PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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The Great Hall
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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TUESDAY, JUNE 7, 2022

PTAC MEMBERS PRESENT

PAUL N. CASALE, MD, MPH, Chair
LAURAN HARDIN, MSN, FAAN, Vice Chair
JAY S. FELDSTEIN, DO
LAWRENCE R. KOSINSKI, MD, MBA
JOSHUA M. LIAO, MD, MSc
WALTER LIN, MD, MBA
TERRY L. MILLS JR., MD, MMM
ANGELO SINOPOLI, MD
BRUCE STEINWALD, MBA*
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS IN PARTIAL ATTENDANCE

SOUJANYA R. PULLURU, MD*

STAFF PRESENT

LISA SHATS, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
VICTORIA AYSOLA, ASPE
STEVEN SHEINGOLD, PhD, ASPE

*Present via Webex

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

9:32 a.m.

* CHAIR CASALE: Good morning, and welcome to the meeting of the Physician Focused Payment Model Technical Advisory Committee, known as PTAC. I am Paul Casale, the Chair of PTAC. So I think I speak for all the Committee members that we're very excited to be here in person after being away for more than two years.

Most of our Committee members are here in the Great Hall of the Humphrey Building in D.C., after many virtual public meetings, and we look forward to a time when we can welcome members of the public to join us in person as well.

* **Welcome and Overview - Population-Based Total Cost of Care (PB-TCOC) Models: Assessing Best Practices in Care Delivery for PB-TCOC Models**

As you know, PTAC has been looking across its portfolio to explore themes that have emerged from proposals received from the public.

In March, we were excited to kick

off a three-meeting series of theme-based discussions on population-based total cost of care models. The public meeting focused on definitions, issues, and opportunities related to developing and implementing these models. Today and tomorrow, we will focus on care delivery model design.

PTAC will hear about lessons learned from the public and subject matter experts, including stakeholders who have previously submitted proposals to PTAC that included relevant elements. We've developed an agenda to explore topics including what strategies have helped entities be successful in bearing financial risk while managing care for different patient populations; incorporating specialty care innovations into total cost of care models; measuring performance and evaluating these models; integrating episode-based or condition-specific models within a population-based model while reducing complexity; and meaningfully addressing equity.

That's just a sample of what we hope to cover at this meeting. In September, we anticipate addressing the payment

considerations and financial incentives that would encourage care delivery practices discussed today in total cost of care models. So if we don't cover a topic that's important to you today or tomorrow, you're likely to hear about it in September.

You can also read our environmental scan and supplemental online material, which is part of our background materials for this series. After the September meeting, PTAC will issue a report to the Secretary of HHS[1], with the Committee's comments and recommendations on these topics.

Today, we have multiple presenters ready to describe their vision and experiences related to assessing best practices in care delivery for population-based total cost of care models. Then the Committee will discuss what we've learned before adjourning for the day.

Tomorrow morning, we begin with opening remarks from Liz Fowler, the Deputy Administrator of CMS[2] and the Director of the

1 Health and Human Services
2 Centers for Medicare & Medicaid Services

Innovation Center. We will also hear from many more experts from a variety of perspectives. We'll then have a public comment period. Public comments will be limited to three minutes each.

If you'd like to give an oral public comment tomorrow but have not registered to do so, please email ptacregistration@norc.org. Then the Committee will have a discussion to shape our comments that will be included in the report of the Secretary of HHS that we will issue after the series.

Taken together, the prep work, the presentations and discussions, and the public comments are aimed at informing PTAC about the latest knowledge from the field regarding the development of population-based total cost of care models in the context of APMs[3] and physician-focused payment models. I'll note that as always, the Committee is ready to receive proposals from the public on a rolling basis.

We offer two proposal submission

3 Alternative Payment Models

tracks for submitters to provide flexibility, depending on the level of detail that is available about their payment methodology. You can find information about how to submit a proposal online.

*** PTAC Member Introductions**

So at this time, I would like for the PTAC members to please introduce themselves.

Please share your name and organization. If you'd like, feel free to share a brief word about any experience you have with population-based payment or total cost of care models.

So I'll start. I'm Paul Casale. I'm a cardiologist. I lead value-based payment and population health for NewYork Presbyterian, Weill Cornell and Columbia University. Next, I'm going to turn to Lauran, and then we'll go around the room for each person to introduce themselves.

VICE CHAIR HARDIN: Good morning. I'm Lauran Hardin and Senior Advisor for National Healthcare and Housing Advisors. I've spent the last 20 years leading and designing

models, and partner with communities, states, payers, and health systems in standing up models, particularly for underserved and vulnerable populations.

DR. KOSINSKI: I'm Larry Kosinski. I'm a gastroenterologist, and have spent the last 10 years of my life, 10 years of my career building value-based programs for a company that I founded and function as chief medical officer, SonarMD. We are specifically currently focused on value-based payments in the gastroenterology space.

DR. WILER: Hi, I'm Jennifer Wiler. I'm the Chief Quality Officer of UCHealth's Denver Metro Area. I'm a tenured professor of Emergency Medicine at the University of Colorado, and co-founder of UCHealth's CARE Innovation Center, where we partner with digital health companies to grow and scale their solutions to improve health outcomes for patients.

I've held a number of leadership roles within specialty societies focused at developing payment models for providers, and was a co-developer of an Alternative Payment

Model.

DR. LIAO: My name is Josh Liao. I'm an internal medicine physician and faculty to the University of Washington in Seattle. There I also serve as the Enterprise Medical Director for Payment Strategies, so support a range of different payment models, including population-based and total cost of care.

I also am fortunate to lead a unit called the Value and Systems Science Lab, where we do research and evaluation on these types of models. So I think about methodologies and how do we evaluate if these models have yielded the benefits we want.

DR. SINOPOLI: My name is Angelo Sinopoli. I'm a pulmonary critical care physician by training. Presently the Chief Network Officer of UpStream, which is a company that enables primary care physicians to participate in global contracting. Prior to that, I was the chief clinical officer for a large integrated delivery system and there founded and built a large network of about 5,000 docs and then also founded a company called the Care Coordination Institute, which

was also an enablement company for delivery systems to provide data, analytics, care management, process improvement, et cetera, and I'm happy to be here today.

DR. LIN: Good morning. I'm Walter Lin, an internist based in St. Louis. Founder of Generation Clinical Partners. We are a medical practice delivering care to the frail elderly in senior living facilities, and also the seriously ill in their homes.

DR. MILLS: Good morning. I'm Lee Mills. I'm a family physician. I'm Senior Vice President and Chief Medical Officer of CommunityCare Managed Health Care Plans of Oklahoma, where we operate a provider health system-owned total capitated plan across multiple lines of business. I came up through medical group management and operated multiple CMMI[4] models and ACO[5] models over the years. Thank you.

DR. FELDSTEIN: Good morning. My name's Jay Feldstein. I'm an emergency medicine physician by training, and I'm

4 Center for Medicare and Medicaid Innovation
5 Accountable Care Organization

currently the president and CEO of Philadelphia College of Osteopathic Medicine. Prior to that, I spent 15 years in the insurance industry and health care both for commercial and government plans, with a fair amount of experience with fully capitated and race-based models. Chinni, I'm going to turn it over to you now for your introduction.

DR. PULLURU: Thanks, Jay. Hi, I'm Chinni Pulluru. I am Vice President of Clinical Operations for the Walmart Health and Wellness Business. In this role, I oversee care delivery in our virtual care platform, bricks and mortar clinics, behavioral health, dental, as well as our social determinants platform.

Prior to that, I oversaw value-based care and care delivery for a large medical group, DuPage Medical, now Duly Health and Care, where I oversaw implementation of value-based care platforms across the care continuum, growing it tenfold successfully.

CHAIR CASALE: Thanks, Chinni. Bruce, if you can introduce yourself.

MR. STEINWALD: Yeah. I'm Bruce

Steinwald. I'm a mostly retired health economist in Washington, D.C. For the past 50 years, I've served in lots of different positions in government and academia and in private sector organizations, doing health economics and health policy in a variety of different settings.

* **Presentation: An Overview of Proposals Submitted to PTAC with Components Related to PB-TCOC Models (Part 2) and Other Background Information**

CHAIR CASALE: Thank you. So now let's move to our first presentation. Five PTAC members served on the Preliminary Comments Development Team, or PCDT, that has worked closely with staff to prepare for this meeting. I'm grateful for their time and effort in organizing today's agenda. At this time, the PCDT will present some of the findings from their background materials available on the ASPE PTAC website.

PTAC members will have an opportunity to ask the PCDT any follow-up questions afterwards. So now I'm going to turn

it over to PCDT lead Chinni and the rest of the team, Walter, Larry, Lauran, and Lee. So Chinni, I'm going to turn it over to you.

DR. PULLURU: Right. Thank you, Paul, and thank you to the team that served on this, as well as the entire ASPE team that helped. So in this presentation, we'll work to discuss best practices, as well as trade-off and barriers of delivery and adoption of total cost of care models. Next slide. I'm not seeing the slides. (Pause.)

[FEMALE PARTICIPANT]: One second, Chinni, we're going to try to get them up.

DR. PULLURU: Right, thank you. Given the --

(Off mic comments.)

DR. PULLURU: Thank you. Given the increased emphasis on developing Alternative Payment Models that encourage accountable care relationships, PTAC is examining key issues related to development and implementation of population-based total cost of care models. The Committee's March public meeting began by focusing on key definitions, issues, and opportunities.

Today's meeting focuses on assessing best practices in care delivery for population-based total cost of care models. Within this context, PTAC is particularly interested in exploring options for integrating episode-based or condition-specific models within broader population-based accountable care models.

From 2016 to 2020, PTAC received 35 stakeholder-submitted proposed physician-focused payment models that have been deliberated on the extent to which 28 of these proposed models meet the Secretary's 10 regulatory criteria, including Criterion 2, which is Quality and Cost.

Many of the PFPM[6] proposals that have been submitted to PTAC include innovative care delivery approaches that could potentially be relevant for population-based total cost of care models.

This presentation provides useful background information to provide context for the rest of today's discussion and tomorrow's discussion.

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6 Physician-focused payment models

Next slide. PTAC has been using the following working definition of population-based total cost of care models as a guide for focusing discussions during this series of theme-based discussions. A population-based total cost of care model refers to a population-based advanced payment methodology in which participating entities assume accountability for quality and total cost of care, and receive payments for all covered health care costs for a broadly defined population, with varying health care needs during the course of the year or 365 days.

This definition will likely continually evolve, as the Committee collects additional information from our stakeholders.

Next slide. The Center for Medicare and Medicaid Innovation, CMMI, has set the goal of having every Medicare fee-for-service beneficiary for Parts A and B in a care relationship with accountability for quality and total cost of care by 2030. PTAC is using the following working definition of an accountable care relationship.

An accountable care relationship is

a relationship with the health care provider that focuses on accountability for quality of care and cost of care for an individual patient or a group of patients for a defined period of time. Within this context, an accountable care relationship would typically include accountability for quality and cost for all of a patient's covered health care services.

However, in some cases, a provider could potentially be accountable for the quality and cost of a subset of a patient's health care services for an episode of care, which could be procedure-specific, condition-specific, disease-specific, or related to a particular medical event.

Next slide. As we move from fee-for-service to a full capitated, integrated delivery model, there are potential implications to care delivery, and we have to take those into consideration, as they impact the design of the models. First, as an organization takes on more risk, there needs to be significant improvement in care coordination, integration, as well as accountability clinically.

This will require increased infrastructure outside of the provider-patient-facing episode. Next, as this need grows, there's also flexibility to innovate in care delivery, including finding new ways to integrate virtual and digital care, whether synchronous or asynchronous. This flexibility shifts the ability to innovate closer to the provider and patient-facing component part of care.

One potential consequence that is necessary and can be viewed as limiting is the potential limitation of beneficiary choice. However, this isn't a negative effect as it often can lead to higher-quality, better outcomes and accountability of the care delivery provider.

Next slide. As we move from fee-for-service methodology to a full capitated model along the risk continuum, the obvious is that there's increased financial risk for the accountable entity. This risk leads to increased accountability to improve value. This increased value is embedded in every model deliberated by the Committee.

The other payment factor trade-off is a reduction in beneficiary cost-sharing. This acts as incentive for the beneficiary member to choose plans that hold the provider organization at increased accountability for both financial risk and value offered.

As organizations take on more risk, there is a shift in health plan or purchaser administrative burden for payment determination to the accountable entity. One important factor in payment factor trade-offs is that it can reduce CMS administration and will be distributed to the accountable entity.

As we consider models in total cost of care, simplicity to administer the model and financial reconciliation, as well as timing, is an important consideration. We will be hearing this from our Committee as we move into future meetings.

Next slide. There are some general consensus about accountable care that we have already recognized. For example, importance in maintaining a patient-centered approach, embedding and improving health equity across the continuum, increasing coordination between

providers that are broadly responsible for accountable care relationship with patients, as well as in integrating specialty providers.

So all of the participating providers have access to tools to deliver high-quality, coordinated, team-based care. The importance of addressing and realizing health-related social needs and social determinants of care, the emphasis on outcome metrics and adoption of improved care delivery processes, focus on evidence-based high-value care, as well as a focus on reduction of waste and gains in efficiency, as well as maintaining budget neutrality, and seeking to reduce unnecessary complexity.

Next slide. There are some areas where additional discussion is also needed. Whether value-based care delivery innovations should focus on high-cost patients with multiple chronic conditions and related episodes of care, or a more broadly defined population. How best do we support providers that are in accountable care relationships, particularly in cases where attribution occurs retroactively?

What is a relative amount of accountability for individual providers versus a higher-level accountable entity? Whether accountability can be shared among more than one provider, and if so, how does this work to distribute financial accountability? How do we integrate screening and referrals for HRSNs[7] and social determinants of health in the context of value-based care relationships, and what types of providers and organizations can serve as accountable entities? How do we expand that potential scope?

How best to disseminate information about best practices and innovations to providers and organizations within these accountable relationships, and how much flexibility should accountable entities have in determining how to manage care for the services they're responsible for?

Next slide. To picturize and discuss the elements of patient-centered delivery and integration, as well as accountability for diversity of patient

7 Health-related social needs

architecture, these particular elements are in no hierarchical order, but rather evenly important if they're divided into four different sectors.

First, in considering different patient needs, we must consider that while most patients get their care with primary care physicians being the quarterback of their care, there are subsets of patients who often see their specialists in much higher frequency, and therefore often see this physician as their primary care physician, for example, a cardiologist for a patient with heart failure, or a nephrologist in end-stage renal failure. Models developed need to acknowledge these relationships and develop accountability for care.

Second, in considering different needs, encouraging provider alignment and coordination is another element encompassed in total cost of care models. We need to look at attribution methodology to further incent this with primary care, even with plurality, even as with plurality with a specialist. We must develop alignment across different touch points

that the patient interacts with the health care system, including social service encompassing social determinants of health and long-term care.

For example, a patient statistically potentially sees a pharmacist 11 times more than a physician. This is an important element to coordination of care and access to care. Leveraging all the ways a patient interacts with the health care system to affect coordination can't be underestimated in our total cost of care models.

