

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

**March 2, 2023
9:30 a.m. – 4:47 p.m. EST
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201**

Attendance

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

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

Angelo Sinopoli, MD, PTAC Co-Chair (Chief Network Officer, UpStream)

Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)

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

Lawrence R. Kosinski, MD, MBA (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)

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

James Walton, DO, MBA (President and Chief Executive Officer, Genesis Physicians Group)

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

PTAC Members Not in Attendance

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

Department of Health and Human Services (HHS) Guest Speaker

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

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

Lisa Shats, PTAC Designated Federal Officer

Steven Sheingold, PhD

****Via Webex Webinar***

List of Speakers and Handouts

1. **Presentation: Improving Care Delivery and Integrating Specialty Care in Population-Based Models**

Jennifer L. Wiler, MD, MBA, Preliminary Comments Development Team (PCDT) Lead

Handouts

- Public Meeting Agenda
- PCDT Presentation Slides
- Environmental Scan on Improving Specialty Integration in Population-Based Models

2. **Panel Discussion 1: Strengthening Advanced Primary Care and Improving Specialty Integration**

Ann Greiner, MCP, President and Chief Executive Officer, Primary Care Collaborative (Primary Care Providers' Perspectives on Specialty Integration)*

Paul N. Casale, MD, MPH, Vice President, Population Health, NewYork-Presbyterian, Weill Cornell Medicine and Columbia University (Improving Specialist Engagement)*

Adam Weinstein, MD, Chief Medical Information Officer, DaVita Kidney Care (Specialists' Chronic Care Management)*

Handouts

- Panel Discussion 1 Day 1 Introduction Slides
- Panel Discussion 1 Day 1 Presenters' Biographies
- Panel Discussion Day 1 Discussion Guides

3. **Panel Discussion 2: ACO Perspectives on Specialty Integration and Improving Care Delivery**

Emily Brower, MBA, Senior Vice President, Clinical Integration and Physician Services, Trinity Health*

Cheryl Lulias, MPA, President and Chief Executive Officer, Medical Home Network (MHN)*

Emily Maxson, MD, Chief Medical Officer, Aledade*

Handouts

- Panel Discussion 2 Day 1 Introduction Slides
- Panel Discussion 2 Day 1 Presenters' Biographies
- Panel Discussion Day 1 Discussion Guides

4. **Listening Session 1: Implementing Nesting in Population-Based Total Cost of Care (PB-TCOC) Models**

Mark McClellan, MD, PhD, Robert J. Margolis Professor of Business, Medicine, and Policy, and Founding Director, Duke-Margolis Center for Health Policy, Duke University*

François de Brantes, MBA, MS, Senior Partner, High Value Care Incentives Advisory Group*

Rozalina G. McCoy, MD, MS, Associate Professor of Medicine, Mayo Clinic, Rochester, MN*

Lili Brillstein, MPH, Chief Executive Officer, BCollaborative*

Handouts

- Listening Session Day 1 Presentation Slides
- Listening Session Day 1 Presenters' Biographies
- Listening Session Day 1 Facilitation Questions

**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 March 2 PTAC public meeting.

Welcome and Overview: Discussion on Improving Care Delivery and Integrating Specialty Care in Population-Based Models Day 1

Lauran Hardin, PTAC Co-Chair, welcomed members of the public to the March 2-3 public meeting. She explained that the Committee has been exploring themes that have emerged from proposals submitted to PTAC by the public, including telehealth, social determinants of health (SDOH), and care coordination. Co-Chair Hardin explained that to support the Center for Medicare and Medicaid Innovation's (CMMI; the Innovation Center) goal of having all Medicare beneficiaries in a care relationship with accountability for quality and total cost of care (TCOC) by 2030, PTAC's 2022 public meetings examined key issues related to developing and implementing population-based TCOC models. Co-Chair Hardin indicated that PTAC would release its report to the Secretary of Health and Human Services (HHS) later in March. Through those discussions, a theme that emerged was how to integrate specialists into population-based models, which PTAC would explore further in the March 2023 public meeting.

Co-Chair Hardin introduced Elizabeth (Liz) Fowler, Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS) and the Director of CMMI.

Dr. Fowler expressed appreciation that specialist integration in population-based models is the focus of PTAC's March public meeting, as this is an area of focus for CMMI. She also discussed some of the Innovation Center's current activities, noting that in 2023, CMMI published a [report](#) in response to the Executive Order on lowering prescription drug costs, and launched a new Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) cohort. Dr. Fowler indicated that in its drug pricing report, CMMI identified three new prescription drug models to consider for testing, and identified three areas for additional research.

Dr. Fowler stated that the Innovation Center plans to announce three or four new models in 2023 on advanced primary care, population- and condition-specific accountable care models, and a state TCOC model. She indicated that these models will focus on underserved populations and make it possible for more safety net providers to participate.

Dr. Fowler discussed CMMI's specialty care strategy, noting that CMMI will be continuing to focus on strategies to drive better integration of primary and specialty care to serve those with chronic or serious conditions. In 2022, CMS published two papers: [Pathways for Specialty Care Coordination and Integration in Population-based Models](#), and [The CMS Innovation Center Strategy to Support Person-Centered, Value-based Specialty Care](#). Dr. Fowler stated that CMS has been identifying challenges, brainstorming model design approaches, and exploring ways to increase data transparency. For example, she indicated that to inform its plan to expand data sharing, CMMI conducted a survey of ACO and primary care group practice participants to solicit feedback on their interest in receiving new forms of data to support specialty engagement.

Dr. Fowler indicated that to offer better information on specialists, CMMI is providing shadow bundle data to ACO participants, which include claims data constructed into episodes of care and provided alongside target prices for attributed beneficiaries. She stated that these data will allow ACOs to analyze spending and care patterns for specialists and offer a new way to engage with specialists.

