordination, collegiality, and information sharing.
  - Ms. Guinan agreed that integration is key to engaging specialists in new models. She argued that this integration is important for staff, as well as specialists, to deliver value-based, efficient care. Ms. Guinan stated that successful integration relies on communication, particularly an integrated medical record and a shared treatment plan. She emphasized that data transparency is particularly key for specialists, who, without such data, often do not have the means to compare their own outcomes against peers. Sharing data with specialists could entice them to join models and support buy-in. Ms. Guinan noted that behavioral health integration has often been successful, and attributed this to the fact that at baseline, patients often seek care from emergency departments (EDs) where care is fragmented. Ms. Guinan stated that AEH member hospitals have integrated primary care and behavioral health as a means to address disparities. She then noted that e-consults can be an effective means to integrate primary care and specialty care, and that this strategy can create an efficient loop between primary and specialty care. In terms of specialties that have thrived under new models, Ms. Guinan highlighted the example of orthopedics under the CJR Model, and noted that many examples of specialist participation in new models occur through bundled care arrangements. She stated that including specialists in a TCOC models is an area that needs more exploration.

- Dr. Chen stated that in addition to the culture of collegiality, lower expected margins from Medicare FFS will provide additional incentive for specialty physicians to participate in new models. Specifically, Dr. Chen noted that CMS projects that FFS Medicare payment rates will rise at a rate that is 0.7 percent lower than inflation through 2030. She added that specialists may conclude that being an efficient provider in an ACO will be more profitable than being a less efficient FFS provider. Dr. Chen stated that in addition to the types of teams discussed earlier, having management teams that reflect the views of both PCPs and specialists is important. Specifically, she emphasized the importance of including specialty physicians in strategic vision and leadership. For example, Dr. Chen noted that surveys show that specialists are less likely than PCPs to report that participating in an APM, or that APMs have influenced their practice patterns or compensation; she also noted qualitative evidence showing that early ACOs did not include surgery in their strategic vision.
- Ms. Holt stated that coordination should also patients, primary care, and specialty physicians to address patients' treatment goals. Ms. Holt added that some patients will have realistic goals to achieve a higher level of function, while some will aim to return to a previous level of function, maintain current function, or slow the loss of function. Ms. Holt noted that coordination and care management processes may be consistent in each case, but that the coordinated approach should respect and adapt to patients' individual goals. She added that collectively agreeing on a goal for each patient and a measurement strategy will improve coordination across primary and specialty care. Specifically, she noted that this approach could include a shared payment tied to the percentage of total time each provider dedicates to a patient with an additional joint incentive payment for working together.
- Chair Casale asked Mr. Poulsen's perspective on who comprises integrated care teams and whether this varies by condition. He also asked for comments on who is accountable for quality and cost outcomes in an integrated care structure.
  - Mr. Poulsen responded that care teams are fluid and responsive to patient needs, but can also be structured for a set of needs that apply to a "general" patient. Mr. Poulsen explained that Intermountain has been integrating primary care and mental health care for 25 years. He explained that Intermountain recognized that patients with similar physical health problems were receiving vastly different amounts of health care, and realized that this likely indicated a behavioral health problem as well. Mr. Poulsen stated that a less obvious example of the need for team care presents in the case of joint replacement. He noted that surgeons were reporting spending substantial time speaking with patients who incorrectly believed that they would benefit from a joint replacement. He noted that the organization addressed this by having another team member speak with these patients about other options to address their joint pain. Mr. Poulsen stated that this step was supported by the surgeons, who may not have supported such a practice under FFS. Regarding the question of accountability in an integrated team, Mr. Poulsen responded that accountability is usually at the organizational level. Mr. Poulsen added that through key performance indicators, Intermountain can track metrics for patient health and satisfaction, as well as avoidable care. Mr. Poulsen agreed with Ms. Holt's statement about understanding each patient's expectations for their health in order to best care for them.
- Chair Casale asked panelists how they have been able to address challenges in getting timely patient data to providers.
  - Mr. Poulsen stated that provider organizations are better positioned to share data quickly compared to insurance organizations. For example, when a cardiology procedure occurs, a

provider organization like Intermountain will know the next day, whereas an insurance company will not know until the bill is adjudicated, which could be 90 days later.