One of the most important elements of care alignment must take into account behavioral health of a patient, and consider how to best provide health access to care, including funding that incentives for providers to develop channels of delivery.

There are -- in delivering future models, we must consider innovation that matches the world we deliver care in: Systems such as advanced primary care, innovating the workforce platform to the top of licensure in team-based care, innovating and encouraging clinical pathways that encompass virtual care,

as well as digital care, that are both synchronous, as well as asynchronous, encourage a patient to engage in their care more effectively.

Allowing for provider systems to innovate these pathways. Team-based care includes integration with community services that address social determinants of health.

The fourth element is the foundational element that encompasses all the other three elements, and that is tools, infrastructure, analytics, implementation, and best practices.

We must support more ready access to data real time, to enable providers to effectualize appropriate care patterns, increasing and facilitating sharing between organizations and risk-bearing entities to encourage best practices.

Some other elements that are in total cost of care models are financial planning implementation resources, to enable smaller, more independent, particularly rural and underserved areas to embrace all the elements that are needed to take on financial

risk.

Next slide. Considerations for integrating specialty care. It may be more effective to encourage patients to receive care from an accountable provider or from providers whose care is being coordinated to a specific accountable entity. However, this can limit patient choice.

Some providers are not comfortable assuming overall accountability for patient-centered value-based care if they only provide a portion of this patient's overall care, and some do not have the analytical tools or prerogative necessary to affect coordination of care with other providers.

Integrating specialty and population-based total cost of care models will require addressing any unintended conflicting incentives built into benchmarks, and total cost of care calculations for shared savings and losses that can also affect care delivery. These incentives may conflict across models, including episode-based models that are currently being implemented and tested separately and siloed.

For example, the definition of which services are included in total cost of care can potentially incentivize cost-shifting. Consistency in the technical implementation of incentives may help encourage participation and advanced payment mechanisms.

Next slide. Some actions for integrating specialty care, including nested models, hierarchical models within the ACO global budgets that operate as an umbrella for accountability. But this requires that the rules and technical implementation of key elements such as benchmarking and saving calculations be designed so they are -- they complement those relevant to the umbrella model.

Next, carve-out models, models that separate accountability for certain services outside of an ACO global budget. Other considerations such as mandating provider participation, including specialty participation in population-based total cost of care models. Population-based total cost of care models may not be able to create sufficient incentives to engage specialists in

some cases, due to a limited supply of specialty care in some markets, particularly underserved and rural markets.

Voluntary participation may result in less accountability, integration, and coordination than would be desirable and necessary for ensuring quality and reducing total cost of care. Structuring technical elements of episode-based models so they are better positioned for integration into population-based total cost of care.

Potential structural modifications include extending the duration of episodes into care bundles, making it easier to incorporate long-term quality of care measures into provider incentives, as well as addressing perverse incentives by encouraging participation and coordination between episode-based models, as well as larger total cost of care.

One of the most important elements is encouraging coordination across accountable entities and population-based models to improve care for patients who do see providers in multiple models. If successfully done, this

would incentivize coordination between accountable entities that may be taking on more or less risk.

For example, between ACOs, between advanced primary care models and an ACO, or between multiple episode-based models, as well as an ACO.

Next slide. One of the most important elements of success in a total cost of care model includes timely data-sharing to maximize success. Many commercial population-based models include the ability for providers to monitor real-time data on utilization, cost, and other performance metrics.

Some of the challenges to effective and timely data-sharing in the current construct include a lack of interoperability, reliance on propriety systems, lack of consistent funding for data collection and sharing, and lack of resources or in-house expertise for smaller practices.

A lag of timely data on financial performance in population-based total cost of care models limits participants' ability to accurately forecast or benchmark expenditures

and tempers the incentives in shared savings. Many new generation ACOs have stated that delays in shared savings payments make it difficult to use the potential payments to engage providers.

Some new generation ACOs left the model altogether because they do not have enough information about their financial performance before the deadline for withdrawing in the next performance year. Some ESCOs[8] have cited similar challenges.

For example, one provider stated, "The hard part is you make decisions now and you do not get a straight answer about what your outcome is if the decisions that you made actually worked. So you are working blind in some situations for years at a time."

Next slide. In the next two slides, we'll see some examples of care delivery model innovations. For example, Program for All-Inclusive Care for the Elderly, or PACE, managed care plans, and integrated delivery systems. So integrated delivery systems are

8 ESRD (End-Stage Renal Disease)Seamless Care Organizations

vertically integrated health service networks that include physicians, hospitals, and post-acute services, advanced primary care models targeting high-risk patients, and complex care management models.

Next slide. Some specialty model innovations that are interesting and been tried are CMMI's Comprehensive ESRD9 Care model. This model allows nephrologists and dialysis clinics and other providers to form ESRD Seamless Care Organizations, a type of ACO accountable for clinical quality outcomes and spending on dialysis services for Part A and B spending.

Other models include diabetes care models. The Maryland Total Cost of Care Model provides diabetes outcomes-based credit and provides recognition to Maryland for investing in initiatives and programs that assist with delaying and preventing diabetes over a course of time. Other models that illustrate this are serious illness models.

9 End-stage renal disease

Innovative approaches in PTAC models include -- several previous PTAC models included innovative care delivery approaches with the potential to improve quality and reduce total cost of care, such as primary care medical homes, specialty-based medical homes, remote specialty care support of staff and skilled nursing facilities, as well as nursing facilities.

Next slide. Unaddressed issues in performance measurement are significant. Sorry, measurement and evaluation are a significant part of developing total cost of care models, identifying appropriate time periods. Cost and utilization measures may reflect long-term patient -- may not reflect long-term patient care goals or patient-centered care.

Addressing disparities. As we've seen with COVID-19, addressing disparities is such an important part of care delivery. Performance-based payments may actually exacerbate disparities if measures do not sufficiently account for variation in patient populations that the providers are different

archetypes in different regions of the country.

Data issues. Standardization of data elements. Standardization of data elements, as well as variation in coding uptake and practice, can affect performance measure viability. Selection. Issues related to selection and adverse selection may affect the ability to generalize the results of advanced payments methodologies more broadly.

Refinement of restratification and severity adjustment. Doing and realizing return on investment for many organizations. Return on investment may be difficult to capture if the scope of the advanced payment methodology is broad. Associated cost and savings can't readily be captured or ROI[10] is experienced over a longer time period, making it difficult for organizations to put in the front-end investment.

Smaller sample sizes. Issues with comparison and measurement for a smaller number of episodes pose a substantial barrier to performance-based payment tied to these

10 Return on investment

performance measures, particularly in rural and underserved areas where these are much needed. APMs must also need to adapt and include new measures, as we see emerging health issues occur.

Next slide. So questions for PTAC to explore. How do we encourage integration and coordination between primary care and specialty providers? Which care delivery innovations are most important for increasing provider accountability and quality with reduction in total cost of care, with broad populations, as well as patients with multiple chronic conditions?

How to best integrate episode-based or condition-specific models within population-based accountability care models? How do we integrate referrals for health-related social needs and embed health equity by addressing social determinants of health within all models? How do we balance trade-offs involved in designing population-based total cost of care models that provide best value to patients? And finally, how to encourage and meaningfully support more providers in

participating in value-based care and transitioning to population-based total cost of care models?

Next slide. Thank you, Paul. I will go ahead and hand it over to you.

CHAIR CASALE: Thank you, Chinni. So before I open it up to the full Committee, I'm just going to first ask the other members of the PCDT, Walter, Larry, Lauran, and Lee, if you have anything to add to Chinni's excellent presentation. So please turn your -- flip your name placard on its end just so I know that you would like to make a comment. Any comments? Larry, start with you.

DR. KOSINSKI: I'll start, break the ice and make the comment. The complexity of transferring risk from an organization down to individual providers appears to be one of our major challenges, and we can find entities to accept that global risk, but how do you -- the only way you can really integrate care between primary care and specialty care providers is if they're also sharing in the risk. Current models today are heavily skewed towards primary care having capitation, and specialists still

being paid discounted fee-for-service.

The other major challenges here in design are that not enough of a percentage of the total revenue of specialists is coming out of value-based care arrangements. We have to reach that critical threshold in revenue to specialists, so that they become part of the solution in the care. So these are all significant challenges. I don't have answers to that, but hopefully our expert speakers later on today will give us some light.

CHAIR CASALE: Thanks, Larry. Any other comments before I open it up? Okay, Lauran.

VICE CHAIR HARDIN: So I'll just briefly add one of the really interesting things as we look at total cost of care equity is in social determinants of health, is where does the payment belong as we move out across the community and partnership with multiple providers that we haven't thought of as part of our integrated system?

So some of our speakers today will be addressing that, and it's a very important component as we look at really embedding equity

in all of our models.

CHAIR CASALE: Thanks, Lauran. I'm going to open it up now to all members. So Angelo?

DR. SINOPOLI: Yeah. I would just add to some of the comments, that it's not only figuring out how to include the specialists, but the specialists that are still attached to the hospitals. How do we include the hospital in that risk too, because they typically control the resources, the money, the budgets, et cetera? So --

CHAIR CASALE: Agree. By the way, Bruce and Chinni, if you have comments, just raise your hand and let us know that you have one. Other comments from Committee members? I'd say one of the things, there's a lot of great information that was presented, and but along the lines of how to cascade that accountability, and into what -- how do you -- and at what level, you know, you can have an accountable entity, but then at the sort of the rubber hits the road as we like to, at the provider level.

How are they going to feel

accountable, and how do you do that within a total cost of care model? Again, I'm not sure the best way to do it, but I know that, you know, it often starts with attribution, which we talked about a lot. So that the provider actually understands who they're accountable for.

I think also mentioned by Chinni in the presentation is around adequate risk adjustment, because we know in the past, in the days of HMO[11], there was sort of shifting of high-risk patients as a way to manage a population which, you know, only made disparities worse rather than trying to address them.

So you know two, in my view, important issues that sort of underpin a lot of this. So hopefully we'll hear more from, you know, during the day around lots of areas, but particularly I'm always thinking about the provider at the provider level. For them to participate, they have to understand, you know, who their patients are, adequate risk

11 Health maintenance organization

adjustment, and then how do they understand their accountability within the system.

DR. LIAO: Great presentation, excuse me, and I had a question really maybe for the whole Committee, but maybe starting with the PCDT. I like that schematic that was shown about the care delivery trade-off. There's always put and takes there and, you know, a few slides later when we talked about picturizing kind of what that would look like. There were a few boxes about care pathways and different delivery models.

So I'm wondering in the work to put this report together, was there anything about, as we think about those arrows, showing, you know, flexibility in the care delivery model design, but potential limitation in beneficiary choice? Was there also anything we heard related to changes in how clinicians practice, you know?

There may be flexibility in the delivery model design, but there may be a desire to reduce unwarranted variation. So what would that look like as clinicians practice, as we move to the right of that

schematic, particularly as we can braid that together with this idea of cascading accountability? So, curious, are there any thoughts or comments that came up there?

DR. PULLURU: Yeah, I'll take the first pass at that. So one of the things I think that was articulated in there was innovation and care delivery, but also looking at how do we embed things like telehealth and digital care, both synchronous and asynchronously, and when combined with a care team that would actually leverage all of, you know, the example with the pharmacist, that would leverage all of the touch points that a patient has.

But not just their physician or provider, but with the entire health care system in order to effectualize that care. I think that was sort of the innovation that was discussed, you know, when we were kind of deliberating.

CHAIR CASALE: Lauran.

VICE CHAIR HARDIN: Josh, I'd just add that across the country, in addition to our research and what I'm seeing in practice. So

it's definitely weaving systems together, so it's no longer a problem to have a behavioral health visit occur in the primary care office and weave those together in the same day, and the same in the community.

So right now, homeless services, for example, are separate from health care services. When you weave them together into an integrated system, you stabilize the population much quicker. People get the care in the site where they want to receive it and where they spend the majority of their time, and there's efficiency then amongst providers, and then you get the results.

DR. LIAO: And I think that speaks to, I think, that schematic right below that about the payment trade-offs, thinking about how do we then extend within the first slide, about covered services, and how does that come together and --

VICE CHAIR HARDIN: Yes.

DR. LIAO: --Chinni's point about telemedicine, you know. Is there a shift in how we think about paying for things in the fee schedule and elsewhere? I think that was

something that came out, and the schematic helped me kind of see that, so I appreciate that.

DR. LIN: Yeah. Just to follow up on what's been said, one of the things I've heard and I think we all know from our practical experience is in the U.S., care follows finance, and as a result, incentivizing the frontline providers in the appropriate way in both quality and cost performance is super-important.

That's why we're really excited to hear from our subject matter experts today, who have really innovative care models, but also payment models to support those care model innovations. I think often what we see are care models that are very successful from a quality and patient care perspective, but if not linked with the appropriate payment model, they fail to survive.

CHAIR CASALE: Yeah, I would agree with that. I'm thinking of many of the primary care providers in my organization are still in

a very fee-for-service RVU[12]-based system, and you know, as busy as their each encounter is and all of the things they need to do, it's virtually impossible for them to be thinking more broadly.

So how does, you know, how to switch that payment model so that they can actually, you know, think around the population that they're accountable for? So we're looking forward to hearing from our speakers today about all of that. Other questions or comments? If not, I want to certainly thank Chinni, Walter, Larry, Lauran, and Lee.

Extremely helpful background to set the table for our discussion today. So at this time, we're going to take a break until 10:30 Eastern Standard Time. Please join us then. We have a terrific lineup of guests for our first listening session of the day.

(Whereupon at 10:16 a.m., the above-entitled matter went off the record and resumed at 10:31 a.m.)

12 Relative Value Unit

*** Listening Session on Assessing Best Practices in Care Delivery for PB-TCOC Models (Part 1)**

CHAIR CASALE: Welcome back. I'm excited to begin our first listening session. Chinni and the PCDT helped us level set with helpful, extremely helpful background information. Now we've invited four outside experts to give short presentations on best practices for total cost of care models based on their experience.

You can find their full biographies on the ASPE PTAC website. Their slides will be posted after the public meeting as well on the website. After all four have presented, our Committee members will have plenty of time to ask questions. Presenting first we have Dr. Debbie Zimmerman, who is the corporate chief medical officer from Lumeris. Please begin Debbie and welcome.

DR. ZIMMERMAN: Thank you. So first slide please. I'm going to talk today about a total cost of care model in a Medicare Advantage population. I don't see my slides. Am I, maybe I'm --

CHAIR CASALE: I think they're putting them up. They're just --

DR. ZIMMERMAN: Okay. I'll do the introduction and that will be good.

CHAIR CASALE: Okay, thanks.

DR. ZIMMERMAN: So we're talking about a Medicare Advantage population. One of my roles is as chief medical officer of Essence Healthcare, which is a Medicare Advantage health plan in Missouri and Illinois. It was started by physicians, so first slide would be great. It was started by physicians with the idea that physicians and health plans working together can really provide better care to Medicare beneficiaries, and I think we've been able to prove that over time.

So I'm going to talk a little bit about that model, and it is really based on partnering with physicians around managing total cost of care, of course balanced with quality and access. So this first slide is like -- this is the take-home message, right? These are the learnings.