Dr. Fowler also stated that CMMI is focused on creating episode-based payment models that are complementary to ACOs and intends to solicit stakeholder input on a future model through a request for information (RFI) to be released later in 2023. She concluded by noting that CMMI is considering the current challenges related to specialty integration in advanced primary care integration models and ACOs; the barriers to integration; which strategies and approaches would best support increasing specialty care provider engagement in ACOs where specialists share accountability with primary care providers (PCPs) for high-value care and bear appropriate financial responsibility for patient outcomes; how high-value specialty care should be defined; and the appropriate performance measures for assessing specialty integration.

Co-Chair Hardin reviewed the meeting agenda, including best practices for structuring coordination between PCPs and specialists; how advanced primary care models and ACOs can improve specialty integration; structuring financial incentives and performance measures; and how to address the unique challenges that safety net providers and rural providers face.

Co-Chair Hardin referred audience members to the background materials on these topics available on the [ASPE PTAC website](#). She noted that the discussions, materials, and public comments from the March public meetings will inform a report to the Secretary (RTS) of HHS on how to improve specialty integration in population-based TCOC (PB-TCOC) models.

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

Co-Chair Hardin invited Committee members to introduce themselves and their experience with incorporating specialty care into PB-TCOC models. Each Committee member provided a brief introduction. Co-Chair Hardin indicated that five PTAC members served on the Preliminary Comments Development Team (PCDT): Jennifer Wiler, Lawrence Kosinski, Soujanya Pulluru, James Walton, and Terry Mills. She introduced Dr. Wiler, who presented the PCDT's findings from the [background materials](#).

Presentation: Improving Care Delivery and Integrating Specialty Care in Population-Based Models

Dr. Wiler presented the PCDT presentation. For additional details, please see the transcript and [meeting recording](#) (8:08-54:05).

Dr. Wiler reviewed the objectives of the theme-based meeting, including increasing specialty care provider engagement in PB-TCOC models and examining issues related to improving care delivery and specialty integration in population-based models.

Dr. Wiler explained that PTAC has deliberated on the extent to which 28 proposed PFPMs met the Secretary's 10 regulatory criteria, including the Integration and Care Coordination criterion. She noted that many of these proposals raised issues and challenges regarding specialty integration, and the goal for the public meeting was to better understand these challenges and how various experts and providers have

sought to address them. Dr. Wiler offered a working definition of the characteristics of specialty integration in the context of value-based care, noting that this definition will continue to evolve as the Committee collects additional information.

Dr. Wiler discussed desired model design elements for improving specialist integration in population-based models. With regards to management, considerations are a consultation or referral, what the relationship looks like from a co-management perspective where there may be shared management or co-management with principal care provided by a specialist, or specialist principal management. Attribution may be self-reported by the patient; or based on wellness or primary care visits, prescription data, evaluation and management (E&M) codes, or other methodologies. Examples of financial accountability models include the current fee-for-service (FFS) mechanism with no shared accountability; non-specialist model entity with voluntary or mandatory risk sharing with participating specialists; and specialist model entity assuming risk in a voluntary or mandatory model. Dr. Wiler highlighted additional characteristics that affect these elements for specialist integration.

Dr. Wiler presented an exhibit highlighting how specialists' roles in delivering care in coordination with PCPs vary based on the extent and duration of involvement needed. The duration of specialist involvement may be brief and limited or extend into comprehensive continued management. Another consideration is the extent to which a specialist is involved. Pre-consultation exchanges between physicians may escalate into a traditional consultation where the specialist evaluates the patient. As the relationship progresses, there may be co-management with shared management of either an acute or chronic condition with principal management by a non-specialist (i.e., PCP). Patients may require co-management for an acute or chronic condition with principal care provided by the specialist. For other conditions, principal management for the duration of care for a chronic or acute condition may be provided by the specialist, as opposed to the PCP. Dr. Wiler provided examples of specialists' roles in coordinating care with PCPs through the lens of nephrology.

Dr. Wiler reviewed potential criteria for identifying specialty conditions that may be more appropriate for bundled episode-based payments versus per member per month (PMPM) chronic disease management payments. She noted that these are important clinical and care management considerations that should inform payment policies.

Dr. Wiler introduced Dr. Kosinski, who presented an example of a cost attribution approach to identify which gastroenterology (GI) disease conditions may be appropriate for episode-based versus PMPM payments. Dr. Kosinski explained that this exhibit presents the results of a study to demonstrate the differences in GI conditions. The majority of disease-specific costs and variability of costs for the GI specialty is driven by the two inflammatory bowel diseases (IBDs): Crohn's disease and ulcerative colitis. IBD should therefore be a major focus for specialty payment models for GI. Conditions such as colon polyps, which are mostly procedural, have minimal disease-specific costs, and have a low beta rating, are best managed through bundled payments. Conditions such as irritable bowel syndrome and celiac disease, which are cognitive, but also have low disease-specific cost and beta ratings, are best managed through PMPM payments. Conditions such as IBD will require a blend of bundled payments for inpatient procedures and PMPM payments for cognitive services. Dr. Kosinski concluded by noting that a similar methodology could be used with other disease categories.

Dr. Wiler highlighted payment design features that support specialty integration currently being used in CMMI models. These models use nested specialty care and various payment designs, including bundled payments, per beneficiary per month (PBPM) payments, and capitated payments. Bundled payments

appear to better support conditions with low variability, whereas PBPM payments may be more appropriate for chronic conditions. Research on capitated payments focuses on chronic conditions and oncology care, and results on the efficacy of capitated payments have been mixed.

Dr. Wiler summarized care delivery challenges related to improving specialty integration in PB-TCOC models, including defining the roles of primary and specialty care providers (including overlap between specialists); defining and measuring high-value specialty care; clinical pathways to support patient-centered care; limited access to certain specialty services; and data quality and sharing.