- Ms. Wunderlich stated that having information on the care their patients are receiving is critical for providers to make progress on decreasing costs and improving health outcomes. She noted that in Maryland, as in many states, all hospitals are connected through a Health Information Exchange (HIE). A major effort has been made to also connect ambulatory care providers to the HIE, so that they are alerted when one of their patients is seen in an ED or admitted to a hospital. Such real-time data allow providers in different settings to have access to the same information. Ms. Wunderlich added that Maryland's HIE has an option for adding a care manager for each patient, and when patients visit an ED, the ED staff can see the patient's care team and if there are any care alerts. Ms. Wunderlich emphasized the importance of having this information available to all providers caring for a particular patient. She added that the HIE also includes prescription drug record-keeping.
- Ms. Guinan noted that claims-based quality metrics can have a two-to-three-year data lag, which is not ideal for getting timely data and feedback to providers. In terms of accountability among primary and specialty providers, she noted that the best process for ensuring continuity of care is for patients to be primarily cared for by their PCP while seeing specialists on as-needed basis, as in the e-consult model. Ms. Guinan added that keeping patients connected through their PCP may improve opportunities to address SDOH, since PCPs are more likely to have the infrastructure to address social as well as clinical needs.
- Dr. Kosinski noted that there has been discussion on bundled payments and asked for panelists' views on what type of team-based reimbursement models have been developed for chronic disease management targeted to patients with either single or multiple chronic diseases.
  - Mr. Poulsen stated that he does not believe the type of arrangement described by Dr. Kosinski has worked, noting that he coauthored a perspective piece in the Harvard Business Review making the case that capitation would be more effective than bundled payments in this situation. He argued that for chronic diseases, the "bundle" would be a patient's care over time, and, by definition, chronic diseases do not have a clear end point. Mr. Poulsen added his view that, in these cases, patients need holistic care, which does not comport with a bundled payment model. He noted that an additional challenge to defining chronic disease bundles is that patients may develop an additional condition that impacts care for the original condition addressed through a bundle.
- Mr. Steinwald asked for panelists' perspectives on whether FFS compensation for practitioners should be phased out or, alternatively, if there is a continued role for it in value-based payment systems.
  - Mr. Poulsen responded that, in cases where a procedure could be done for financial reasons rather than patient needs, FFS inherently creates perverse incentives. He added that Intermountain is seeking to move away from FFS where feasible, such as for employed physicians, but he stated that there is not currently a mechanism to move away from FFS for independent physicians. Mr. Poulsen stated that applying appropriate metrics, such as key performance indicators, can overcome perverse incentives associated with FFS. However, Mr. Poulsen noted that, in his view, it is preferable for the payment mechanism to directly provide beneficial incentives rather than relying on performance metrics to overcome underlying payment incentives. For this reason, Mr. Poulsen added that he would support ending FFS payments altogether.
  - Dr. Chen stated that the view that the FFS system is inefficient and creates perverse incentives is widely shared. However, she noted that some other countries have systems with FFS with global caps, which limits the incentive to provide a high volume of services.

She also noted that there are mechanisms that are a combination of capitation and FFS, for example, with use of bonus payments or penalties built into an FFS structure. These mechanisms can also alter the incentives for high service volume associated with FFS, reducing the inefficiencies of FFS without abolishing FFS. She added that having some care paid through FFS provides a benchmark for spending. However, Dr. Chen noted that she does not support FFS as a payment mechanism for new services like telehealth or other new technologies.

### **Committee Discussion**

Chair Casale opened the Committee discussion and noted that PTAC will be issuing a report to the Secretary of HHS that will summarize findings from all three public meetings covering population-based TCOC models. He added this portion of the meeting provides the Committee members with time for general discussion to reflect on what they have learned from today's presentations and discussions. He added that the Committee members will also review potential comments for the report to the Secretary later in the session.