On the right-hand side are our outcomes. So just to say okay, have we been

able to achieve the results that we're looking for, and we think of it in terms of the Triple Aim Plus One, right? So we do see per capita costs in our population when we compare to traditional Medicare. Risk-adjusted, adjusted for age, gender, you know, geography, risk, chronic conditions, et cetera, we were able to lower costs by 26 percent. I'm going to talk a little bit about how that happened.

Quality. Well, we've been four and a half stars now, those of you that know star ratings, an imperfect measure of quality, but it's a reasonable one. Measures quality of care and quality of service, which is the way we think about it, right? We're actually a five-star plan this year, so very excited about that.

We've got the consumer experience, five-star, and PTAC survey and a member satisfaction survey, very low disenrollment. So evidence of a great consumer experience and our providers are very much aligned with us. So given those outcomes, what is it that drives those outcomes, and I know we're focusing on that first one around total cost of care.

So what did we think drove those results? So we did a study. The way our plan works is every physician is in a medical group, because in order to have total cost of care incentives, you really need an actuarially credible population, so you have to aggregate lives. In addition, one of our drivers we'll talk about is that you sort of need that learning environment and mentoring environment. You need that in order to perform work, right?

So we looked at each of these groups, and we said what were the drivers of performance, and we used total cost of care as the outcome, and these were the six drivers, and these six drivers actually predicted 90 percent of performance, because there's large variation between the groups we looked at.

I'm going to go through each of these. That's really what I'm going to talk about today. So not surprising first to aligned incentives. The first one is that contract between the payer and the provider organization. Second is, how does it trickle down to the individual physician? How am I incentivized?

The third one, which is the biggest lift, is actually changing the way care is delivered, and we spent a lot of our time thinking about that, and that is the heaviest lift. We think core to that is the delivery of accountable primary care. We think that the biggest lift is changing the way primary care is provided, but the rest of the delivery system needs to change as well.

Enterprise engagement means there needs to be some commitment, right? If I only have a couple of my patients that are in a value-based care, a total cost of care contract, and the rest are in fee-for-service, I'm not going to make the changes I need to make in my practice. As a health system, I'm not going to make the changes, the investments that need to happen if I don't have that commitment.

Leadership in government, really, really key for all the physicians in the group, right? Getting people to change behavior is very hard. Getting physicians to change behavior, potentially harder. You really need great leadership, and then lastly the right

information. So I'm really going to talk about these things. These are what I think is core to total cost of care management.

So the next slide. I already described on the left-hand side our model. Our model is every patient has accountable primary care, but accountable primary care is in the group, and every group is in a value-based contract. All of them, 100 percent have total cost of care incentives balanced with quality and access.

Complete, complete transparency. The payer and the physician groups are totally aligned. Everything is included in that contract, and they understand exactly how it works. And we invest. We're going to talk a little bit more about that, so next slide.

A great example of what does it mean to manage total cost of care? We spent a lot of time saying what's the difference between an unmanaged population and a managed population, because the more we know about that, the more we know what programs to develop, the more we know where to focus.

This basically says risk score on

the X axis, cost on the Y axis, compared to traditional Medicare. Lower costs for high-risk patients. We all know that. Spend a lot of time, complex case management, end of life, reducing readmissions. We know that. The thing that warms my heart that really speaks to population health is you have to invest in the low-risk patients, significant increase in investment and services in those lower-risk patients. That's population health, right? Everybody.

We've never seen a medical group be successful in total cost of care in Medicare, if they don't see at least 95 percent of their patients once a year. It just doesn't work.

The next slide talks again about how this 26 percent reduction occurs, but it's not an overall equitable reduction. Decreased inpatient, increase outpatient, decreased specialty, increased primary care. It really does change the distribution of costs.

Next slide, please. Talk really quickly. You'll be able to get a chance to read these slides, and you can certainly ask questions. But I'm going to talk quickly now a

little bit about each of these different drivers. On the left-hand side, the aligned incentives between payers and physicians.

We've talked about it, total cost of care, complete transparency, making sure that the level of risk meets the providers where they are, putting a provider group at full risk and having them pay the payer back just is not a sustainable model, and then really investing and helping them perform is really key.

Again, balancing those total cost of care incentives with quality and access is also really, really important. And then on the right side how it trickles down. We spend a lot of our time working with physician groups. It's out of our control how they pay their docs. But we spend a lot of time working with them on how to put in place a really fair and equitable compensation model that incentivizes, you know, shared learning, shared accountability, improvement of everybody, right?

You don't just want to reward those that are high-performing. You want to figure out how to take, we like to call them high-

volume, high-opportunity providers, those -- and how to mentor them and improve their performance.

So a mix of, we're a group, we're sharing together in how we perform. That makes us accountable to each other, but also I've got to have some skin in the game as an individual physician, right? So we spent a lot of time talking about that with our groups.

Next slide. This one could be a whole hour, and 10 minutes is tough to fit it in. This is really how do we change the delivery of primary care, and how do you change the way care is delivered? We spent a lot of time. Yes, care management programs, those described on the right are really important. In my experience, if you don't change the way care is provided, these care management programs will not get you to that 26 percent reduction in overall costs.

That physician and that patient, that APP[13] and that patient, that team and that patient, you have to change the way that care

13 Advanced practice provider

is delivered, and you have to change the way obviously that patient also is caring for themselves. So really, really important.

We've spent a lot of time and defined what we think the hundreds and hundreds and hundreds of activities are that are necessary to deliver accountable primary care, what the attributes are to deliver accountable primary care, and we work very hard with groups to make this change.

Next slide. This is really just a description of some of the investments we make. We put feet on the street. We put people in the offices with one purpose and one purpose only, and that's to help them change their practice to produce those outcomes that we talked about earlier. That's everything from the way they schedule to, you know, pre-visit planning, daily huddles, you know, how to actually work with your team.

So everybody practices at the top of their license. How to work with APPs and make sure that your, you know, your patients are getting the best care possible. We have something called rapid practice transformation

where we work with offices to help change the way they practice, and we even have a boot camp for providers.

Welp, that's my time. Next slide. I have my, I had my timer on. So okay. I cannot emphasize leadership and organization. Really key, I already said. Key, we invest in these. You need mentors.

Next slide. This might be last one. Oh, you can skip this one. But it's really important that you have the right structure and that data does trickle down, and the last one is having the right information. I need to know how I'm performing at the population level, because if you ask me, I think I'm doing great. I need to see where my opportunities are as a system and as an individual physician, and then when I have that patient or individual in front of me, I need to know about that individual.

What are their gaps in care? What is their care across the continuum? Have they been taking their medications? Have they been in the emergency room? What specialists have they seen, and we believe need to have insight

into the cost of care? How can we hold physicians, providers accountable for the cost of care if they don't have insight into the cost of care?

So in our model, they have that ability to drill down to the claim level to see the cost of care. I think that's my last slide.

CHAIR CASALE: Thank you, Dr. Zimmerman. Great presentation. We're saving all questions from the Committee until the end of all presentations, so we'll hold our questions for now. So next we have Dr. David Kendrick, who is a principal investigator and CEO of MyHealth Access Network. Dr. Kendrick, please begin.

DR. KENDRICK: Thank you for inviting me to give this presentation today. I'm the CEO of MyHealth Access Network and the Health Information Exchange for Oklahoma. I also chair the Department of Medical Infomatics and just awaiting my slides here. Other disclosures. Immediate past chair of the board

of directors for NCQA[14] and also -- next slide, and also on the board of something called the Patient-Centered Data Home.

Next slide, please. Next slide. So our experience with the models from CMMI is pretty extensive. We were originally in CPC[15] Classic, CPC+, AHC[16] as well and now entering into Primary Care First, and so these are hopefully practical lessons learned from on the ground work supporting, really picking up where Dr. Zimmerman's last slide ended, which is with information technology infrastructure.

Next slide, please. So there are five categories of lessons learned I want to convey to you today with some sub-bullets, and I'll try to get through them all.

Next slide. So the first was multi-payer models. We've really enjoyed those and CPC Classic -- I'm not sure. Where am I? All right. So in -- back one, please. Thank you. So in the CPC Classic, of course we had multiple payers, and one of Dr. Zimmerman's

14 National Committee for Quality Assurance
15 Comprehensive Primary Care
16 Accountable Health Communities

principles, most of the patients and every participating practice were in the model, and that also brought lots of infrastructure to bear.

However, it also created a burden for community convening and governance, to help those private commercial payers work together with a large, one of the largest federal government agencies to do this work.

Next slide. And the -- on the model execution side, so now we're into the weeds of what technical changes we were able to make, first, the scope of data available to providers is critical.

Next slide. And we always thought about claims data being a mile wide but only an inch deep, and the data in each clinic being a mile deep but only an inch wide. So real patient data looks like this, and this is the role of our organization, is serving as a help data utility, to make sure that the full picture of each patient's care is available, and of course the more -- the sicker the patient, the more fragmented their data, and that's really the theme of our work.

Next slide. Then of course 20 percent of commercialized changed payers every year, which essentially is a death and birth event from the perspective of that payer with data.

Next slide, please. We quantify that data rigorously in -- that fragmentation rigorously in Oklahoma. We show about 70 percent of every patient encounter, I mean 70 percent of every patient seen, has data in more than one clinical location. That's actually over 90 percent now, we've updated it.

This corroborates, is corroborated by data from MyHealth that show that the average PCP[17] has to coordinate care with 225 other providers in 117 other organizations, which makes this infrastructure critical.

Next slide. And you have one chronic disease, that numbers goes up. Two chronic diseases is virtually 100 percent fragmentation.

Next slide, please. Even when we take large EHR[18] vendors, including Epic and

17 Primary care provider
18 Electronic health record

Cerner, that fragmentation is about the same, about the same 70-30 split, and it only grows. That fragmentation only grows.

Next slide. This is our network in Oklahoma. We have more than 1,400 locations connected with live flowing clinical data, as well as claims and other types of social needs data. More than 110,000 clinical encounters a day statewide, and as you can see, if you read the bottom, it's more than just hospitals and clinics.

We're talking about mental health facilities, pharmacies, long-term care, urgent care and even social service agencies, and this is critical because just looking at EHR data doesn't get this job done.

Next slide, please. However, the data in MyHealth looks like this. These are patients who received care in Oklahoma at some point in the last two or three years, which means these patients are moving around, and we have to have a national look at this data in order to provide comprehensive care.

Next slide, please. We provide patients and our providers with a common look

at a patient chart. It's a summarized version. It's cleaned up and organized across all of those sources of data, clinical data.

Next slide, please. The next concept aside from data is that patient attribution is a difficult concept for providers, and it's not accounted for usually in the internal analytics of the EHR.

Next slide, please. So what happens here is MyEHR tells me about patients I've seen in the last 12 months, but Blue Cross thinks my patients are attributed via a different set of logic, and Medicare models each have their own models and Medicaid, and each commercial payer assigns patients to me differently.

So you can see that quick, very quickly providers have a majority potentially of the patients they're obligated or accountable for outside of their line of sight. By "line of sight," I mean they're not seeing them automatically in their quality measures, and they're not seeing them in their denominators.

Next slide, please. Alerting in sentinel events, of sentinel events is

critical.

Next slide, please. So this is care fragmentation alerting, somewhat like ADT[19], an advanced version of ADT alerting. Tells me of all my patients seen or touched in the last 24 hours and what activity that was, no matter where it was.

Next slide. Next click please. 30 days readmission monitoring. Tells me immediately when my patient registers for care somewhere or an impending 30-day readmission, whether it's in ER[20], urgent care, et cetera.

Next slide, please. Performance measurement and reporting. Our lesson learned here is that community-wide quality measurement is required to assess true performance results.

Next slide. So MyHealth serves as a health information exchange, and health payer utility is a trust third party for measurement. We sit in between the payer and the provider, and indeed among in between the social service agencies as well, and then in that capacity serve as both the health information exchange

19 Admission, discharge, and transfer
20 Emergency room

in an all-payer claims database. We're able to take the most relevant and recent data from multiple sources to calculate the quality measure, and here's why that's important.

Next slide, please. So recall this diagram. These same patients, if they're all diabetes, have diabetes, they're going to have multiple hemoglobin A1cs taken over the course of the years in all the different clinics where they work, where they are seen.

Next click, please. And as you can see, each of those EHRs are going to report a completely different set of quality results, based on the hemoglobin A1c that they can see. It's the classic blind man and the camel problem, and they're each going to describe different components of the animal.

And so that -- what the problem is here I've got four patients. I've got 11 different measures of performance. Which one is true? Well, the fact is none of them are true.

Next click, please. However, that's the state of the art today. So if you take that table, turn it on and decide that's the

upper left chart, you can't add that up to a population number. You can't tell me at the belly button level what performance is for this population, whereas in a Health Information Exchange, the health data utility, we take the most recent result for each patient and uniquely calculate that patient's status.

Next click. And so in Oklahoma, we know everybody who's in control, out of control, or excluded from a measure, and then we can use our attribution logic or the attribution logic provided by each of these stakeholders to determine what the performance is, and you can see each of those calculations of performance on the right. They're very easy to make, once you apply the attribution logic.

This is the way we handle quality measures. You can see there are also geographic regions there. That's public health basically, and even employers engage.

Next click. Other things about performance measurement. One of the real downsides to total cost of care models is this incentive it creates to fire the sickest patients and avoid having sick patients on your

panel.

So I think there's an opportunity here to incent providers to take on the sickest patients, if you start to measure and reward deltas in performance. Counts of patients that improve versus counts of patients who did not improve, and start to apply that approach to measurement at least for a component of the model.

You should use common metrics across all models, and that goes without saying, and more rapid and interim final results so that we don't have to end the model, lose all the infrastructure, and then scramble to rebuild it. We really need more real-time quality measurement and so on, and that's possible with this infrastructure.

So next click. Some specific model feedback. Of course, we have the cost models that we can report on by service line, and this is across all payers. That's critical for practices to understand and for them to study each payer's proprietary reports.

Next click. So the next click, next set of items are about model-specific results.

So CPC and CPC+, we found – next click – effective care coordination requires health information exchange, and we also submit electronic referrals.

We studied this extensively starting in 2007, and this was really the process of making referrals of patients across a community, especially where patient referrals are happening outside of an organization.

We found thousands of referrals that were simply dropped, and everybody's aware that at the end of the year, staff are on the phones calling clinics, trying to close loops on referrals simply to meet that metric. That's artificial in our opinion.

Next click. So we studied and found that there are about 25 unique states a referral could be in, and if you have an electronic hub in the middle that could monitor these states, next click, you could have a workflow like this wherein the sending and receiving provider, whether they're a PCP or a specialist, doesn't matter.

But sending and receiving can coordinate all the steps of that referral, and

even feed that back into the electronic health records system.

Next click. Then we were able to demonstrate significantly improved rates of loop closure happening behind the scenes with the machines handling tracking of the results of that, rather than labor-intensive phone calls.

Next click. The next item here was to leverage that infrastructure to do electronic consultations, to enable specialists as consultants to triage the cases, to make sure they needed to see them before they saw them. This has become critically important to practices when they take on risk, and what we were able to demonstrate using this workflow –

Next click, was a significantly, a significant cost reduction within each patient from before to after their consultation, as well as across all populations, those who received the electronic consult versus those that did not for $130 PMPM[21] cost savings, comparing those two populations.