Dr. Wiler reviewed examples of specialist approaches to care delivery that support high-value care, including specialist visit duration and frontloading care. Specialists seeing fewer patients and spending more time with each patient could support care improvements such as diagnostic decision-making, provider-patient relationships, care management, and patient education. Frontloading care may be more costly initially, but may generate cost savings and improve long-term outcomes.

Dr. Wiler reviewed considerations for structuring data sharing and communication to support specialty integration, highlighting the variation in how providers use and share data.

Dr. Wiler summarized payment model challenges related to improving specialty integration in PB-TCOC models, including insufficient financial incentives for encouraging specialists to move toward value-based care; identifying appropriate attribution methods; determining the amount of flexibility and specialties or conditions for nesting in PB-TCOC models; arranging for structuring entity- and provider-level risk; increasing participation of safety net and rural providers; and creating meaningful benchmarks for evaluating high-value care.

Dr. Wiler presented an exhibit illustrating the utilization and cost variability across different disease conditions, which should inform the development of specialty-focused models for nesting in PB-TCOC models. Dr. Wiler presented an exhibit showing an example of nesting a payment model for a single condition or episode, explaining that for condition- and procedure-based episodes, there is typically a billing code trigger followed by a fixed episode length.

Dr. Wiler highlighted that although a number of programs use benchmarks to evaluate high-value care, there is an opportunity to better define effective benchmarks.

Dr. Wiler summarized the areas of focus for the public meeting, including increasing specialty care provider engagement with shared accountability and appropriate financial responsibility; issues related to specialty integration in advanced primary care models and ACOs; approaches for structuring coordination between PCPs and specialists; options for defining and embedding specialty episodes within population-based models; the role of health information technology (HIT); addressing challenges affecting safety net and rural providers; and identifying appropriate performance measures.

Panel Discussion 1: Strengthening Advanced Primary Care and Improving Specialty Integration

- Ann Greiner, MCP, President and Chief Executive Officer, Primary Care Collaborative
- Paul Casale, MD, MPH, Vice President, Population Health, NewYork-Presbyterian, Weill Cornell Medicine and Columbia University
- Adam Weinstein, MD, Chief Medical Information Officer, DaVita Kidney Care

Co-Chair Hardin moderated the panel discussion with three subject matter experts (SMEs) offering their perspectives on strengthening advanced primary care and improving specialty integration. For additional details, please see the transcript and [meeting recording](#) (54:20-2:11:13).

Panelists introduced themselves and provided background on their respective organizations. Full [biographies](#) and [panelist introduction slides](#) are available on the ASPE PTAC website.

- Ann Greiner explained that the Primary Care Collaborative is a nonprofit, multistakeholder organization with a commitment to strengthening primary care as a foundation for a high-performing health system. She highlighted the essential roles that care coordination and integration play in patient-centered care, but stated that coordinated, integrated care is harder to achieve as patients continue to receive care from multiple physicians and struggle to retain primary care. The Primary Care Collaborative advocates for restructuring payment systems for primary care, noting that adequately funded primary care will ensure that interdisciplinary care teams can provide coordinated care to improve patient outcomes, reduce inequities, and lower costs.
- Paul Casale shared that he leads population health initiatives at NewYork-Presbyterian, Weill Cornell Medicine and Columbia University, which includes a Medicare Shared Savings Program (MSSP) ACO with about 5,500 clinicians serving approximately 40,000 beneficiaries. He noted that this ACO emphasizes specialist engagement and has earned shared savings in each of the last five years while maintaining quality scores above 90 percent. Dr. Casale also explained that, as a cardiologist, he is active in the American College of Cardiology, which is also working on how to engage specialists in accountable care, identify high-value specialists, structure risk sharing, identify performance measures, define accountability and attribution, and maintain flexibility.
- Adam Weinstein explained that he is the Chief Medical Information Officer at DaVita Kidney Care, which is one of the two largest vendors of dialysis in the country. He discussed the role of nephrologists in chronic kidney care, especially as conditions intensify and the nephrologist begins to serve as the primary care coordinator. Nephrologists play a big role in educating patients and high-risk populations, and mitigating high-cost disease progression. Care coordination is particularly important in kidney care where nephrologists are often coordinating across dialysis organizations, transplant centers, and different health systems. Dr. Weinstein suggested that the specialty suffers from a lack of opportunity to share responsibility for patient care with patients' other providers. For additional detail on Dr. Weinstein's background and organization, see the [panelist introduction slides](#) (slides 1-12).

Panelists discussed different approaches currently being deployed to facilitate coordination between primary and specialty care, as well as challenges associated with improving specialty integration. The following are some highlights from this discussion.

- Primary care lacks sufficient data for understanding cost and quality of care associated with specialists to be able to make referral decisions. Technology that identifies which information should be transferred when a referral is made should become standardized.
- In addition to quantitative data, there is the need for better qualitative information gathered through enhanced relationships between PCPs and specialists.
- There is a need for a data coordinator to manage data, as well as a care coordinator who is responsible for engaging with patients. Care coordinators need to be funded, as they are in the Kidney Care Choices (KCC) Model, and also need to be integrated into the patient care journey so that care coordinators can develop relationships with their patient panels.
- E-consults can be an effective tool for enhancing coordination and integration, from advising PCPs on which tests to order, to ongoing involvement in patient care. However, if specialists are assisting

PCPs through e-consultations, it is important to leverage care coordinators to ease the administrative burden on physicians.

Panelists discussed how advanced primary care models and ACOs can encourage specialist engagement. The following are some highlights from this discussion.