- Dr. Kosinski noted that the majority of today's SMEs recommended significantly changing or eliminating the FFS system. He added that the other side of the spectrum is the idea that all physicians should be salaried. He said the main takeaway was that FFS requires substantial changes and that the current system is not keeping FFS costs under control.
  - Mr. Steinwald recalled that Bob Berenson had once said FFS needs to be fixed so that it can be abolished. He stated that the challenge is that FFS needs to be fixed so that its claims data can be a more reliable input for the value-based care models that are designed to ultimately replace the FFS system.
  - Dr. Kosinski and Dr. Pulluru recalled one expert who said remaining in FFS should be made less appealing for providers.
- Dr. Pulluru observed that a common theme across SMEs was that models should incentivize the organization and not the provider. She found that this idea conflicted with the idea that the provider should prosper under value-based models. She noted that profits in ACOs are often not distributed to providers but rather go toward ACOs' infrastructure. Therefore, incentivizing organizations instead of providers may not result in the provider receiving the benefits of value-based models.
- Jay Feldstein agreed with Dr. Pulluru that when financial incentives are paid to the organization, the provider does not realize the potential benefits of the model. He added it is unclear how to better integrate specialists into a capitated payment system. He noted that the SMEs provided helpful theories to improve specialist integration but could not provide details on how to address this issue. Finally, he added that policy makers have still not determined how to best compensate PCPs. He recommended policy makers view paying for primary care as an investment, but added he is unsure where the capital would come from to pay for this necessary investment.
- Chair Casale stated that Mr. Poulsen's comments regarding accountability were useful. He recalled the theory that advancements in technology will result in accountability being blended across primary care and specialty providers. As a result, the model payments should be primarily salary-based with some bonus component instead of incentives promoting a specific behavior.
- Dr. Wiler described several themes that resonated with her. She recalled that multiple SMEs highlighted the importance of projecting urgency and inevitability of value-based payment efforts.

She noted that presenters commented on market forces among employers that are reflecting risk-aversion and a resistance to changing benefit structures. Dr. Wiler observed that the Committee has frequently discussed nested care models but has not discussed nested incentives with a deliberate strategy for engaging each tier of stakeholder in the health care payment and delivery system (e.g., payer, health care system, medical group, provider) discussed in Dr. Chernew's presentation. Finally, Dr. Wiler noted that SMEs described a continuum of strategies for moving away from the current payment environment, ranging from making model participation mandatory to strongly incentivizing participation. She added that this may include incentives at every level of care delivery. She observed that multiple SMEs agreed with the idea that a multi-payer strategy is critical for success.

- Dr. Mills noted that no SMEs offered a solution for a TCOC model that adequately pays both specialists and PCPs. In this case, he stated that the solution may be to have a population-based TCOC model with a capitation payment made to a single accountable entity made up of a team of providers that assumes financial risk and responsibility. He added there may be episode-based bundles that could be integrated into this model approach. In addition, Dr. Mills stated that the commercial market's approach to risk may serve as the catalyst for determining the direction of health care payment models in the country. Dr. Mills expressed concern at the possibility of Medicare establishing a completely different risk model from the model used by commercial payers. He explained that this would present significant challenges to providers who would have to operate under two different financial models and associated incentives. Dr. Mills recommended that policy makers should develop a risk model that can meet the needs of both the Medicare and commercial health insurance populations. Otherwise, Dr. Mills warned the health care system could become more fragmented.
- Dr. Sinopoli agreed with Dr. Mills' assessment of the commercial market's impact on the health care system. He added that the SMEs described the contrast of issues related to specialist engagement in different markets. He noted that Intermountain can achieve specialist engagement because it owns 50 percent of the pre-payment contracts in its market. As a result, he explained that specialists in the area must engage with the organization to survive financially. Dr. Sinopoli noted that this market dynamic does not exist in many rural areas. He stated that the challenge is to engage specialists and PCPs in areas where there is no ACO or associated infrastructure to support value-based care. He noted those areas represent 80 percent of the county's population.
  - Mr. Steinwald stated that he was skeptical that commercial payers' approach to risk would be an important factor in determining the direction of value-based care models.
  - Dr. Sinopoli agreed that he does not think trends in the commercial market will serve as the tipping point. He noted that the commercial market is a very different model. He explained that the commercial payers were focused on price, site of care, and utilization management. He added that employers care about those factors because their population is typically much healthier than the Medicare population. He said one plan he evaluated had the largest spend on childbirth services. He explained that while some employers' populations more closely resembled the Medicare population, in general, it did not make sense for a managed care organization to manage these populations because the return on investment (ROI) is typically much lower than the Medicare population.
- Dr. Liao noted that while PTAC is appropriately focused on value-based payment models, if MA and the fee schedule are not reformed, then the impact of APMs may be limited. In addition, Dr. Liao