21 Per member per month

Next click. We also were a part of the AHC model. Next click. We actually were able to put in place a model that could reduce provider burden for screening social determinants of health.

So this shows that just like clinical data is highly fragmented, so too is social services, social determinants data, and you can see these – if a patient needs a food pantry, they are very likely to need housing or transportation or other social services. So we set about trying to defragment this data as well.

Next click. We put in place a mobile screening system triggered by what we uniquely knew as a health information exchange, that is, the patient registration for care, delivered a screening to the patient's phone they complete while in the waiting room in under three to four minutes. They complete that screening. We score it immediately.

Next click. Next click please. Then if they're positive for a social need, we have a database of almost 5,000 community services across the state of Oklahoma tailored,

and we're able to deliver back – next click – to the patient's phone a tailored referral to meet their needs as closest to them or nearest where they're sitting physically at that time, and they can simply click a link and be talking to the food pantry or the housing service while they're still waiting to be seen in the emergency room or the clinic.

We also feed this data back into the practices so they're aware of this information. Next click. So we've now offered more than 2.8 million actually offers for social needs screening. We've had over a half a million responses, and we've dealt with 100,000 social needs at this point and referred them for services.

This scaled very well and turned out to be a COVID-proof process, as people had their phones even during telemedicine.

Next click. And so we can tell by – very granularly where social needs are by sites of care. Next click. By payer type as well, and we show of course even commercially insured patients have a 17 percent rate of social needs in our community, and this is of great interest

to those populations.

Next click. So we've demonstrated we can work with clinical data, claims data, and now social determinants of health data. We put the three together into this site, the virtual cycle of improvement.

Our biggest challenge now is that these models are ending, and so our social needs screening program has nowhere to go. It's ending.. We're working on sustainability, but all the indicators are that it's going to be a positive result for the model, but at this time, there is no follow-on model to extend it.

The same thing with CPC+. Data aggregation ended for us in 2021, so we've given up the ability to work with that claims data unfortunately. However, when we put the three together, we've been able to demonstrate -- next click please -- maximal impacts.

So for example, when we compared practices in CPC+ who also participated in AHC and did the social determinants of health screening, you can see the blue line there. Significantly different cost trend for those practices.

Next click. And utilization of emergency rooms among the practices who participated in the social determinants of health screening, as well as CPC+.

Next click. So the sweet spot is putting all of these together, and next click. You can see the three on the left. The daily visits of my patients on the upper right, the total cost of care in the middle on the right is the trend of cost spend, and the lower right is the trend of this patient's social determinants of health needs, social needs, and then I'll start to wrap it up.

Next click. Same patient -- different patient, different cost trend, different emphasis. Next click. And so -- next click. What we were able to show was that dwell time was one of the most important things as we move from CPC Classic to CPC+. Those practices in red moved through CPC Classic into CPC+ and had a different start time.

So I became convinced that the dwell time in these models was one of the most important interventions, and over time, everyone could achieve these results if they

just had enough exposure to it.

Next click. This was the same information but for cost trend. Next click, and then I'll close.

So next click. So one of the things that I, we've observed in our community is we spent 10 years building this infrastructure hand-in-hand with these CMMI models, using them as the direction to build this infrastructure, and really believe that this serves as a great laboratory for rapid start-up of these models, quick evaluation, and the ability to iterate quickly on those results, and then finally a channel through which to deploy those results.

Thank you, guys, for your time, and I'll be ready for any questions that may come along.

CHAIR CASALE: Thank you Dr. Kendrick. So now we have Ms. Yi-Ling Lin, a health care actuary and financial strategist, who joins us from the Terry Group. Please go ahead.

MS. LIN: Hi, good morning, good morning. Thank you for having me today. My presentation is going to be a little bit

different. It's going to be pretty high-level. I know numbers sometimes scare people, but I'm going to try to boil it down to a couple of different sort of fundamental principles that we've learned as we've worked with our clients.

I am a consulting actuary, and our clients tend to be hospital systems, physician groups, also payers and employer groups. So we've seen this sort of thing from a variety of different perspectives within the industry.

So next slide, please. So what I'd like to concentrate on today are three fundamental principles that we've noted, that we think that will really move the needle if people sort of pay attention to it. You know, what we don't want to do is be moving our chairs on the deck of the Titanic, right? We really want to be steering the ship to try to avoid that iceberg.

And so a lot of things we feel like right now are geared towards trying to just do short-term benefits and really lose kind of the long-term focus of trying to improve the health of the entire country and our populations, and bend that cost curve for the long term.

So the first thing I'm going to talk about is the use of historical data, and what I feel is an over-reliance on it. Data is really important, don't get me wrong, but there is just this crutch that we're using that really says that we are trying to look in the past and expect that the past is going to be totally indicative of the future, and I don't think that's actually true.

The second thing I'm going to talk about is this one-year time horizon. So everything in the industry right now, the way that people get paid, all the quality measures, everything is on a one-year time horizon, but we all know that health care is not a one-year time horizon. So there's this mismatch that's going on there.

And then the third thing I'm going to talk about is the use of risk scoring. So risk scoring or risk adjustment is that mechanism where we try to assign a value to somebody's health status, and then we actually use that for a variety of purposes within the industry. So these are again only three fundamental principles. There's obviously a

lot of other things that are very important, but we're going to concentrate on these three today from an actuarial perspective.

So next slide, please. So using historical data, as I said what I believe is that there is an over-reliance on historical data. So my experience with working with our payer clients and our provider clients is that they ingest all this data, which is very valuable, but then they set measures for next year based on those historical measures, and they might say something like well we -- and I'm going to use some really round, non-realistic numbers but just easy to follow.

So my cost per patient per month is $100 from last year from my data, and let's try to hold the trend so that next year the cost is no more than $105 per month per patient. And so that ends up getting into contracts, value-based contracts where that measure, that 105 is the target.

Well, that's an anchor to the past. That's not really a direction for the future. Is $105 really the right amount, or is the right amount really $85? Or should it be $125

if we increase a bunch of preventative services and things that are not being used appropriately?

So that trend number anchoring on historical data I think is misleading in the sense that we really need to find something in the future that says what we really believe that utilization of the health care services and costs in the future should be some dollar amount, and then putting a plan together to get some Point A where we are now, to where we think we should be in the future, not always anchoring to where we are or where we have been.

The second thing that I've noticed that happens is that that $105 target amount that's for next year really penalizes organizations that do really well in total cost of care arrangements. So what happens is, you know, everybody starts, and let's say we're going to start everybody at that $100 historical data, and next year we're going to have you target 105, okay.

So Provider System A meets that 105. Well, great. The mechanism for all these

contracts is that well, now your experience under our plan is $105. So next year we're going to increase that another five percent. So your base is now $105, but Provider System B does better. They beat it, and they come in at $102. Well, the way the mechanism works is now Provider System B is held to the $102 plus five percent.

And so what's happening is that Provider System B is performing better, and yet they're being penalized by being paid less in the future, because we continue to anchor on that historical mark. And so what this encourages is that the systems will say oh, I see the $105 mark. I'm going to barely beat it. So I make a little money on this arrangement so I look like I'm doing well, but I'm really not shooting myself in the foot for Year 2, Year 3, Year 4.

And so I think we really need to evaluate contracts and mechanisms for payment that are based solely on trends. We really need to be looking at benchmarks and where we want to be in the future, and then get that from Plan A to Plan B, so in a spectrum.

The next slide, please. I may be having a lag in my Internet. Are you guys seeing the next slide, that one-year time horizon?

CHAIR CASALE: Yes, we're seeing that.

MS. LIN: Okay, great. So the next thing I want to talk about is that one-year time horizon. So a lot of these contracts and arrangements are based on these one-year measures, as I said.

This is payment, this is quality measures, all sorts of things. And so what happens is that provider systems are constantly asking, well, what's my ROI? Why should I invest in XYZ care management program? Why should I invest in community outreach? Why should I invest in XYZ initiative?

And those questions, while they may be very altruistic and within the mission of those organizations, unfortunately, they do have to answer to the financials. They need to stay afloat, right? They need to stay open for those populations, and so the constant question of what is my ROI measured on a one-year time

horizon continues to come up and continues to impede long-term progress towards serving the population and improving care for everybody.

I think this one-year timeline also encourages a lack of planning for years that are unpredictable, right? So I'm -- because it's a one-year time horizon, I'm always going to assume that next year is going to be a normal year. And so for insurance companies, they don't tend to behave this way, and insurance companies have been around 100 years, some of them.

And so they manage things like reserves, reserves meaning I have a bunch of money set aside for bad years, and if I happen to have a good year, I might be able to release those reserves, meaning I can take that money that I set aside and say, oh, I've had a great year. I don't need to keep this much, right, because I've had a great year. I'm going to let some of that go and let that premium cost go down for next year.

If I have a poor year, then I have this pile of money on the side that can help mitigate some of those high costs. So that's

how insurance companies manage their finances. I don't see the same thing for provider organizations right now. I don't think that that sophistication of financial management has kind of worked its way into that part of the system, and so I think we need to be encouraging that sort of thing.

The other things on the slides that I've just pointed out are things that we all know just from the last couple of years, the crazy things that are happening, right? We have supply chain issues, people having trouble getting the things that they need. We have a situation now where medical inflation is actually above normal CPI[22] which is -- or under normal CPI, which is completely abnormal, right?

Normally CPI, as we've experienced in decades, is very low, and then the inflation is higher. We've actually flipped right now, which is very strange. And then of course, the pandemic and the mental trauma and everything that's going on, and we don't know the long-

22 Consumer Price Index

term impacts of all of that on folks, and we won't know, I think, for a very long time. People turning away care that they should be, because they're afraid of catching COVID and all these other things.

So next slide, please. I think this is actually the last slide, so hopefully I was brief enough. So the use of risk scoring. So risk scoring or risk adjustment is this mechanism that was invented to try to tag a value on every individual that says how much will this person cost either this year or next year. There's two different kinds of risk scoring.

But risk scores were developed algorithmically, mathematically as a predictor of cost. They don't actually reflect somebody's need. So for example, a risk score for some -- for a woman who is currently pregnant is actually pretty high for the current year because we know she's going to have a baby this year, right?

But next year, that risk score should come down, and that's the way a risk score works. It is based on cost. But it's not

actually based on that person's health need. So what happens though is that people are using this scoring mechanism sort of against its intentional purposes. So the intentional purpose was to predict cost, and people are using risk scores to allocate resources towards care management or pinpoint folks that need more, more outreach or things like that.

It is also being used for payment purposes, and so as a provider system, if you've taken on risk for a population, and that risk score for the people you've gotten is artificially low, because those people have not been going to the doctor because they've not been getting their preventative services. That risk score is going to be low because their history says that they don't use services.

But the reality is that person, those people's health needs are actually high, because they have not been using their preventative care and taking care of themselves for their chronic conditions, et cetera. And so there's this mismatch here of predicting cost and what people's actual health needs are.

Now I believe that a lot of risk

scoring mechanisms, and there's a variety of them out there, are starting to incorporate SDOH[23]. But I caution that SDOH measures often in these risk scoring mechanisms right now are based on proxies, proxies such as zip code, proxies based on race, proxies based on income level.

These again are proxies, right? So they don't actually say need. We're just trying to guess as an overall, you know, what's the need of this zip code? But that doesn't actually get down to the individual level where if you're using this risk score to deploy some care management tools or aim interventions at specific people, it's not going to get there, right, because then I'd be aiming at an entire zip code, not a specific person where we know something is truly needed for that person.

So I think investments in the system using risk scoring should be deployed everywhere, and not just to people who are covered under these Alternative Payment Models.

23 Social determinants of health

So often, these risk scores are only used for a specific contract or a specific, you know, value-based system, but what happens at a provider level is you don't actually treat somebody when they come in the door and say, oh, you're part of this contract. I'm going to do this differently, and you're part of this contract, I'm going to do this other thing. That doesn't quite happen.

And so we need to encourage adoption of all these things across the entire population, not tied to just specifically that contract that you're in. So I think my time is up, so I will hand it back over. Thank you so much for having me.

CHAIR CASALE: Thank you. So our last listening session presenter is Ms. Shari Erickson, who is the Chief Advocacy Officer and Senior Vice President of Government Affairs and Public Policy at the American College of Physicians. Her organization submitted a proposal to PTAC jointly with the National Committee for Quality Assurance. Shari, please go ahead.

MS. ERICKSON: Thank you so much for

having me, and I appreciate the opportunity to speak to the group. As was indicated, ACP[24] submitted this model, submitted a model to the PTAC previously, and along with NCQA. Just as a little bit of background for those that aren't aware, American College of Physicians represents 161,000 internal medicine physicians across the country and internationally. We have members that are -- they're general internal medicine physicians, as well as those that are subspecialists in internal medicine as well.

So that's why we were really interested in looking at models that could really incorporate, involve both primary care, as well as subspecialists in ways that hadn't really been introduced before. Our model ultimately -- go to the next slide please -- our model ultimately was recommended by the PTAC to HHS for a five-year pilot to address and refine some of the issues that were raised from the review process.

It was identified as meeting all the

24 American College of Physicians

criterion that are specified by the Secretary for these models, and so we're hopeful that we can continue these discussions with CMMI and others that may try to move some of these aspects forward.

This is a reminder for those that may not be as familiar with the model. It includes sort of a process that first engages the patient with their physician in a collaborative manner to agree that a specialty referral is appropriate, that referral occurs to a specialty practice.

In this process, the specialty practice prescreens this referral and accompanying documentation to ensure that it is truly appropriate, so that we eliminate any potential additional challenges with regard to administrative burden, et cetera, for inappropriate referrals that may occur.

The visit then with that specialty practice triggers an active phase of attribution for this model, and the specialty practice role may vary. They could be involved in co-managing the patient's treatment, they could be the primary manager or somewhere in

between, to ensure the most appropriate care for the patient.

Next slide, please. So in the process of developing this model and then also in terms of the overall input that ACP provides to CMS and other payers, et cetera, on value-based and total cost of care models, we really identified a number of best practices from our perspective to truly help clinicians engage in these types of accountable care arrangements.

A big one, and this is -- I think many of the things I will say now are reflective of things that you've already heard from the other presenters. The measures really need to be focused on a more limited set that are truly patient-centered, actionable, appropriately attributed, and evidence-based for these public reporting and payment purposes.

We also need to find mechanisms to support the use of clinically meaningful measures for internal quality improvement. Incentivizing the use of QI[25] measures really

25 Quality improvement

will allow for greater innovation opportunities and engender trust, which I know came up earlier as well. There needs to be some safe harbor opportunities for practices to engage in innovative types of approaches here.

We do need to move, you know, and that will take some time to evolve us to that place. In the meantime though, we could try to move towards measurement more at a practice level than at the individual clinician level. We at ACP have actually reviewed a number of internal medicine-relevant measures for validity, and we recommend prioritizing the use of those, and also prioritizing the use of measures focused on prevention, things like cancer screening, tobacco, alcohol, and drug use screening, et cetera.