- Aside from vertically integrated hospital systems, there needs to be a contract mechanism to connect independent practices with ACOs.
- Sharing risk across the disease spectrum is more likely to encourage value-based care transformation. However, this is challenging to implement because as a patient's needs become more complex, the typical PCP no longer feels capable of managing care and hands off care management responsibilities to a specialist. There are, however, upstream opportunities through activities such as e-consultations that can help mitigate risk and facilitate the development of financial relationships between ACOs and specialists. These relationships are easier to establish if all providers are employed in the same organization.
- The relationships developed between primary care and specialty care cannot be overly complicated or burdensome. Additionally, clinicians need to know which patients are attributed to them, as well as who is responsible for managing their care.
- The current FFS system, which is also used in MSSP, does not leverage what primary care could do if it were paid on a capitated basis with funds to cover care management activities. However, MSSP has the potential to enhance care coordination efforts. Research suggests that MSSP ACOs with a higher number of PCPs are more likely to use E&M services than low-revenue ACOs, and are better able to reduce costs.
- E-consultations can help reduce unnecessary referrals, keeping patients in primary care settings and avoiding more costly care. Additionally, specialists have more time to see the patients who really need to be seen.

Panelists discussed efforts in care coordination to implement proactive, high-touch care. The following are some highlights from this discussion.

- Providers need the data and technological infrastructure to identify populations for outreach and manage patients proactively. Small, safety net practices may require additional support to provide proactive care.
- A lot of proactive care can be handled virtually. For example, with respect to hypertension, blood pressure can be monitored using Bluetooth-enabled blood pressure cuffs linked to electronic health records (EHRs), which allows clinicians to track patient status. Similarly, high-touch, proactive care for heart failure can be achieved through remote patient monitoring, which has been associated with reductions in emergency department (ED) visits, hospitalizations, and readmissions.
- In nephrology, care coordinators screen at-risk populations to identify patients who have not yet received care, and nephrologists have a checklist of items to review with every patient. Because these types of care coordination activities do not bring in much revenue, providers struggle to maintain care management and coordination activities.

Panelists discussed increasing payments to primary care—whether it would be an increased FFS payment or a PMPM that would cover management costs—as well as how these payment changes would help with care integration. The following are some highlights from this discussion.

- The answer is not necessarily higher FFS payments, but rather moving to prospective payments. One study found that a primary care practice needed to have at least 60 percent of its revenue

coming through capitated payments before the practice felt comfortable investing in a comprehensive team to deliver proactive care management. It takes a team to manage patient needs and analyze patient data.

- While prospective payment is the goal, it is important to be cognizant of earlier challenges to introduce health maintenance organizations (HMOs) and capitated payments. PMPM payments may therefore be a good incremental step as the health system moves from FFS to full prospective payments.
 - Currently, there are more data available and better performance measures for evaluating capitated payment systems to ensure that the right infrastructure and guardrails are in place as the system transitions.
- To effectively transform how practices operate, PMPM payments need to be sufficient. Additionally, even if a practice elects to participate in a model, the individual practitioners in the model may still be operating under what is essentially an FFS arrangement, resulting in a disconnect between the incentives of the practice and the practitioners. Restructuring payment mechanisms therefore requires a reasonable transition period.

Panelists discussed how specialty engagement and integration could improve an organization's MSSP performance. The following are some highlights from this discussion.

- Even though patients may be attributed to an ACO, a significant portion of patient care may be delivered outside of the organization.
- There is an opportunity through care coordination and integration to help lower costs by ensuring patients are admitted into the most appropriate care settings (e.g., an outpatient setting rather than the ED). PCPs and specialists can better coordinate and manage care so that patients do not end up in the hospital and instead are managed in an outpatient setting.
- Medicare patients who are discharged from the hospital can be considered higher-risk patients, especially with respect to potential readmission. There are opportunities to lower costs through improving care coordination and developing partnerships with post-acute care facilities.
- Vertically structured, more integrated organizations allow for the implementation of standard practices—for example, when a patient should be referred or the role of the PCP versus the specialist. Unfortunately, there is not a universal approach to apply this through payment methodologies alone.

Panelists discussed compensation methods for e-consults to better incentivize care coordination between PCPs and specialists. The following are some highlights from this discussion.

- There are a limited number of billing codes for e-consults, and they are not well-reimbursed. Some health systems have allocated internal funding to promote these activities; however, this is a temporary solution and may not work for all organizations. Providing funding for e-consults signals to practitioners the importance of these activities.
- Accommodation for telehealth appointments in the physician fee schedule has improved due to the COVID-19 pandemic; however, these payments should better reflect the burdens associated with delivering care via telehealth.
- Sharing risk across providers may also encourage the use of provider-to-provider e-consults. E-consults should not be funded by a piecemeal payment system, but rather through a global system such as PMPM payments.
- If a system is developed to pay providers differently, it would encourage transformation surrounding the use of technologies, formation of care teams, and creative ways to address patient needs while reducing costs.

Panelists discussed which payment features are missing from the current system and which payment policies would be helpful to help implement these features. The following are some highlights from this discussion.

- Full-time care managers and care coordinators need to be funded through capitated contracts.
- It will take decades to implement these capitated payments and restructure practices in a way that is not disruptive to physicians. Practices will have to restructure physician compensation so that they are incentivized to provide value-based care; these incentives cannot occur just at the organization level.
- There is a need for interoperable population health and data aggregation tools that are capable of producing actionable information. Some of these technologies may also free up staff to work on other tasks that cannot be automated in the same way.
- Appropriate measures for assessing quality, utilization, and costs are needed.
- To move toward prospective payment, it is essential that clinicians understand the patients for whom they are accountable and for what period of time. Prospective payment systems should also include risk adjustment for SDOH.
- Policies should address the issue of clinician burnout, which can be alleviated in part by reducing administrative burden or reimbursing for these activities through global payments, especially for PCPs. With respect to specialists, it is important to address prior authorization challenges.
- To address fragmentation in care, payment policies should prioritize primary care. Investments in primary care do not necessarily mean increasing practitioner salaries, but rather, supporting infrastructure and building out teams to provide the value-based, proactive care needed to help reduce downstream spending.