stated that there was a common theme throughout the discussions about the need for provider incentives to encourage participation in TCOC models. He noted that some of the SMEs mentioned the potential of continuing use of a five percent APM bonus, as well as the benefits of using externally set benchmarks that are decoupled from observed spending as effective incentives. He said the APM bonus is useful but that it serves as a rate increase anchored in the FFS approach, as opposed to a value-based approach. He emphasized that designing the right incentives will be key. Dr. Liao recalled SMEs' suggestions to simplify and reduce the total number of models. He noted there may be tension between that desire to reward providers' efficiency and the challenges inherent in doing so. For example, explained that some providers have complex patient populations where some level of inefficiency is appropriate. He noted that there will likely be a trade-off between simplicity and designing models that account for different levels of desirable efficiency. Finally, Dr. Liao observed that most presenters discussed episodes, and said he was interested in learning more at tomorrow's meeting about the role of episodes. He noted that it will be important to think though how episodes are handled.

- Dr. Pulluru noted that SMEs did not discuss waste in health care spending. She added that they did not discuss the amount of money that goes toward Revenue Cycle Management collection or determining patient eligibility. She explained that only 10 cents of every dollar spent on health care went to the provider. Dr. Pulluru stated that simplifying models may reduce the amount of health care spending without affecting the funds paid to the provider. She also observed that SMEs did not address challenges with primary care access in rural areas. She noted that it is unclear how to implement a capitated primary care-focused model when there are no PCPs in the area. She noted that her company works in many areas where the pharmacy serves as the only local health care provider. She commented that today's conversations focused on solving problems for areas familiar to SMEs and Committee members, specifically suburban America, but did not cover how to address challenges faced by rural areas.
- Dr. Sinopoli commented that he heard conflicting perspectives from SMEs regarding whether payment models will naturally achieve desired model outcomes. He added that payment model designers and implementors should be given the flexibility or freedom to create the care models needed. He emphasized that his takeaway from today's conversation was that the team-based care model is key to success and that the payment model should provide the freedom to accomplish team-based care within the care model.
  - Dr. Liao agreed with Dr. Sinopoli's description of the role of payment models. He said that financial incentives are focused on achieving the organization's goals, but that clinicians' decisions are affected by other factors such as being a good team member, serving as a patient advocate, and practicing evidence-based medicine. He noted that clinicians that serve in all of those roles are not necessarily impacted by a payment model, but that those other priorities can be subsumed in a payment model set up the right way that recognizes clinicians that are not making decisions based on economic principles of marginal utility.
- Dr. Wiler commented that today's conversations reflected the operational challenges in these models. She recalled several academic SMEs describing the challenges of benchmarking, risk adjustment, and attribution. In addition, she noted that one SME discussed the challenges operating in long-term care markets and, that after a decade of work, they are just now sharing data. She hoped that the Committee continues to balance policy solutions with identifying practical implementation solutions, noting that many of these issues do not affect just suburban America.

- Chair Casale noted that the presentations made him think of the Comprehensive CJR Model. He recalled Dr. Chen’s comments that CJR is likely the most successful model. He noted that there were many reasons for that success but observed that the provider-focused incentives were a major driver of success. Chair Casale indicated that it was easier for the CJR Model to develop provider-level incentives than it may be for other models and highlighted CJR as an example of how financial incentives combined with coordinated care can achieve desired model outcomes. He emphasized that there was still a lot to learn about how to engage and incentivize specialist participation. Additionally, Chair Casale emphasized the importance of data, noting that not all health care systems can provide real-time data. Instead, he observed most health care systems rely on claims data, which have a time lag. He noted that improving access real-time data should be a priority in developing electronic health records (EHRs) systems, as it is a major hurdle to implementing TCOC models.
  - Dr. Pulluru expressed surprise that having a shorter claims data turnaround was not a requirement for MA payers when they bid for plans. She noted that most MA plans have worse turnaround times on providing data than CMS.
- Dr. Lin appreciated that the LTC ACO presentation provided statistics on the ACO’s savings. He stated that the savings of 12 to 16 percent per beneficiary demonstrates what can be achieved through value-based care.

### **Review of Draft Comments for the Report to the Secretary (Part 1)**

Audrey McDowell presented slides outlining potential comments and recommendations for PTAC’s report to the Secretary based on the three population-based TCOC theme-based discussions. She indicated that the Committee will have a structured discussion over the next two days about potential comments PTAC may want to include in the forthcoming report to the Secretary.