The other thing that we've recommended strongly is that performance targets need to be provided to clinicians and clinical care teams in a prospective and transparent manner, and that this feedback be accurate, actionable, and timely and appropriate, and attribution and benchmarking are critical. This came up earlier in the

conversation.

Voluntary patient attribution is really a gold standard, but patient relationship codes are one promising form of attribution. But absent these, we need robust case minimums that should be used. Usually, benchmarks need to be fixed across all participants. Relative benchmarks, as we've seen, create really arbitrary winners and losers, and we need to use the most current data available, perhaps via shorter performance periods, to try to move this forward.

Next slide, please. Other best practices that we've identified and that are really incorporated into our model are that the primary care and specialty care practices need to be able to work collaboratively to establish a patient care plan. It needs to be customized to account for individual patient and family circumstances and preferences.

This leads to a more, yeah, a mechanism to really truly have patients engaged in their care and be able to, for lack of a better word, say being more, sorry. I'm having some background noise. Being more able to

engage in their care in a way that it actually helps move forward higher quality outcomes.

Also tied initially, an additional piece of this are care coordination agreements between primary care and specialty practices. It needs to be clear that all involved in the patient's care understand their role and expectations.

Actually, we just recently put out just last month an updated policy around this that gets into some detail as to how this can occur, that some of the best practices can be around this, clarifying when the specialty clinician is acting as that patient's primary clinician, or if they agree to co-manage a patient's care.

There are a number of different critical elements and helpful elements, et cetera, that should be engaged in trying to do this. Communication of data-sharing protocols needs to be clearly established within these agreements. These are including mechanisms that ensure notifications are prioritized based on urgency.

These are all things that can and

should be established up front, in order to ensure that these models are successful. We need clarity when the handoff needs to occur back to primary care. There are templates that can be put in place for these types of transitions of care that do account for patient preferences, and each practice should establish an internal plan within that practice that establishes and defines team members for each of the clinical and care coordination tasks.

Next slide, please. So how do we encourage specialty engagement? There are a number of models that were spoken about earlier, where we've had primary care clinicians involved in them, that are a little bit more challenging, I think, to engage specialty care clinicians in a number of models.

One of the issues is that these models really haven't been scalable to different types of specialties, and that's something that, you know, we propose through our medical neighborhood model, is something that could occur, you know, something that could be scalable but also built on a

fundamentally similar framework. This allows it to be understandable, predictable, et cetera, to the primary care and specialty practices.

Communication and information-sharing is critical. Specialty clinician practice should be involved in pre-screening. I mentioned this earlier, all referrals and the accompanying documentation, and I discussed earlier the care coordination agreements. Reimbursement structure needs to be able to support specialty care engagement, and there also needs to -- we also need to ensure that we're reducing unnecessary and duplicative work and administrative burden.

This is why triaging those referrals and having that pre-screening is critically important. Total cost of care models need to incorporate incentives for patients to engage with those that are participating, things like transportation, copay waivers, et cetera, just innovative ideas that we can consider layering into these models. And total cost of care can be reviewed and aggregated in each practice, as well as across both primary care and specialty

care practices.

Next slide, please. How do we operationalize this, and this is something that's laid out in that paper that I just mentioned that we released just about a month ago. It includes critical elements of the referral that need to be included. We need a prepared patient, that's again working together with the patient up front to ensure that they know what's happening and why.

We need to have patient demographics and scheduling information. All kinds of special considerations for that patient should be and can be considered up front, including their language needs, any other cognitive needs that they may need to be addressed, caregiver assistance, et cetera.

The referral information needs to clearly identify what the clinical question is. Why is this referral happening and have the data associated with it. And we outline some core data that should be incorporated in these referrals. And then our referral request needs to have referral tracking associated with it, both in primary care and the specialty care

practices, again through care coordination agreements, to lay out how this occurs and ensure that the turnaround and the closing the loop happens.

Next slide. And a response. So moving beyond the referral itself, and that's really what we delve into in our newer paper, is, you know, there needs to be a clear answer to the clinical question or, you know, addressing the reason for the referral, and there needs to be agreement this is the type of thing that can be laid out through the care coordination agreements.

What is the role of specialty care both now and over a longer term for this patient? And we need to confirm new and existing or changed diagnoses that occur during the specialty practice visit, medical and equipment changes. Also any testing that's occurred or additional procedures, and it needs to be clear what education was provided to the patient and what still is recommended moving forward.

Are there any secondary referrals that occurred, and then can any recommended

services or actions be done by the primary care or the patients that are medical homed that needs to occur following the specialty practice visit?

Can we get next slide? The other thing is there needs to be a clear indication of what the specialty care practice is going to do. What has the patient been instructed to do, and what is the referring -- what the referring physician needs to do and when. This is critical to successful care coordination beyond the referral, and we need to find, you know, easy to find and refer in the response note all of these elements.

Next slide. Moving on beyond this and really something that could be layered into this type of a model is integration of behavioral health, with primary care, as well as with specialty care, if you think about it in the context of a model such as this. The collaborative care model is one model that allows patients to be seen by primary care and evaluated for behavioral health issues, in consultation with psychiatry and then be referred as needed.

And that's a good start, but I'll say the challenge with this is that the implementation of a model like this in primary care is not really supported today. The up-front cost to build the infrastructure to do this successfully is just simply not covered through the existing codes and payment mechanisms that are out there right now.

So how can we consider integrating a model such as this with the medical neighborhood model, allowing even the specialty care practices to engage more fully in the care of patients and those with complex needs?

Next slide, please. The other aspect I want to hit on which came up earlier too in a couple of the presentations is the need to address health equity and social drivers of health. One of the things that ACPs are calling for now and moving forward in particular is payers need to prioritize inclusion of underserved patient populations in these models. We need to do this with every single model.

It's just no way we can figure out how to do it if we don't do it now. We have to

create validated ways to measure the cost of caring for these patients, and I believe this was spoken about earlier as well. Those that are experiencing health care disparities and equities based on personal characteristics, you know.

Those who are disproportionately impacted by social drivers of health. How can we start to figure that out if we don't incorporate them into the models moving forward? And patients and practices and clinicians need to be incentivized to engage in innovative approaches to do this, you know. There need to be safe harbors set aside perhaps for those practices that really are interested in taking on some innovative ways to help do this within their practice.

And actually I'll mention that ACP has more policy on this coming soon actually. We have a paper being released in the next few weeks that will detail some additional ideas around this issue. But it's critically important that it be layered in moving forward to all models.

Next slide. I think that's it. I'm

finished. So I just saw my note to wrap up as well, so perfect timing.

CHAIR CASALE: Great, thank you. So thank you all so much for sharing your experiences with us today. You've certainly helped us cover a lot of ground during this session.

So now I'd like to open up the discussion to our Committee members for questions, and just a reminder to turn your tent cards up when you have comments and questions. Lee.

DR. MILLS: Sure. Thanks so much for those great presentations. I'm interested, Dr. Kendrick and Dr. Zimmerman, if you all can comment on both the complexity of the metric universal process and the critical nature of the timeliness of data, reporting, and financial accountability in a total cost of care environment?

DR. ZIMMERMAN: Sure. You want me to start?

DR. KENDRICK: Absolutely.

DR. ZIMMERMAN: I'll start with my menu you had on payment. So in Medicare

Advantage, you know CMS has done us a favor. They've actually pre-defined a set of quality measures that we're all working on. Interestingly, there's 40-plus measures that go into star ratings. We actually put about 10 to 15 in the physician contracts, because those are the ones that we believe they can influence the most.

Some of them are actually not star measures; some of them are proxy measures like the access to care measure I mentioned, because we know -- for instance, readmission rate is not credible even at a medical group level likely, depending on how many lives they have, and certainly not an individual physician level. But we know that if you follow up within seven days, you will reduce readmissions by, you know, 63 percent in our study.

So what do we incentivize physicians on? That follow-up. So we have those defined measures, wonderful. They're, you know, many of them are, you know, NCQA and we are very clear on the two standard measures wherever possible, proxies when we need to. But to your point about the timeliness, I can't influence a

follow-up if I wait for a claim for readmission. I can only do that if I know someone was discharged from the hospital.

So the ADT feeds in and partnering with HIEs[26] is really critical so that we know, and we have a lot of health systems who say well, we know all about our discharges. Well, yeah. You know if they're within your health system. Fifty percent of your care for your attributed population we know occurs outside your health care, your system. So we need that, and I love the concept of a national HIE, because patients travel, right, and so I love that idea.

And then lastly, I'll talk about timeliness for cost of care. Using claims payment for cost of care, it is retrospective. It is delayed. I have lots of conversations with physicians to say I understand, you know, it's already happened. But let's look at what that trend tells us, and let's identify opportunities. Let's -- it is very, very valuable.

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26 Health information exchanges

Now not to the risk adjustment issue, which I loved, you know, about future care. But at least we can look at trends. Do we have an opportunity in inpatient and outpatient? Do we have an opportunity to care for heart failure patients better? Do we have a Hispanic population that has a higher cost of care, a higher ED[27] visit rate? Let's look at our opportunities.

So that retrospective perspective, I think, is okay, you know. We have a two-month delay, a pretty short delay. That's actually okay for that, but I need timely information to be able to act on it, that discharge, that ED visit. So I don't know if that answered your questions but --

DR. KENDRICK: So okay great. Thanks. So I would make three quick points as well. The first one is in the current measurement approach and the data availability scenario, I think you've heard from all of the presenters about the workarounds that have to be put into place, you know, the proxies in

27 Emergency department

essence for social determinants and other things that most get stuck with.

So I'm in the business of making that data available in real time, and then exercising, acting on that data, because of course the work we're doing is not some blob of 1,000 patients. It's literally a million decisions on a thousand patients that happen every day, that we're trying to influence the most complex system you can imagine.

So having the low-level patient data on each of these domains of information is critical. It's just unfortunate that our current measurement approach doesn't get it done, and we need to be, I think, measuring patient-centric at the community-wide level across all sources, and in that vein then, one of the things we did was on the charter board at NCQA was to focus on shifting the concept from certifying and validating the measures themselves, to certifying and validating the data set being used to do the measurement.

Because the data set can be certified to be complete with all sources of data on the patient's record, and accurate code normalization. Identity resolution can be good. Then we can involve our measurement approach to measure the right things, because as Dr. Zimmerman was indicating, we only have to find a proxy for 30-day readmission, some proxy activity someone can do because there's no way to accurately measure it without the full community data.

The last thing I would mention is the real-time or the more rapid availability of cost of care. I was a medical director at Archimedes, which is a California start-up, where we did full-scale simulations of human physiology and anatomy and predictions of things, and one of the things I worked on there, we actually got a patient done, was using clinical data outputs to drive predictive cost.

And so I really think that with the live clinical data, we could arrive at some conclusions and approaches that would allow us to see what the cost is probably going to be

six months from now when we get the fully adjudicated claims coming back from different organizations, and that that would be a really good directional indicator to provide very early on in the process for providers.

CHAIR CASALE: Great, thank you. I think Jen, you're next?

DR. WILER: I too want to thank all of our presenters for excellent presentations, and just so much valuable information. My question is for you, Dr. Kendrick. It is so impressive what you've been able to put into place, and I think there's a couple of things that we can learn from your experience that I'd like to ask about.

You mentioned that in order to create this impressive system around data analytics that serves up real-time data at the point of care, to help influence decisions and ultimately patient outcomes, requires 10 years of build and infrastructure. And I like the word that you used around "dwell time", and that not only creating the infrastructure is important, but then letting the process work to actually actualize the outcomes.

So this Committee talks about that a lot around a couple of items, and I'd like you to comment on them. The first is around capital to build this infrastructure. It takes -- there is risk in building the infrastructure with delayed opportunity to evaluate its performance. So my first question is or request is to hear a little bit more about capital investments.

And then you mentioned sadly it sounds like the current payment model or infrastructure will be retiring with grants, and that could you -- we also talk often about care model redesign, payment incentives, and then obviously the last factor is sustainability, where we do see high-quality outcomes.

So my other questions or what I'd like to hear more about is what's your sustainability plan?

DR. KENDRICK: Great questions. So let's see. So the last two slides that I did not get to, unfortunately I took too long, indicated, would have shown you that there are 75 other organizations like MyHealth across the

country that are already in existence. They're not all at the same level of sophistication, some more, some less.

But suffice to say that the work at the community level within these states and regions has been done to build these governances. It covers about 290 to 310 million lives in this country already. So there's a substantial infrastructure there, and the good news is it's infrastructure. So it wasn't built specifically to be a research lab for CMMI; it was built because of the interoperability pressures that ONC[28] faces and that the providers all face to meet meaningful use, and they are not just to check boxes in federal government programs.

But we know to avoid making mistakes, to avoid prescribing things patients are allergic to and, you know, doing the wrong procedure on the patient and so on. And so that infrastructure has had a pretty steady -- had steady investment starting in 2009 with the American Recovery Act and the beginning of

28 Office of the National Coordinator for Health Information Technology

meaningful use, and even before that, as much as a decade or two before that, several communities around the country began building an infrastructure.

So I emphasize that this is like an interstate highway system, right? But we use the term now -- we're trying to get away from the term "health information exchange," because it makes it feel like a health care program. We're starting to use the term "health data utility," to indicate that look, this is like clean water or electricity. It's an essential component of every community.

It just so happens that the work of CMMI could build on top of this, could really leverage these things, and that these are not unicorns. They exist in many places, and again I will emphasize it's that base of governance and trust that has to exist in order to build the technology on top. Technology is the easy part generally, and we've been blessed with great governance and collaboration across -- even when we had a state government that wasn't really engaged in making this happen, the community was able to pull it together.

So that's the answer I think hopefully to your first question. I'm happy to take a follow-up on it, and the second question was about, can you remind me, sorry?

DR. WILER: Comments about sustainability.

DR. KENDRICK: Oh yeah, yeah. So we always build, you know, these organizations are generally nonprofits for a reason, right? It's tough to ask everybody, especially say tribal health systems for their data with a profit motive on the back end. So we build these as nonprofit organizations, and unfortunately the major funding for meaningful use to sustain them and continue to grow them ended last October a year ago.

So they're on their own now and into sustainability mode. MyHealth didn't really have access to those funds, but we were able to bootstrap and build thanks to CMMI models, and so as you can see we sort of used -- we think of CMMI models as the stepping stones we've used to expand our functionality, which is why it's even more acutely felt when we have to pull back on capabilities because the end of a

model has arrived.

There was an audible scream across Oklahoma when we had to delete all of the Medicare data from the CPC+ and CPC programs, because we can -- what I showed you, that we're great directional indicators of impact. We'll never be able to finish that research because we had to delete the data behind it.

And really the health data utilities, the only place you're going to enroll the commercial claims and the Medicare claims together in one place to be able to analyze them. So in terms of sustainability in what we've done is say look, we now have a shrink-wrapped product for social determinants of health screening, and we sign up -- in terms of lives, we think we can deliver that service to everybody in Oklahoma.

We've already announced we want to be the first state to have border-to-border universal social determinants of health screening and intervention. We think we can deliver it for 25 cents a screening, which is remarkable when you think about the labor cost it would take just to do those individual

screenings with a human.

So we've put it on the marketplace in Oklahoma, and we're hoping that payers and health plans and programs sign up to take advantage of these services.