Panelists discussed best practices to incentivize specialty providers to participate in a TCOC-based system. The following are some highlights from this discussion.

- Some models, such as the Comprehensive Kidney Care Contracting (CKCC) payment option within the KCC model, offer incentive payments based on quality. There are also TCOC payments included in CKCC payments. However, the best outcomes seem to be associated with practices assigning a clinical lead and an administrative lead to manage, coordinate, and deliver care.
- To prevent disease progression and control costs, it is necessary to move care upstream. This includes establishing the right care guidelines, such as determining the best time to refer a patient to a specialist or opportunities for remote patient monitoring. There are small fees within the current FFS system for chronic care management that could help facilitate some of this work.

Panel Discussion 2: ACO Perspectives on Specialty Integration and Improving Care Delivery

- Emily Brower, MBA, Senior Vice President, Clinical Integration and Physician Services, Trinity Health
- Cheryl Lulias, MPA, President and Chief Executive Officer, Medical Home Network (MHN)
- Emily Maxson, MD, Chief Medical Officer, Aledade

Angelo Sinopoli, PTAC Co-Chair, moderated the panel discussion with three SMEs on ACO perspectives on specialty integration and improving care delivery. For additional details, please see the transcript, and [meeting recording](#).

Panelists introduced themselves and offered background on their respective organizations. Full [biographies](#) and [panelist introduction slides](#) are available on the ASPE PTAC website.

- Emily Brower discussed Trinity Health’s experience as an ACO and integrated delivery network working across a broad geography. Trinity Health is seeking to advance its payment strategy to take on greater accountability and move all payments to fully integrated TCOC payment models. The organization has participated in both population-based and episode-based payment models to align and integrate care, supports, and services for patients during critical care periods. For additional details on Ms. Brower’s background and organization, see the [panelist introduction slides](#) (slides 14-16).
- Cheryl Lulias shared details on Medical Home Network’s (MHN’s) model and approach to creating a Medicaid ACO focused on transforming care delivery in the safety net. She described how MHN’s Illinois ACO undertook efforts to identify high-risk, high-cost beneficiaries and address potentially avoidable costs. MHN formed the Behavioral Health Mobile Crisis Team (BHMCT), a partnership between MHN and a community mental health center, focused on addressing the complex needs of patients who have been identified as needing a high level of care management to prevent rehospitalizations. Ms. Lulias described the payment model for the program, which includes up-front care management fees to cover staffing and care management activities, as well as incentives for avoidable costs and utilization. For additional details on Ms. Lulias’s background and organization, see the [panelist introduction slides](#) (slides 19-24).
- Emily Maxson introduced Aledade as the largest independent primary care network in the country, and shared details and lessons learned from Aledade’s efforts to integrate specialty care providers into its ACO through technology-driven services and analyzing data to identify populations that would benefit from different interventions. She shared that primary care networks possess entrenched referral patterns, and despite expressing great satisfaction with e-consult platforms, providers rarely use them. She described how Aledade has seen success with highly targeted third-party interventions, such as an intervention focused on advanced care planning, where Aledade contracted with an external company to conduct these conversations in a cost-effective and productive way. She also described how Aledade experimented with incorporating cardiologists and nephrologists into its primary care ACOs, which emphasized the importance of developing and maintaining robust primary care relationships. For additional details on Dr. Maxson’s background and organization, see the [panelist introduction slides](#) (slides 25-28).

Panelists discussed common approaches to facilitating coordination between primary and specialty care providers in different types of ACOs. The following are some highlights from this discussion.

- Initial efforts to facilitate coordination begin with inclusion of specialist providers into leadership and governance positions in the ACO and should extend to care redesign, care pathways, and day-to-day care coordination. Specialty care providers, particularly in attribution-eligible specialties, should participate in care coordination teams and contribute to patient-centered care plans.
- Multi-specialty clinics participating in ACOs benefit from data analysis regarding patient patterns, such as when patients seek care from within the clinic or elsewhere. This analysis can help specialists improve quality and patient experience.
- Specialists should be as specific as possible in their documentation of patients with chronic conditions, to build higher-quality communication between specialists and PCPs.
- E-consults have been successful when they are highly integrated in provider workflows, but they require defined workflows and detailed communication between primary and specialty care providers.

Panelists discussed challenges on improving specialty integration among their particular types of ACOs. The following are some highlights from this discussion.

- Among ACO REACH participants, there are no levers to narrow networks to prevent the use of low-value providers.
- ACOs with specialist participation are looking to improve referral pathways and develop greater integration beyond care management and toward integrated medical management.
- ACOs do not have control over practices, particularly specialty practices that are not part of the network. Providing data to PCPs about specialists can empower conversations between PCPs and specialists to help reduce unnecessary procedures and costs.
- Additional resources to address SDOH and improve care management can help PCPs and specialists enrich the patient experience.
- Specialists are not incentivized to manage TCOC because attribution is usually at the PCP level. Rewards for care management and attribution to specialists for select services could help better integrate specialists.

Panelists discussed how to effectively nest models into the ACO structure. The following are some highlights from this discussion.

- Nesting requires determining accountability and distributing financial rewards appropriately.
- ACOs should be responsible for TCOC, and so should be able to make decisions about which models or bundled payment programs they want to employ for each population, episode, payer, and provider. The bundled payment construct should be taken inside the overall TCOC accountability of the ACO.
- Larger ACOs with specialists and hospitals in their network could also serve as partners for smaller ACOs without specialists in their network to offer bundles to improve care and reduce costs.

Panelists discussed the use of e-consultations and the role of virtual specialty care to drive specialist integration and impact utilization. The following are some highlights from this discussion.

- Providers did not like an anonymous e-consult platform leveraging an independent network of specialists. They preferred a non-anonymous e-consult model leveraging both a local network of specialists and a broader national network of specialists. Integration of local providers did not meaningfully change or improve integration of e-consults into providers' workflows.
- One e-consult platform used the specialty network of one hospital system and experienced better success with focused integrated workflows and models to ensure predictability of responses.