Ms. McDowell reviewed the topics for potential comments, which may serve as the structure for the report to the Secretary subject to PTAC feedback.

Ms. McDowell reviewed potential comments related to desired vision and culture for value-based transformation.

- Dr. Wiler confirmed that the comments made earlier in the session by Committee members will be incorporated into these slides.
- Dr. Mills suggested that “population-based TCOC model participation among a broad range of providers” was more of a tactic and did not describe a vision or culture. He suggested rewording the comment or removing it.
  - Mr. Steinwald recommended not including the comment.
- Dr. Sinopoli suggested adding a comment about the goal of data-driven care delivery processes and decision-making.
  - Dr. Mills indicated that this comment also reflected conversations at the prior public meeting.
  - Dr. Feldstein suggested adding the phrase “based on actionable data” to the comment about “a culture of accountability for clinical, quality, equity, and cost outcomes,” and Dr. Sinopoli agreed with this approach.



Ms. McDowell reviewed potential comments related to services included in TCOC.

- Dr. Wiler suggested incorporating a comment on capital costs. She added that this could include costs related to data, care coordination, and infrastructure.
- Dr. Lin asked whether the comment about “defining TCOC as including Medicare Part A and B expenditures” conflicts with the Committee’s working definition of TCOC, which assumes accountability for quality and TCOC for all covered health care costs. He asked whether this definition should include, for example, radiation treatment costs, pharmacy benefits manager (PBM) costs, and device costs.
  - Ms. McDowell responded that the comment reflects PTAC’s conversations that defined Medicare APMs as including Part A and Part B. She added that the Committee has heard discussions about the importance of Part D expenditures as well. She deferred to Committee members on whether they wanted to include those additional expenses and noted that there are additional complexities when adding those services to TCOC.
  - Dr. Kosinski indicated that drug coverage is mentioned in the comment about “testing the impact of including specialty drugs in TCOC models.”
  - Dr. Liao suggested addressing Dr. Lin’s comment revising the comment about “developing a standardized, patient-focused definition of TCOC” to reflect that the definition of TCOC can differ in the short-term and long-term.
  - Dr. Mills recommended framing the comment about Part D coverage in TCOC models as something to be tested before moving forward with including it in payment models. He added that the majority of Part D costs are not in the control of the care team because they are based on contract prices that Medicare negotiates and are beyond the physicians’ influence.

Ms. McDowell reviewed potential comments related to types of incentives provided.

- Dr. Sinopoli suggested adding a comment about financially incentivizing high-touch, team-based care models.
  - Dr. Liao agreed with Dr. Sinopoli’s suggestion and further suggested adding language about how payment models can account for autonomy.
- Dr. Mills noted that all the SMEs discussed incorporating a glide path into value-based care models that starts with no downside risk and limited upside risk. He added that no SMEs suggested that the glide path is an FFS model with a pay-for-performance bonus, but rather a value-based model with limited risk that increases over time.
- Mr. Steinwald suggested adding language about disincentivizing participation in FFS to encourage participation in value-based payment models.

Ms. McDowell reviewed potential comments related to multi-disciplinary team-based, patient-centered care. Committee members had no additional comments.

Ms. McDowell reviewed potential comments related to balanced use of, and coordination between, primary care and specialty care.

- Dr. Liao recommended rewording the seventh comment to avoid tying primary care to cost reduction. He noted that Dr. Feldstein had previously described primary care funding as an investment not necessarily tied to cost reduction.

- Chair Casale agreed with Dr. Liao’s suggestion.
- Dr. Kosinski suggested that the fourth comment was a tactic rather than a care delivery feature.
  - Dr. Mills agreed that the comment described a tactic but explained that it spoke to how to monitor balance between primary and specialty care.
  - Dr. Wiler recommended expressing the sentiment that models that were effective in outcomes, cost reduction, and quality had high levels of some kinds of utilization and engagement. She agreed that monitoring the data was a tactic, but recommended stating that high-touch approaches with more engaged care teams can result in reduced costs.
  - Dr. Kosinski recommended updating the comment to not just monitor the data but to act on it.
  - Dr. Liao suggested incorporating Dr. Wiler’s point into the fifth comment describing care coordination between primary and specialty care providers.
  - Dr. Pulluru suggested combining the last two comments on the slide to say, “improving coordination and alignment, including high-touch care, when necessary, between primary care and specialty providers.”
    - Dr. Sinopoli stated that the issue with combining these comments is that the resulting language focuses on the physician when the model should be encouraging non-physician patient engagement.
    - Dr. Wiler suggested using the term “care team” instead of provider.
    - Dr. Pulluru suggested keeping the two comments separate and updating the comment regarding “monitoring primary and specialty encounters” to focus on encouraging team-based or high-touch care as appropriate.
- Dr. Mills recommended revising the sixth comment because it currently reads as though the Committee is suggesting paying specialists just to engage with the PCP. Instead, he recommended updating the language to reflect that the model should incorporate specialist involvement and coordination without necessarily emphasizing financial incentives.
  - Mr. Steinwald suggested eliminating this comment, noting that the other comments capture specialist and primary care coordination.