CHAIR CASALE: Great, thanks so much. Jay.

DR. FELDSTEIN: Thank you, and again great presentations by all our presenters. I have two questions for Dr. Zimmerman. My first one is I appreciate the cost savings from a fee-for-service comparison, but I'm curious. Have you been able to sustain your trends year over year within your plan, either cost savings or reduced medical trends?

And my second one is what's your approach to your pharmaceutical cost management?

DR. ZIMMERMAN: Okay. So we look at it -- we look at medical costs in multiple ways, and that was just one that was sort of an easy benchmark. But yes, we look at trend. Now, you know, I hope you'll allow me to exclude 2020-2021, because as I say to my CEO, you know, a pandemic is not really good for

medical costs, right?

Either we're underspending because people aren't getting the care they need, or we're overspending because, you know, people are sick. So 2020-2021, excluding those, we do look at our trend year over year, and we have had a significantly lower trend than the industry. So if the industry was at four or five percent, we were -- we were having a much lower trend sometime in the one or two percent.

Now again, did not hold through 2021, so we're fingers crossed for 2022. So we do look at -- we do look at other, other data. The other thing that we've seen, and I'm going to get your name wrong, but Yi-Ling, you can speak to this too, right? We've seen different areas pop up in medical cost. Like I'm old, Medicare beneficiary age, so you know, I remember when inpatient was the majority of the spending.

Well, that's not the case anymore. It's significant, but that's not the case anymore, and we've seen pharmaceutical costs, which is why you're asking I'm sure, increasing both in the medical spend, specialty spend, and

in ambulatory pharmacy. So we do see different things, you know, increasing over time, so we do look at all the trend. It isn't as simple as the overall trend.

And then your question on pharmaceutical cost is I will say interestingly, we have a plan in California and California physicians historically have not taken cost, total cost of care. You know, we think they're very, very advanced, but they take medical cost, but they don't take total cost of care to include pharmacy. We think it's really important to do both, because of course it's important that people adhere to their pharmaceutical regimen in order to manage medical cost.

So we do cover things clearly as a payer. We have our partner, our PBM[29], so we can work with them on preferred networks, on you know, all sorts of things there. But we also work very hard to balance the pharmacy and the medical costs.

So for instance, a few years ago we

29 Pharmacy benefit manager

came out with a zero copay insulin benefit. Why? Because what our physicians told us was insulin was putting their beneficiaries into the coverage gap, and they weren't able to afford it. It was really impacting their overall, their health and the real cost of care. So we invested and said we need to take away that barrier. So we do think holistically about pharmacy costs. We do traditional prior auth and those sorts of things.

But we also spend a lot of time on both technology and programs to increase med adherence and then on the medical side we work in areas, for instance, oncology or rheumatology. We work with the specialists and programs to improve the effectiveness of the care that we're providing there. Did that answer your questions?

DR. FELDSTEIN: Yes, thank you.

CHAIR CASALE: That's great, thanks. Josh.

DR. LIAO: Great. Just one more echo for all the great presentations that will be heard. I actually have two questions for Dr. Zimmerman as well, and maybe I can separate

them because the first one is a little bit, a little bit long. But you showed some very impressive results in Slide 2 and 5, and then I was struck by a word after that that showed up in Slides 6 and 8 around maturity.

This idea that, you know, right out of the gate giving full risk and then paying back to the payers not what we want. And I think in principle that's true, and I'm wondering if you can kind of give us more detail around how you thought about maturity with respect to incentives for early behaviors for managing populations? Contrast that with more mature or later incentives, or the sizes of those? What were those behaviors?

And then kind of related to that, I think you mentioned on Slide 8 that the care management programs were structured in a way based on maturity. So again, how did you assess that, maturity in the context of care management, and how do those supports change over time, kind of early versus late? We'd love the detail on that.

DR. ZIMMERMAN: This has been a huge learning, right? So early on in the plan, our

plan was started by a group of physicians who already were really good at managing total cost of care. They had the infrastructure, they had the data and analytics, they had the case management programs, and they were really good at it.

And it's like great, we'll just provide all the right data, all the right contracts, all the right, you know, and we're good to go. Well, that has not been our experience, and so we have learned the hard way that it is not just -- of the six drivers, it isn't just putting that in place, right? You actually have to understand what it is, what does it mean to deliver accountable care?

So here's what we do early on, and it is a work in progress. I am not telling you we have it 100 percent right yet, because we just don't, and so we're all learning, and I love this hearing from each other, and my mind's sort of going a mile a minute.

But so here's what we do around contracting. To put a group -- so a couple of things. One is you get an actuarially credible population. So if you're starting out in a new

market, and we're opening a new plan, and a medical group only has 300 patients. It is -- it's not fair to put them in total cost of care. Elaine, I'm assuming you'd agree with me.

I don't know what that number is. Our actuaries tell me it's about 1,500 to 2,000. I don't know if you'd agree with that, but something like it. You need it. So first of all, you have to be careful about the number of lives. Even if you have the number of lives to put a group at total cost of care, downside risk I think is not responsible initially.

What we do is we thought long and hard about most behaviors. Now we're using Medicare Advantage as an example here, so I'll use those drivers. What do you need to do in Year 1? Here's what you need to do. You only need to do a few things. You need to number one make sure that you document the chronic conditions, right? You need to document the chronic conditions so that you get an accurate premium the next year, but you also need to know. We need to know who your diabetics are. We need to know who the diabetics are that have

complications, and we can't manage the population without that, so we need to know that.

Second is we've got certain quality metrics that the star rating Year 1 is that performance period. We've got to start working on those. We've got to put in place that collaboration, that leadership, that shared performance, that accountability, those incentives, all of that in place. We've got to put that in place.

And then it is about two things: access to primary care. You've got to see all your patients, and you've got to see sicker patients more, and in our model we like our primary care physicians to see their patients at least as often as they see a specialist. It isn't that they don't need to see five specialists; if they need to see five specialists, they need to see you just as much. So we do a PCP to specialist ratio, and we look at -- we look, try to get that to about one.

Follow-up after discharge and the access to care. Call me first. Educating the consumer. Making sure that they understand

your world, as their primary care may be different than it was last year. Let's talk about what I'm going to do for you and what you're going to do as well. You have some accountability in this too, right?

And then the fifth one from Year 1 is around managing those highest-risk patients. Like let's start with those, right? Let's know who they are, not necessarily just using a risk score. I agree with Yi-Ling. We have, we have a methodology that looks -- because there's a lot of people with very high-risk scores that we can't do anything about, right?

If you have a transplant, you know, we could maximize our reinsurance and our contract. We probably can't change the trajectory of your disease. Who is impactable? Who do we find that's impactable? Let's identify those people. Let's manage those. Let's put in place complex case management, end-of-life programs, transitions of care programs, those sorts of things.

But that's it. Let's work on those things. Let's put those things in your contract, right? And then over time evolve,

and that's come from a lot of learnings. So maybe I answered both your questions.

DR. LIAO: Thanks, that's very helpful. My second is I think hopefully quick. I've raised this issue of kind of how alignment occurs down to the level of clinicians or clinical groups, and in one of your slides, you mentioned that the goal for physician compensation is 30 to 50 percent under value, under value-based compensation.

I'm wondering if you can comment on maybe two pieces of that. One, those results that you showed, the impressive results, was that at that goal? Were you able to achieve those even short of it? And two, have you found that, you know, the results track with the level of compensation, or is there a threshold that you're seeing that we would need to get to to see those results?

DR. ZIMMERMAN: Yeah, yeah, yeah. Now you're asking questions about human behavior, right, and what incentivizes human behavior. I think that we did see that those groups that had the 30 to 50 percent compensation performed better. But it was --

is it because that's how I'm paid? Sure. It's also -- think about it, and we've heard this from many presenters. It's also where resources are devoted. It's also where information is shared, right?

We're all working towards those. It's a priority for me, but it also is a priority for my organization. And so we're all working in the same, in the same way. I do like to say though that people and physicians, physicians are people, are incentivized by a lot of things, and let's remember that.

And you know, you'd like to be recognized for your good performance. Here's a really, really quick story. I've given awards among our 12 physician groups for the highest performance on clinical metrics. One year I gave, and that was the year of the winter Olympics. I gave medals: gold, silver, bronze. I brought a little step stool in. The gold team, you know, the gold physician medical director stood up a little higher than the other two. It cost $35. That silver team said we're going to get you next year, and they were number one the next year. And we're like go

ahead and compete. .So don't forget that there are other things. We want to do a good job. Physicians, for instance, that work for a health system may think very differently about their goals in life than an independent physician group. So we want to model that compensation so it meets individual goals.

DR. LIAO: Thank you. As a human, a physician, and a behavioral scientist, I appreciate that.

CHAIR CASALE: Thank you. Walter.

DR. LIN: I also wanted to just extend my gratitude to all the presenters. All very informative, it was really good. My question is also for Dr. Zimmerman. It strikes me that one of the important tools, Essence and indeed all Medicare Advantage plans have at their disposal to achieve their results is that of a narrow provider network, one consisting of higher-quality, lower-cost providers achieved through contracting and credentialing. This is a tool that has historically been missing in CMMI, value-based demonstration projects, as one of the key tenets of CMS has always been the preservation of provider choice for

Medicare beneficiaries.

My question is how essential is a narrow network of providers to the success of the impressive outcomes from Essence and Lumeris you shared with us, and do you think it is possible for CMS to move to a world of value-based care without somehow limiting provider choice?

DR. ZIMMERMAN: Yeah. Hi, Dr. Lin. It's a great question and one that I think we are going to be able to answer, because we are going into other markets with different products that will have larger networks. So ask me in a year or two, and I'll have a real answer for you. Now it's a hypothetical.

So I think than narrow, it's a definition of engaged. I think you can have a broad network if the physician organizations are actually engaged and committed to managing the population, and I will say in St. Louis you know this very well. We actually have almost every health system in our network, and that's from a primary care perspective. And then from a specialty perspective, I think the same thing goes. If we have an engaged primary care, what

we have found is we can have a very large network of specialists. We can even pay them a premium, higher than market, because they're going to see the more complex patients.. They're not going to see the, you know, the sort of less complex patients so they may see fewer patients.

But those that they see will be more appropriate, and we'll make sure to give them a premium for caring for those patients and coordinating care with primary care. So I do think we can get there without it. I think those other levers are ones that we really need to think about. Whether it be referrals, utilization management, ability to pay differently.

Yes, I think without some of those levers, I think it will be difficult to achieve those savings, and then lastly, I'll say maybe we don't need to get 26 percent savings either. I think we'd all like to mitigate our trend and see some, we'd love to see some downward. But we can all do this together and really help solve this problem for our country.

CHAIR CASALE: Great, thanks.

Larry.

DR. KOSINSKI: Well, I'm going to split the questions around a little bit and not pick on Dr. Zimmerman anymore. I would like to ask Shari a question, and I have to preface this by saying I was one of the subject matter experts on the ACP document that you referenced, most of which you talked about was structural.

But have you done much work on the payment model associated with your recommendations?

MS. ERICKSON: Sure, yeah. So, we really haven't had an opportunity to do so because there hasn't been an opportunity to implement it within the Innovation Center or with others at this point. So we'd be very interested in doing more along those lines and we -- and so, you know, I think that that's something that it looks maybe we can have somebody else who could comment on this as well.

But we have not had an opportunity to do a lot more testing of it, other than what's laid out in the detailed proposal.

CHAIR CASALE: Dr. Kendrick, did you have your hand up?

DR. KENDRICK: Yeah. I was just going to comment. I also participated early on in the development of this ACP model, and our experience on the ground was that what you're asking providers to do, especially in this triage event that the specialist might engage in, is really kind of a fee-for-service activity to get their attention to it.

And we found that something on, you know, Level 2 kind of Level 3 payment would get the right level of attention to these consultations to get them dealt with, so that we could have a guaranteed dermatologist opinion within 48 hours, for example, and we did that across thousands of referrals. So just to give you some, some ballpark.

MS. ERICKSON: And to add onto that, I would say we have continued discussions among our subspecialty societies to engage interest in doing some testing of the model. So there is interest out there along these lines should we be able to move it forward.

DR. KOSINSKI: Thank you.

CHAIR CASALE: Angelo.

DR. SINOPOLI: Yeah. My question is again for Debbie, and so thinking back to your comments about the specialty care, particularly in more tertiary systems for the specialty care patients. So it's low percentages of those are actually at-risk patients. What are you doing or what have you seen in terms of being able to engage those specialists to really participate with a primary care doctor around driving value?

DR. ZIMMERMAN: Yeah, it's a great question. So as always, and I think you heard this from all the presenters today, we're trying hard to use our data to direct us as to where the opportunities are. And so for instance we find our -- Dr. Fusco is our medical director for Utilization Management. Let's just it's the three O's and the C's. It's cardiology, ophthalmology, oncology, and orthopedic surgery, and then we see a lot of dermatology.

So we try to focus on where the opportunity is, where is really the opportunity to educate and train. It varies, but the

majority of time we find that specialists are our best advocates here, who will meet with primary care physicians and say look, you know.

When you're presented with this problem here, let's develop, you know. We can develop some clinical governance or, you know, here's how you care for this patient. Here's, you know, try this first. Use conservative therapy first. I don't really want to see them until you've done XYZ and educate them, and then -- and that conversation can happen.

I do find a lot of -- we also, we've also been using data, episode grouper data and then some other data around unnecessary care to identify opportunities with specialists, and to me that data goes first to the specialists. It does not go to the primary care to try to change referral panels.

This goes to the specialist first, number one to ensure that the data's credible, number two, we need everybody to get better. We will not solve this problem by saying oh, we've got, you know, 30 percent high-performing, you know, cardiologists. We're going to send everybody there. That's not

going to -- that's not going to help. We have to get everybody to improve. So to me, that data goes to the specialists. The specialists vet it, the specialists identify opportunities. They work together to improve the care both within their subspecialty, as well as the way they interact with primary care.

CHAIR CASALE: Great. We have about two minutes left. I have one question for Yi-Ling around benchmarking. I thought you had a lot of interesting comments related to the challenges of using historical benchmarks. I'm just curious your thoughts of alternative ways of calculating benchmarks, and how do you take into account improvement over time that's likely to occur for those who are in a value-based arrangement?

MS. LIN: Yeah. I think, don't get me wrong, but historical data is very important for getting a frame of reference, but I think there's an over-reliance on it was my point. And so for benchmarking purposes, we want to look at where you're at, and we want to look at where we think you can be. Maybe the best-performing provider systems in the country,

looking at specific measures to say what are the desirable readmission rates, what are the desirable, things like that, and then -- and build a path between the two. So, I don't think that always anchoring to the past or to your immediate results, or the results of your neighbors is always the best. Let's try to find what the ideal state is, where we are currently at and build that bridge between.

CHAIR CASALE: Great, thank you. So at this time, I want to thank again our panel and all of our speakers. Just terrific presentations. I think we could keep this discussion going much longer. But we need to take a break, which we are taking now until 1:00 p.m. Eastern Time. So please join us then.

We have a great lineup of guests for our second listening session on assessing best practices in care delivery for population-based total cost of care models. Thank you.