Panelists discussed how to encourage specialists to participate in value-based care. The following are some highlights from this discussion.

- Specialists indicated that they are willing to participate without additional financial incentives, and are primarily motivated by reduced barriers, better coordination of care, appropriate referrals, strong relationships, and support for complex patients. Specialists have not been motivated by financial incentives or PMPMs, as much as they have by the idea of improved care and patient management.
- Specialists thrive in an FFS system in a way that PCPs do not, and payment systems need to demand that specialists pay attention to value.
- Efforts to reward specialists can include ways to attribute patients to specialists and share savings with them, but the FFS system is not designed to accelerate change.

Panelists discussed if there are any specialties or conditions that should be excluded from value-based payment models connected to ACOs and the importance of multi-payer alignment. The following are some highlights from this discussion.

- All conditions should be included within value-based payment models because all conditions are important to patients and have the potential for improvement through value-based models.
- A multi-payer approach allows more patients to be attributed to the model, which simplifies the provider experience, facilitates increased practice transformation, and enables better population health.
- Inclusion of all conditions and specialists in models can enhance the possibility of taking a team-based approach. In certain circumstances, leaders of care teams can be attributed specialists to increase specialist accountability.

Panelists discussed the role that specialists and ACOs can play to encourage health equity when delivering care to different ACO populations. The following are some highlights from this discussion.

- Health equity is integral to value-based care and can be integrated into ACOs by measuring disparities and focusing efforts on those areas with high levels of health disparities.
- Health equity can also be incorporated into machine learning algorithms and data analysis by retraining algorithms to intentionally acknowledge and accommodate historic disparities in data.
- Care management can be targeted to the highest-need populations through risk stratification based on SDOH.
- EHRs provide a place for both specialists and PCPs to track care plan goals and a patient's longitudinal care journey. Medical risks, social risks, and behavioral risks should all be tracked and incorporated into care.
- ACOs can highlight particular high-risk populations and target them for quality measurement to prioritize interventions and encourage reduction of disparities.

Panelists discussed how to design models to integrate specialists within ACOs while maintaining a competitive marketplace. The following are some highlights from this discussion.

- Information on high-value, low-cost specialists would enable ACOs to bring value-minded specialists into their networks.
- Price transparency, value transparency, and quality transparency are extremely difficult to achieve, but an important place to start would be universal access to this information for patients.
- Timely, risk-adjusted reporting data will be important to support ACOs, particularly when engaging with specialists.

Panelists discussed attribution-eligible specialists and how they are incorporated within ACOs. The following are some highlights from this discussion.

- Patients are internally attributed to a PCP, but in the absence of a PCP, patients are attributed to the attribution-eligible specialist. This process also helps identify patients without PCPs and connect them to PCPs when needed.
- Specialists participating in the ACO have not been concerned with receiving PMPMs or shared savings but are primarily concerned about working together with PCPs as a network of providers to create a medical home for patients, while eliminating barriers and addressing pain points.

Listening Session 1: Implementing Nesting in PB-TCOC Models

- Mark McClellan, MD, PhD, Robert J. Margolis Professor of Business, Medicine, and Policy, and Founding Director, Duke-Margolis Center for Health Policy, Duke University
- François de Brantes, MBA, MS, Senior Partner, High Value Care Incentives Advisory Group
- Rozalina G. McCoy, MD, MS, Associate Professor of Medicine, Mayo Clinic, Rochester, MN
- Lili Brillstein, MPH, Chief Executive Officer, BCollaborative

Co-Chair Hardin moderated the listening session with four SMEs on implementing nesting in population-based TCOC models. Full [biographies](#) and [presentations](#) can be found on the ASPE PTAC website.

Mark McClellan presented on opportunities for integrating specialty care within population-based payment models.

- Specialty care should be incorporated throughout the patient’s care journey, from diagnosis to supportive care or end-of-life care.
 - Incorporating specialty care earlier in the patient journey can increase the likelihood of better patient outcomes.
 - To date, most payment reforms have been acute, episode-based models such as bundled payments.
 - There are a variety of types of critical specialty care: specialized care episodes, whole-person care, and longitudinal coordinated care.
 - The majority of specialty care spending involves interaction between specialty care and other providers, particularly primary care and advanced primary care groups.
 - Policies and payments should support integrated longitudinal condition management, including supporting engagement between specialty providers and PCPs.
- Payment reforms should expand support for long-term condition management, rather than acute events and procedures. Specialists should participate in sustained models that focus on avoiding hospitalizations and the need for major procedures.
- This can be achieved through specialty condition models.
 - Specialty condition models can support CMS’ suggested transition to mandatory acute episode bundles and its long-term goal of having all Medicare beneficiaries in coordinated, longitudinal care models.
 - Specialty condition models are condition-based, person-level payments for common conditions nested between whole-person TCOC accountability models and acute episodes. They are intended to provide support and sustainability for care coordination in order to maximize longitudinal patient outcomes.
 - Nesting could be voluntary for physician-led ACOs and mandatory for hospital-based ACOs.
 - Specialty condition models can nest within acute event models, which in turn fit within TCOC models, on either a mandatory or voluntary basis.
 - Promising areas for specialty condition models include musculoskeletal conditions, longitudinal cardiology care, dementia, and Crohn’s disease and ulcerative colitis.
 - Short-term steps for implementing specialty condition models include implementing shadow bundles with reporting and data sharing, developing condition-level measures, and aligning FFS changes.

For additional details on Dr. McClellan’s presentation, see the [presentation slides](#) (pages 2-15), transcript , and [meeting recording](#) (0:30-12:50)

François de Brantes presented on how to implement nesting in PB-TCOC models.