Ms. McDowell reviewed potential comments related to targeted population-based interventions to prevent or mitigate populations’ risk of developing adverse health outcomes.

- Dr. Wiler suggested that this section should describe adverse health outcomes as an unexpected or unanticipated outcomes. She noted that as patients age, there will be progression of diseases that cannot be prevented but can be mitigated. Dr. Wiler added that these comments are trying to capture that complex patients require a special focus from a care team with resources that may be different from other patient populations.
- Mr. Steinwald noted inconsistent use of quotation marks around “rising risk” in the comments. He suggested simplifying the language and not using terms such as low, medium, or high risk because risk is a continuum.
  - Dr. Mills agreed with Mr. Steinwald’s recommendation.
- Dr. Mills recommended removing “for lower-risk patients” from the third comment.
- Dr. Liao noted that the title referred to in this section refers to complex populations, but the bullets do not focus on complex populations. He also recommended specifying the definition of risk, whether it means costly care or bad health outcomes.

- Dr. Lin noted that the LTC ACO highlighted a focus on palliative, advanced, and hospice care for populations with complex needs.
- Dr. Sinopoli added that high-risk, complex patients have intense care management needs and, as a result, have fewer gaps in care management than the majority of patients who are not as closely managed. He noted that ignoring this large proportion of the population would be unwise and suggested that there should be some process to identify those patients to address gaps in care. As a result, he recommended leaving the “for lower-risk” clause in the slide’s third comment.

Ms. McDowell reviewed potential comments related to the identification of health-related social needs and connection to appropriate resources.

- Dr. Liao recommended clarifying the second comment that high-risk patients means they are at high risk of having care affected by social drivers of health. He also suggested clarifying both the short-term and long-term goals articulated in the third comment.
- Dr. Sinopoli stated that the conversation about SDOH is focused on identifying needs and referring patients to social services. However, he noted the Committee has not discussed expected outcomes or accountable entities for addressing those social needs.
- Dr. Pulluru recalled discussions about the need to incentivize partnerships with community organizations. She recommended including language about tying reimbursement to having community partnerships.
- Vice Chair Hardin highlighted the issue of navigating to “nowhere.” These are situations where providers may want to make referrals for patients’ social needs, but the local community does not have adequate resources to address those needs. She said the challenge beyond incentivizing screening and partnerships was how to invest in the system of response that addresses those social needs and how that system can share in the accountability and rewards of TCOC models.
- Chair Casale recommended updating the first comment to emphasize the importance of making effective referrals, in addition to reducing administrative burden on referring providers.
  - Dr. Sinopoli suggested making two separate comments to cover reducing administrative burden and making referrals more effective.
  - Dr. Mills suggested removing the phrase “making referrals” from the first comment as that reflects a tactic that is not all-encompassing of addressing patients’ social needs. He appreciated how the third comment addresses the need for a standardized social needs screening instrument.

Committee members agreed to continue reviewing potential comments to the Secretary during the September 20 public meeting.

### **Closing Remarks**

Chair Casale thanked everyone for participating on September 19, including the expert presenters, PTAC members, and participants listening in. He noted that they will continue discussions on payment considerations and financial incentives for TCOC models on September 20, which will begin at 8:45 a.m. EDT and will feature two listening sessions, as well as time for public comments.

**The public meeting adjourned at 4:12 p.m. EDT.**

**Approved and certified by:**

//Lisa Shats//

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Lisa Shats, Designated Federal Officer  
Physician-Focused Payment Model Technical  
Advisory Committee

12/2/2022

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Date