(Whereupon at 12:00 p.m., the above-entitled matter went off the record and restarted at 1:01 p.m.)

*** Listening Session on Assessing Best Practices in Care Delivery for PB-TCOC Models (Part 2)**

VICE CHAIR HARDIN: Good afternoon and welcome back. I'm Lauran Hardin, Vice Chair of PTAC. I'm pleased to welcome our second listening session on assessing best practices in care delivery for population-based total cost of care models. We've invited four outside experts to give short presentations on their vision for population-based total cost of care models, based on their experience.

You can find their full biographies on the ASPE PTAC website. Their slides will be posted there as well. After all four presentations, our Committee members will have plenty of time to ask questions. Presenting first, we're honored to have Dr. David Grossman, who is the interim Senior Vice President of Social and Community Health at Kaiser Permanente. Please begin, David.

DR. GROSSMAN: Great. Thanks so much, and thank you for this opportunity to present Kaiser Permanente's total cost of care model today. I'm a pediatrician, and I lead

Social and Community Health, where our team oversees integration of social health assessment and interventions, so that we can provide socially informed care to our members, and this is of course done to KP's work on health equity.

Next slide, please. For those that you are -- that are not familiar with Kaiser Permanente, really a quick primer. We are the largest private nonprofit integrated health system in the United States with over 12-1/2 million members, about 23,000 employed physicians, and over 200,000 employees in addition.

Our care span includes the full continuum. It also includes a set of eight non-proprietary health services research centers. Our plan, and as I'll describe, you know, in the following slides, our health plan and our care delivery are deeply integrated and intertwined, and sometimes are difficult to, you know, dissect separately.

Next slide, please. So this, this map. Next slide, thanks. This map shows the distribution of our member population in the

U.S., and as you can see the significant majority of our members reside in California. In many of them, we are largely concentrated in metropolitan areas or large population centers, and our penetration generally runs in any community from about 20 to 40 percent of the insured population.

Next slide. So although Kaiser Permanente is actually a brand name, I think for the purposes of the discussion it's important to tease out what actually is Kaiser Permanente. It's actually a set of discretely separate chartered, mostly nonprofit organizations that are all focused on serving our enrolled members.

The Kaiser Foundation Health Plan at the top there provides the main function to the health plan, and then serves as the distribution source for global payments to the other organizations in the group. The Health Plan manages its hospitals through a separate nonprofit called Kaiser Foundation Hospitals, through a series of hospital service agreements, and those services are provided either in Kaiser Permanente facilities or as

needed in contracted facilities.

In California, it's mostly owned. Outside California, it can be either owned or contracted. Some regions like Washington, Washington state, and Georgia, for example, do not have Kaiser Foundation Hospital-owned hospitals. Care is provided in contracted facilities, Kaiser Permanente, but the care is actually provided by the KP providers.

So then the Health Plan also has medical service agreements with eight separate Permanente medical groups, all self-governed and one for each region. California has two regions.

The medical groups are mostly shareholder-owned, but some are now moving towards a public benefit model where, as some of you are aware of, a certification called a B Corp organization that serves community interests. Each Permanente medical group has a medical services agreement with its regional health plan subsidiary that provides mutual exclusivity, and gives the medical group control over things like clinical guidelines, policies, network composition, and also appeals

process.

So next slide. Thanks. So Kaiser Permanente is distinguished not only by its integration of care, finance, and delivery, but also the integration of the components of care delivery. So we provide the full constellation of care in most regions. The model is also, importantly, is primary care-centered, and the entire system is linked through an electronic record, which allows providers, regardless of where you're at in this wheel, you can see all aspects of care delivery, including all aspects of care coordination and case management.

And both mental health and social health are fully integrated into that wheel and into the system.

Next slide. So the, KP's global budgeting process allows a lot of flexibility in how care is delivered. The constraints of what we perceive an arcane fee-for-service don't – do not generally exist. So specialty care can often be delivered through teleconsults to primary care without any kind of billing process or a need for worry about having to see the patient in person in order to

satisfy billing requirements.

In our system state, you know, throughout our system, and I've practiced most of my career here in Washington state, we've been, for example, you're really able to adapt to COVID. So our telehealth encounters rocketed to about 75 percent with virtual encounters, without any concerns about revenue loss from the conversion, and it allowed us to be much more flexible, I think, than many of our competitors.

Kaiser Permanente was one of the earliest adopters of the electronic health record and that investment was absolutely critical to our success in becoming tightly integrated and also enabled much more patient engagement and becoming patient-centered, with the earliest versions of the patient portals that were offered by Epic.

The Care Everywhere Program, which we use, also an Epic product, has been also critical to our ability to offer seamless care across state lines, regardless of whether our members move temporarily or permanently. So this has obviously an impact in reducing

redundant care or redoing previously done services because all those past services are easily visible.

I think finally another major difference in the experience of our medical groups is that they spend far less time having to adapt practices for different payers. So the coverage policies at Kaiser Permanente align fully with medical group practice guidelines, they're developed by the medical groups, and that many of these referrals for services are auto-approved based on the Permanente affiliation, in essence gold carding.

And for patients, I think it's a really distinctly different experience as they're not caught in the middle between providers and plans, you know, fighting over coverage and payment.

Next slide, please. So the medical groups are actually paid a global fee that's based on a capitation formula, and then -- and they in turn pay their physicians and other providers on a salary basis. There's a negligible fee-for-service billing inside our

system. We have to do it generally more for external requirements, and as I'll talk about in a second, for some other special purchasers.

But the medical groups can earn extra incentives both as a group, but also reward individuals based on quality and experience, performance targets that are set through a process between the Health Plan and the medical groups called Memorandum of Understanding. So those members may or may not pay an incentive, depending on performance. It's generally driven entirely on strategic initiatives and quality.

The source of the revenue to drive our system is obviously largely premium payments from purchasers, but also includes substantial patient cost share revenues. There's very little fee-for-service in our system, but for those employers that are self-funded or risk-based, the model is driven by fee-for-service payment plus a global capitation fee that covers much of the non-billable integrated services like case management and care coordination that are vital to the success of our model.

Next slide, please. So our latest integration experiences with bringing social health into the mainstream of medical care, and as a nonprofit, we do have a long legacy of serving not only our members, but also invested in the health of the communities in which our members reside, recognize the importance of public health and the environment, and the social environment.

So KP provides about $3.6 billion in community benefit that are a combination of charity care, but also an extensive grant and community investment portfolio. The focus is on a set of key areas that are mostly commonly uncovered through our community health needs assessment process, which we do across the country.

We also recognize the importance of doing social health needs assessments at the member level, and we're now making that visible at the point of care and in the electronic record for purposes of care coordination and care planning, as well as socially-informed care.

Next slide, please. So this next

box represents sort of the model that we are using in social health. We are still in the process, and this is still -- we're still, I would say, in the relatively earlier phases of this journey, where we are set up to identify the social health needs of our members by using standard tools, and then through that process connecting our members to resources in the community, and those can be through a variety of pathways which I'll describe in a second.

And then enabling and supporting a follow-up with those members, particularly those that have complex social needs or a mix of complex social and clinical needs, and ensuring that they get the appropriate follow-up as part of their overall care planning.

This in turn allows us to monitor the use of these community-based services and amass data and understand the performance of our community partners, and their ability to help, and it informs our local investments in those community-based organizations, much in the way we would be supporting a provider network.

So next slide, please. This is my

final slide, and in this as you can see here, what we're doing is the screening process is through a variety of pathways, which include episodic care using standard screening, which could be done either through the provider, or say, medical assistant, or through digital self-service tools, or through actually even outreach to a call center that we staff for purposes for people who desire to actually go direct through that medium.

We've also listed in our web an ability for a social services locator platforms that's available to the public, so that they can see what kind of resources are available in their zip code. We have set up what we call a Thrive Local platform that is powered by Unite Us, that provides electronic communications and connections with community-based organizations in our communities. We have over 5,000 community-based organizations that are connected to the network, and when a provider sends a resource referral, it's delivered electronically just as it would be in our system to a specialist.

And then we can monitor to make sure

it was accepted, that the service was received, and then the feedback is actually received back into the electronic health record. The areas that we're focused on in these areas, we're putting an emphasis early on food resources, on housing resources, social isolation, and financial resources.

We also are using our ability to use artificial intelligence, as well as, you know, algorithmic logic to identify members that are likely in need of services, even without screening them, and reaching out to them and offering them services like food assistance. Recently, we reached out to about 4.2 million of our members to enroll them in SNAP[30], and we were successfully able to enroll probably about, of those, about 80,000 took advantage of that opportunity and successfully completed an enrollment application into SNAP through that outreach.

So those are some examples of how this works, and of course, this is all needs to be integrated, very closely integrated into our

30 Supplemental Nutrition Assistance Program

care delivery system and to our health plan, and as we're finding more and more purchasers are interested in understanding how they can play a role on this effort as well. So with that, I'll conclude and turn it over back to the moderator. Thank you.

VICE CHAIR HARDIN: Thank you so much, Dr. Grossman. That was very interesting. I'm sure Committee members will have many questions for you. They're holding those until after all four presenters have completed. Next we have Dr. Ali Khan, who is chief medical officer at Oak Street Health. Please go ahead.

DR. KHAN: Thank you so much for having us, and thank you to the Committee for this opportunity, specifically to Dr. Chinni Pulluru for making this possible. We're thrilled to be here today, to really dig into, you know, our findings from the wild, right? What's making this work for us, both from a value-based care perspective and a health equity perspective in the real world, and exactly what we're doing.

So we'll try to dig into a little bit of context, but really focus very similarly

to where Dr. Grossman was, around how that integration of information and where, you know, details and follow-through really matter.

So next slide, please. So you know, from a context setting perspective, none of this is obviously surprising to this Committee, but important to recognize. We know the challenges before us in American health care.

We are expensive, we don't necessarily get the value or the output that we hope for from a quality perspective in terms of what we spend, and all too often, particularly for seniors and older adults, negative experiences, chronic disease burden, and cost concentration are all forcing those seniors to make choices every day, as my patients do on the west side of Chicago, between whether to pay for a medication or whether to pay for an electric bill, and how, you know, that impacts their overall quality of life and their activation as a whole, right?

Ninety-six percent of Medicare spend obviously relates to chronic disease, and we see this all the time in the hospitals where I work and in the primary care setting, where

myself and many of my colleagues at Oak Street work, and thinking about how we address this in a multi-faceted model is really the core focus for us.

Next slide, please. Of course, we also know that for many communities, these problems are even more concentrated. I happen to work in this map of Chicago in the darkest, the darkest quadrant on the west side through to the left of your screen, in a community called East Garfield Park, which is only separated from downtown in the Loop, that white center in the middle of the map, by three miles and about six train stops.

We have about 18 years in terms of life expectancy, which is not surprising when we see the overlap between social vulnerability, as measured by the CDC[31], health risk factors, and race, and what that does in terms of how social risk factors drive considerably worse outcomes, as underscored during the COVID-19 pandemic.

Next slide, please. We see those

31 Centers for Disease Control and Prevention

same challenges through good data from RAND and CMS when we look at some of the process measures that many of us know and love. So when we look at racial and ethnic disparities, consistently whether -- from in either gender, we see notable discrepancies in screening, in treatment, and in prevention across racial and ethnic categories.

The challenge of the work ahead of us becomes quite considerable when we think not only about raising the bar in terms of elevating the quality and the consistency of care delivered for this segment of the population, but also how we reduce inequity within that work at a very, you know, thoughtful and intentional level.

Next slide, please. That really is the basis for us at Oak Street Health. We are a national network of primary care centers for Medicare-eligible patients. We operate 100, actually 140-plus centers over 20 states, soon to be 21, as we head to Colorado in a few weeks, taking care today of about 115,000 members at full risk with us, either Medicare Advantage, Medicare/Medicaid dual eligible

programs, or direct contracting today. There are 150,000 members overall, including traditional Medicare fee-for-service beneficiaries.

Next slide, please. Which as you can see spans much of urban and working class communities, suburban and immigrant communities across 20 states, including much of the Rust Belt, the Southeast, the Southwest and increasingly into, you know, more atypical urban settings. We are not in Southern California, we are not in South Florida. We have attempted to make this work in communities like Chicago; Philadelphia; Cleveland; Memphis; Jackson, Mississippi; Dallas-Fort Worth; and Albuquerque, New Mexico.

Next slide, please. The reason for this kind of motive in the 10 years since we were founded is really because of the people that we serve, 42 percent of whom are dual-eligible for Medicare and Medicaid, 86 percent have at least one chronic condition. Seven, most of whom come to us on their first visit with seven or more medications.

I can tell you, you know, as someone

who every week, including tomorrow, starts every visit with pill counts and bottle checks, that far too often our patients are coming to us on seven, eight, nine, 10, 11 medications, but they're wondering why they're passing out every three days.

What they don't see is that they've got three prescriptions written by three different people, all for the same anti-hypertensive or Lisinopril at the same dosing, and that they're dutifully taking each one.

And so -- and yet their blood pressure is in the systolics of, you know, the 90's which is quite low, and they're wondering why this is happening to them. Or they ask, you know, I've been getting my medication online – from a mail order pharmacy, and I've got it all with me.

And they bring enormous bottles dating back three years or more of the same Metformin that they continue to receive every three months, thus, you know, checking the mark on whether their prescription drug was filled from a Medicare quality perspective, but without the actual last-mile focus on whether

they're actually taking those medications.

So we spend a lot of time with each of our patients, particularly many of whom are obviously Black, Latinx, or indigenous, and 50 percent of whom, and we know this because we screen 100 percent of them, have at least one social risk factor if not more than one. So this is, you know, this is not cherry-picking. This is really dealing with the bulk of the challenge in American medicine for the populations who need it most.

Next slide. We see this, you know, across the way. It's not solely an Oak Street problem. Good data from Humana earlier this year shows that the majority of Medicare beneficiaries enrolled in Medicare Advantage are carrying two or more social risk factors, right, and that oftentimes it is not loneliness, and it is not housing security, although those are certainly quite large problems, but financial strain, right, and the simple work of ensuring that is everybody accessing the financial supplements that they're eligible for, and that they're screened, and they're actually getting those

resources, is one of the biggest challenges which is, you know, something that we focus on.

Next slide. So we promised to focus on the details, and so I want to be candid in terms of how we do this, both at Oak Street and across the way. The first piece here more than anything else becomes really focusing on our differentiation moving from reactive to proactive primary care, whether it's us, Aledade, Cityblock, the Chens, so on and so forth.

We can take capitation in this setting, being at full risk, and it enables us to invest in three things relative to typical primary care: time, resources, and follow-through. Time, as you can see in the setting of distinct differences in how many patients that we are taking care of from a panel perspective, that enables more focus and builds -- using the ability to leverage large multidisciplinary teams, to really dig in on the challenges, both social and medical, for those patients.

Visit length, where for us the average visit length is 40 or 60 minutes; the

most common length is 40 to 60 minutes with each of our patients, and we're seeing them on average nine times a year as opposed to, you know, from a Medicare standard perspective of 1.4 to three times a year, and then that shift to proactivity, right, where we are constantly looking to make sure people don't fall through the cracks, and our operating models are geared towards regular, frequent touch points, and so in a high-intensity model to ensure that people do not fall through the cracks and that our focus on crossing the T's and dotting the I's remains in place.