- For any payment effort to succeed, it must be relevant to and actionable for those who participate. Models must also be meaningful, covering enough of the cost of care of patients to make a substantive impact.
- Specialty condition models nested under population-based management allow for specialists to provide longitudinal specialty care management and address all aspects of specialty care spending, including condition management, minor procedures, major procedures, and acute events.
- Procedural bundles can be nested within specialty bundles, which are themselves nested within TCOC. Each bundle could have its own specific benchmarks, making all providers accountable for optimizing beneficiary outcomes and achieving savings accumulated under TCOC.
 - Reconciliation can occur at the procedural level, the condition level, and the TCOC level.
 - Sub-risk contracts should be used to align incentives across the delivery system.
- This nesting framework encourages proceduralists to optimize procedures, physicians managing conditions to minimize acute events and low-value procedures, and those managing TCOC to find the most effective, efficient specialty providers.

For additional details on Mr. de Brantes' presentation, see the [presentation slides](#) (pages 16-22), transcript, and [meeting recording](#) (13:02-22:40)

Rozalina McCoy presented on patient attribution, particularly for patients with multiple or serious chronic conditions, when nesting models within PB-TCOC models.

- Attribution for patients with multiple or serious chronic health conditions is complex, as patient care typically involves multiple touchpoints with multiple providers.
- Challenges to patient attribution include patients lacking PCPs; patients receiving care from multiple providers and networks with different EHRs; variation in data quality and access; and difficulty assessing outcome measures, which cannot be easily linked to a single provider or organization.
- There are a wide variety of attribution methods, each of which produces vastly different measurement results. Methods can vary by the types of providers that can be attributed and the exclusivity of attribution.
- It is important to move beyond patient-PCP attribution because team-based care and non-visit care are associated with improved patient outcomes and should be accounted for.
- Attribution models would ideally identify accountable entities that can meaningfully affect measured outcomes directly or indirectly.
- Specialists can be integrated with primary care as either stand-alone (e.g., in integrated health systems or referral practices) or co-located (e.g., providing consultative care or co-management) specialists.
- Specialist engagement is not static, as chronic health conditions go through different phases involving different levels of specialty involvement and coordination with primary care and other specialties. Different attribution models can respond to this complexity, but they need to balance practicality with accuracy and fairness.
- Patient attribution is often done through retrospective or prospective identification from claims data, with both methods involving different challenges such as uncertainty and gaming the system. There are additional challenges with choosing the unit of comparison, eligible clinicians, exclusivity,

and assignment thresholds. Another method of attribution is to have patients identify the provider most responsible for their care, but patients often do not know who that is.

- Assigning responsibility begins with determining accountability and whether the responsibility rests with a single clinician or is shared among multiple clinicians. Models must then identify the accountable clinician (for clinician metrics) and the accountable team/system (for team or system metrics).
- Weighted multi-attribution models could allow patients to be attributed to all clinicians involved in their care based on pre-determined weights, but they have not been heavily explored in the current health care contexts.
- Ultimately, there is a lot of uncertainty about how to attribute patients, but it is important that attribution models are tested, verified, and reviewed to ensure that they are fair and equitable. In TCOC models, measures should prioritize care teams and health system level interactions.

For additional details on Dr. McCoy’s presentation, see the [presentation slides](#) (pages 23-36), transcript , and [meeting recording](#) (22:47-39:55)

Lili Brillstein presented on specialist engagement within episodes and other models nested within PB-TCOC models.

- Payment models have transitioned from FFS to more “collaborative silos,” such as patient-centered medical homes (PCMHs), ACOs, and episodes of care or bundled payment models.
- Specialists have many concerns about participating in Alternative Payment Models (APMs), including a lack of trust, fear of the loss of practice control or the ability to make clinical decisions, assuming risk and the potential for revenue loss, and increased administrative burdens. Language such as “mandatory,” “bundled payments,” and “value-based care” can impact physician perception and heighten these concerns.
- In order to best engage specialists, invite them to collaborate throughout the design and refinement of models to make sure that the models are administratively practical and clinically meaningful.
- Considerations to incentivize specialist participation include:
 - Recognizing and respecting that each specialty is unique.
 - Inviting specialists to be represented in leadership and on ACO governance boards and committees.
 - Creating financial models that do not immediately put specialists at a disadvantage.
 - Sharing longitudinal data to encourage engagement, collaboration, and improvement.
 - Cultivating and nurturing relationships through communication and collaboration.
- The spirit of collaboration will enable comprehensive accountability for care quality, patient experience, and TCOC.

For additional details on Ms. Brillstein’s presentation, see the [presentation slides](#) (pages 37-45), transcript , and [meeting recording](#) (40:00-54:11)

Following the presentations, Committee members asked questions of the presenters. For more detail on this discussion, see the transcript and [meeting recording](#) (54:16-1:29-02)

Presenters discussed how to identify the relevant population and attribution techniques for specialists in specialty condition models. The following are some highlights from this discussion.

- The goal of specialty condition models is to serve a population of patients requiring collaboration between primary and specialty care, with both primary and specialty providers sharing patients and offering different levels of care and attribution depending on patient severity and individual needs. Attribution involves many challenges, but costs should be parsed out to different providers as needed. The goal should be to replicate the financial and attribution mechanisms of an integrated delivery system so that systems and communication function seamlessly even when providers work across systems and organizations.
- Attribution is especially difficult when there is not an overall accountable provider or entity, which can be a challenge with longitudinal conditions. Hospital-based ACOs will likely require acute episode-based payments because it is too difficult for hospital-based ACOs to shift payment and resources to a more longitudinal model. Conversely, primary care ACOs can serve as a template to facilitate interactions. Common conditions can serve as big opportunities to support collaboration between primary and specialty groups or longitudinal specialty care providers, with some control over when attribution occurs, providing a path forward to engage specialists through capitated payment, limited risk sharing, or responsibility sharing.

Presenters discussed the merits of adjusting terminology to discuss disease-based models, rather than differentiating models into primary care and specialty-based models.

- Model development should focus on creating collaborative models leveraging the expertise of both primary and specialty care, rather than creating specific models for each provider type. Rethinking language can improve engagement and facilitate success.

Presenters discussed the necessity of, and reasons for mandatory participation in payment models. The following are some highlights from this discussion.

- When there is strong evidence regarding the efficacy of models, participation should be mandatory. Models should be tested and focused on longitudinal management of conditions before being mandated.
- CMS' consideration of moving toward mandatory versions of acute episode models reflects an ongoing challenge with payment models, highlighting how savings for Medicare are difficult to achieve in specialty payment models without appropriate benchmarks or mandatory participation. It will be difficult to achieve truly person-centered, longitudinal care that is fiscally responsible without mandatory participation, but mandatory participation needs to be thoughtfully executed. Hospital-based ACOs can sustain mandatory participation because they are already accountable for the TCOC of patients attributed to them, and transitioning away from procedure-based payment can support hospitals moving toward longitudinal care models. It is not realistic to think that only voluntary participation can drive the health care system away from fragmented FFS, procedural-oriented care.
- The language surrounding the transition from FFS toward value-based care is important to consider when engaging with providers. Providers do not like to hear that models are "mandatory," but rather prefer to hear about "evolutions" in payment models.

Presenters discussed the importance of integrating community partners and health-related social needs (HRSNs) in the longitudinal management of patients. The following are some highlights from this discussion.

- It is extremely difficult to address SDOH under FFS, whereas ACOs and other models have developed programs to address nutrition needs and transportation needs, and to build care teams. Adoption of APMs can facilitate the ability of specialty care providers to offer early and preventive interventions to address HRSNs.
- Value-based models are more focused on patient outcomes, rather than what is covered, and can begin to incorporate transportation, food, and ancillary services to assess what will have the biggest impact on patients' health and outcomes.
- SDOH and other external factors are important elements for managing chronic diseases and individuals with multiple comorbidities, yet are primarily offered by community and non-clinical partners, which often are not reflected in claims. External partners need to be presented in claims so they can participate in shared savings.

Presenters discussed how to incentivize patient participation in disease-based models. The following are some highlights from this discussion.

- Higher-quality care for patients is an important benefit, but models should be designed with patients in mind. Patients particularly care about their care experience and outcomes, and specialty care models could provide patients with additional information and data, such as provider scores and patient-reported outcomes.
- Collaboration between primary and specialty care is necessary, but likely will not change until financial and other incentives encourage that partnership. Additional information will help inform PCPs about high-value specialists and encourage collaboration and joint accountability for financial and clinical outcomes.

Committee Discussion

Co-Chair Sinopoli opened the floor to Committee members to reflect on the day's presentations and discussions, noting that PTAC will be issuing an RTS of HHS to describe the Committee's findings on delivering and integrating specialty care in PB-TCOC models. The Committee members discussed the following topics. For additional details, please see the transcript and [meeting recording](#) (1:29:20-1:54:46).

- Telemedicine and e-consults can be leveraged to drive primary and specialty care coordination, particularly in areas where access to specialists is limited.
- Payment models should consider the costs of up-front infrastructure investments that lead to future high-value care and cost savings.
- Payment models should incentivize the continuation or expansion of technology-enabled care.
- Practice transformation takes time and investment. The focus should be on long-term improvements, instead of short-term return on investment.
- A multi-payer strategy would ensure that a sufficient proportion of a provider's patient panel is tied to value-based care, making value-based models more attractive and effective.
- Specialist-focused models should be "carved into" population-based models, not "carved out."
- Price and data transparency can show where there is the opportunity to create value.
- Prospective attribution is a best practice, and models should consider letting patients affirm their attribution to a provider. Weighted attribution models should also be considered so that

attribution is not based on a single provider-patient relationship, which does not reflect real-world care delivery.

- To make a meaningful shift toward value-based care, models must pivot from the testing phase to a sustainable, mandatory program.
- Care models should focus on longitudinal, whole-person care.
- Payment models should acknowledge the wide variety of specialty care (i.e., acute episodes, procedure-based, longitudinal care) and focus on integrating clinicians rather than carving out different conditions or subspecialties.
- Shadow bundles provide ACOs with data on specialists' care patterns and episodes. It is important for financial incentives to account for variability in disease episodes.
- Health equity should be an integral part of how payment models are designed and implemented, not just an outcome that is studied.
- Care coordination is imperative, but there is not yet a good definition of what good care coordination looks like and how much effort is involved. For example, with an e-consult, it takes time for the specialist to do the consult, but what kind of effort does it take for the primary care team to submit the consult, digest the results, and communicate with the patient? Payment models should be able to quantify and incentivize this care coordination effort.
- Outside of payment mechanisms, policy makers should consider how models can value collaborative relationships between primary and specialty care providers.
- Models may have the unintended consequence of adding friction to relationships among providers and between providers and their patients. One of the Committee's goals should be to ensure an active future health care workforce that feels fulfilled in their relationships with colleagues and patients.
- Artificial intelligence technology is prone to bias and may exacerbate the health care challenges faced by underrepresented groups. Payment models alone cannot solve discrimination in the health care system, but policy can support more holistic transformation.
- It is crucial to have adequate data to measure quality and cost.
- Physicians require teams to manage administrative burden and support longitudinal care.
- The focus should be on disease-specific solutions, rather than specialty-specific, since attribution, risk, and the services required vary based on disease.
- Engaging specialists in PB-TCOC models is complex; maybe the simplest solution is to have specialists operate in an FFS system, while the accountable entity is at the organization level where patients are attributed through PCPs.

Closing Remarks

Co-Chair Sinopoli adjourned the meeting.

The public meeting adjourned at 4:47 p.m. EST.

Approved and certified by:

//Lisa Shats//

5/8/2023

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

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