Second is resources. Those big teams are teams of physicians and nurse practitioners and physician assistants, yes. But they're also nurses, rural community health workers, podiatrists, pharmacists, you know, social workers, behavioralists, chaplains. We've come together with each of us working at the top and the bottom of our licenses, to ensure that we can actually fill in the details.

We don't wonder whether our patients have gotten a test followed up. We actually

find out to ensure that piece of follow-through, right? Instead of wondering about med affordability, we can connect somebody in real time now going to a pharmacist to help identify what makes sense from a formulary perspective, but also to understand which pharmacies are available that will deliver in a home setting in a way that's convenient, and connect them to our social workers and patient relation managers to ensure they've got the income supplements that they -- that they're entitled to to reduce that cost of care.

Instead of hoping that our patient with severe mental illness is going to see the state's BH[32] clinic, we have behavioral health embedded in health. So I can do a warm handoff and deal with everything from SUD[33] and SMI[34], to garden variety depression and anxiety, to make sure that we're handling things in real time and doing so together.

It's so easy as a practicing primary care physician to get caught up in the day-to-

32 Behavioral health
33 Substance use disorder
34 Serious mental illness

day of somebody who's presenting to me with an urgent issue or who needs a form signed or who needs something in that moment. So that without the intentionality, the shift to proactivity or the team structure to get it there, we wouldn't get the results that we deliver, because we catch people when they stumble. We try to help them when they're worried.

Next slide, please. Of course, data and you know, population health rigor obviously helps influence this approach. A lot of the work that we do is supported by first and foremost integrating a number of different data sources publicly available and proprietary, to get a whole holistic picture on our patients.

We leverage that in terms of helping us to understand what the dosage of primary care is in terms of the frequency and intensity that -- at how we want to engage in longitudinal primary care, to help us put that picture together and determine a level of worry that we have for our patient.

Population health management becomes the second piece, right, where we have a number

of different tools that are expanding every day, by which we can generate consistency, to engender the proactive thinking at regular intervals and pull in the kind of democratizing tools like integrated specialty care through electronic consultations, home-based primary care, medication management, and others, to really ensure we're dealing across or working across the whole ecosystem.

And third, really, is that care navigation support, right, so that making sure that we're holding the hands of our patients to -- we have the time to do the right thing, to do all the steps required. And it’s that kind of work, whether it's happening by me or it's happening by a primary authority, somebody else entirely, that's the hard deeply meaningful work that we do every day in our sector, particularly at Oak Street, right.

We enable the time, resources, and follow-through through a model that's optimized for this population, data-driven, and intentionally holistic, to build trust.

Next slide. We see that trust play out in the kind of work that we can do, even with the

segment of the population that is obviously heavily underserved through traditional measures. We see major, you know, sort of national standards from diabetic control, breast cancer screen, colorectal cancer screening, and as our peers do in the value-based care space, that we can consistently take a population that is at higher risk and has more structural barriers to achieving five-star performance, and bring them to that level over and over again, state after state over the past 10 years that we've shown.

Next slide, please. We see this particularly in our -- in the integrated behavioral health, where we know that by rigorous screening, consistent warm handoffs, and integration with behavioral health team and care plan into the primary care setting, we see substantial reductions in depressive symptom management from within Oak Street, than from general population trends, be it even in the best places, like New York City Health and Hospitals, have really championed both this measure and really focusing on patient reporting outcome measures.

Next slide, please. This is -- we see this, these results outside of Oak Street as well. This is excellent data from Aledade showing their trends from the utilization perspective, as they have driven a number of independent practices into, you know, more substantial, more engaged primary care relationships, what that effect has on both ER utilization and patient utilization and total cost of care.

Next slide, please. I think the challenge for us is like how do we move past these utilization measures, right, that we all quote against a data set that some would argue may not even be comparable from a traditional Medicare into really demonstrating true impact on the patient and true impact on what their journey is and how we've actually bent that cost curve, that utilization curve.

For us, from what we have, we can see, over and over again, moving away from investing three cents on the dollar in American primary care, from a health care dollar, into flipping that paradigm on its head, as we've been able to do in the value-based care

experience, yields, consistently, this kind of impact in terms of, you know, more than halving a possible admissions and ER visits relative to Medicare benchmarks, dramatic reductions in 30-day readmission rates, even when we include observation stays in that space, and higher patient, you know, outcomes and satisfaction.

Next slide, please. For us at Oak Street, we've seen this. We won't go here because we're running out of time.

Next slide, please. One more, sorry. There we go. For us in Oak Street, as a MSSP-ACO[35] for five years, we saw with deploying the same model without the benefit of risk adjustment, without the benefit of a lot of things often MA[36] is labeled for, we achieved the intensity of the care model with the fourth highest savings rate of all 513 ACOs in the cohort, with a significant, you know, taxpayer savings to patient versus the CMS target, showing that the value-based care model can produce these consistent results over and over again.

35 Medicare Shared Savings Program ACO
36 Medicare Advantage

Next slide, please. One more please, just in the interest of time. So despite progress in quality and equity, we are, we try to be very honest that we think that the value journey has moved from toddler stage into gangly pre-adolescence and adolescence at this point. We're excited about this conversation today around, you know, thinking about what does incentive design look like in terms of expansion of Medicare payment models and more deeply link equity and quality, equity and payment reform in equal measure, as what we are debating today with Medicare stars and what we are seeing with the -- in the first signals of ACO REACH[37].

How do we think about this from a scalability perspective when we think about the entire segment that still serves sub- 10 percent of Medicare beneficiaries? How do we apply those lessons of scale to Medicaid and to high-risk commercial segments? And then thirdly, I think, is really, what really resonates is, the pursuit of clinical

37 Realizing Equity, Access, and Community Health

excellence, right?

I know a number of colleagues, they will be digging in on this. What are the right measures? How are we evaluating clinical outcomes and equity in equal measure? How are we integrating those with patient report outcome measures, and what benchmarks are we driving towards? Can we do that collectively, or should those be proprietary?

We at Oak Street say no. We're going to drive towards the future that we know we need to have. Thank you for your time today. I'm looking forward to the questions.

VICE CHAIR HARDIN: Thank you so much, Dr. Khan, for that very interesting presentation, and perfect transition to our next speaker, Dr. Dana Safran, who is president and chief executive officer at the National Quality Forum. Please begin.

DR. SAFRAN: Good afternoon. Thanks very much for the introduction. I'm really pleased to have the opportunity to be part of this panel today, and much of the information that I'm going to share with you really dates from before I was in my current role as

president and CEO of NQF, and back from a time when I was on the executive team at Blue Cross/Blue Shield of Massachusetts.

I'll be talking about some of the particular methods that we used in our global budget contract called the Alternative Quality Contract, or AQC, that I think really differentiated that model's ability to achieve the twin goals that we had of improving cost -- improving quality and outcomes while reducing cost and cost growth.

So that will be the first segment. Second, I'll talk a little bit from the perspective of what are the highest-priority gaps that I think need to be filled for value-based payment models to be successful, and then finally I'll talk a little bit about the issues around health equity and adjustment for social risk.

So if we go to the next slide, please. I'm going to assume given your background that most of you are quite familiar with the Alternative Quality Contract, so I won't walk through that model. But for any of you who are familiar with it, this is a model

developed in 2007, launched in 2009, so well before the ACO movement was underway, and in fact a catalyst for that movement because of some of the results that I'll share with you that emerged from this work.

The things that differentiated the model from, at the time, what were the traditional fee-for-service payment models, were a provider systems being paid on a global population-based budget, having symmetrical two-sided risk on that budget, having a significant opportunity for upside earnings based on quality performance on a very broad set of quality and outcome measures, and having long contracts, five-year period contracts with a fixed cadence of inflation pre-defined before the contract started so that providers understood what growth would look like over each of the five years and decide to come down over time, so that by the end of the period, growth looked like general inflation and not the two, three times inflation rates that we had in 2007 when we began.

So next slide, shows you just a snapshot of the -- next slide, please. Thank

you. Shows you a snapshot of the quality measures that I developed in 2007, and that was really a part of this payment model, the opportunity for quality to be the important backstop against any impulse to stint that might occur from a global budget set of incentives with two-sided risk.

What you see is that there were two settings, ambulatory and hospital, and for each setting we had a range of process, outcome, and patient experience measures. Today's measure sets, I would argue, look very similar to this measure set developed in 2007, and that's what I'll be speaking about in the second segment of this set of remarks.

But if we go to the next slide, one of the things that I really wanted to emphasize for this audience is that there were some particular methodological innovations that we used in our incentive model that I think really contributed very importantly to the success that the AQC had in driving improved quality and outcomes. Two that I would highlight are besides having the broad quality measure set that you saw on the previous slide, for each

measure we had a range of performance targets, not a single number. That was novel at the time.

At the time, performance-based payment really typically had one performance target, and a provider either made that and got rewarded or missed it even by hundredths of a point and got nothing, which was very demotivating. So having a range of targets was very important.

The other thing that was important that we did was we based those targets on absolute performance, not relative performance. In the Q and A, we can talk a bit about how we did that if you'd like. But the net effect of that was that it was not a tournament among providers in the model. So as a result, our providers in our network statewide were very willing to collaborate and share best practices, because one organization's success at gaining ground in the quality measure set did not come at the expense of another provider.

And what you can see is that across the range of performance targets from what we

called Gate 1 to Gate 5 on the X axis, providers had the opportunity to earn up to an additional 10 percent on that global budget, which was tens of millions of dollars in most cases.

Next slide. I won't spend a lot of time here, but one of the reasons that the AQC model was as influential as it was, nationally and even internationally, was that we had the great, good fortune to have a team from Harvard Medical School studying the results of what we were doing while we were doing it, publishing year by year by year, and showing in fact that this model was improving quality and health outcomes.

You see that panel, roughly in middle of the screen, with the blue line signifying improved outcomes in our cohort, the orange line signifying outcomes in a national set of benchmarks. And what you'll notice is a very, very steep increase in the performance on outcome measures from the third data point, which is the year that the contract launched, all the way through the follow-up period.

And this improvement in outcomes

really required novel care models, very much like what Drs. Grossman and Khan have described, where we think outside the literal and figurative box of the clinical setting to where patients live and work, in order to address the unique individual barriers for each human being, of what will stand between them and good outcomes.

That's very different from the care models that we get as we know under fee-for-service. We also saw significant cost savings, and those are captured in a series of *New England Journal* and *Health Affairs* articles, the latest of which was an eight-year retrospective that showed 12 percent cost savings over, over traditional fee-for-service contract models.

Next slide, please. Actually, I think in the interest of time, I'll skip this slide. I can come back to it later. This is about how we shifted the incentives after several years, but we can still link the shared savings to quality performance. We can talk about that if that's of interest.

This slide I'll just speak briefly,

because I think Drs. Grossman and Khan have really articulated the kinds of care delivery innovations that lead to the -- that are really significant improvements in quality outcomes and costs that we are talking about. But these are the four broad areas that summarize the kind of interventions that we saw our network making from the very first year and all the way through.

Next slide. So one of the really critical, this is the second part of my remarks, gaps that we have is, as I pointed out, measure sets today look very much like the one that I developed in 2007, and yet for over a decade, we've been saying we need to move to more outcomes-oriented measure sets.

When I was contributing to the work of the LAN[38], we called these "big dot measures," and the value of moving to big dot measures for value-based payment is really many-fold. But one of the points of value is the measures in measure sets today and in the one I developed for the AQC really are the

38 (Health Care Payment) Learning and Action Network

product of a fee-for-service mind set, very much process-oriented. You do a thing, you get paid for the thing, you measure the thing.

Whereas, really what we're trying to get to in value-based payment are the outcomes, and fortunately those allow for a much more parsimonious measure set because, you know, global budget contract, if you're measuring on process it’s going to have to measure an awful lot of things, whereas if we move to big dot outcome-oriented measures, we can be much more parsimonious and much more consistent with the real intention and purpose of value-based payment.

But despite nearly a decade of consensus that that's where we need to go, we haven't gotten very far.

Next slide shows that there are five -- next slide, please. Shows that there are five broad clinical areas that represent more than 50 percent of medical spend for both commercial and public sector payers, and yet very few, if any, outcome measures exist in NQF's endorsed portfolio of measures.

So this is one of the priority areas

for me as the CEO of NQF, hoping to make progress on this in the years ahead. I know we're at the end of my time, so I'll just say a few words about health equity if I could.

Let's jump ahead two slides, please. This is a set of results that were published in *Health Affairs* from the AQC, and what I want to draw your attention to here is the yellow and the green line at the top, and what that was showing was that the AQC was succeeding in narrowing long-standing disparities in health care quality among our lowest, our most vulnerable, patient populations relative to the most advantaged patient populations.

You can see from the blue and the orange line just below that, no such closing of the gaps was occurring outside of the AQC. And it helped to shape my own perspective about how we address social risk in payment models. What I share right now is my own perspective.

If you could jump ahead two slides, please. My own perspective and not that of NQF, which is why I don't have NQF's logo on this final slide, but my perspective is this, that at this time where we are all prioritizing

improvement in health equity, we can invest in health equity by adjusting payment, not adjusting measure scores for social risk.

We can adjust payment in other of two ways or both, by having providers with higher social risk receive preferred base payment rates or a lower benchmark, as is done in the ACO REACH program. We could also create a multiplier so that for a given level of performance, those with a higher social risk are earning more for the same level of performance.

In this way, I would say we have our cake and eat it too on the concerns expressed by both sides of the argument, those saying, you know, we need to adjust for social risk, those saying we can't adjust for social risk because we -- if we do so on the measure side, that we mask and conceal the important differences that can be there.

We can have our cake and eat it too by adjusting, but on the financial side, and in so doing, invest in health equity as opposed to obscuring the disparities. So thanks for your attention. I look forward to our discussion.

VICE CHAIR HARDIN: Thank you so much, Dr. Safran. That was very interesting. Our last listening session presenter is Dr. Adam Weinstein, who is chief medical information officer for DaVita, Incorporated, and an advisor for the Renal Physicians Association. Please go ahead.

DR. WEINSTEIN: Thank you and thank you for inviting me to this conversation. You know, today I'm wearing my Renal Physicians Association hat. We are an advocacy organization representing nephrologists throughout the United States, and I think in contrast to my colleagues here, I bring sort of the tactical frontline physician representation of what these models can mean for doctors and patients.

I want to take a few minutes to start with, and if you could move to the next slide, please. The definitions. So the world of nephrology is an acronym-laden world filled with lots of very specific definitions, and I'm not going to go through all of these, but I wanted to include this in the slide deck for future reference.

The two you're going to hear me talk the most about is CKD, which is chronic kidney disease. I think many of us are familiar with that term, but ESKD[39] and ESRD are used interchangeably, and it is the state in which a patient no longer has enough kidney function to sustain them without dialysis or a transplant. The rest of the vocabulary there is there for your review if you need it throughout the rest of the presentation.

Next slide, please. So I want to start by talking about the physiology and the logistics of kidney care delivery. In contrast to I think many of my colleagues here, you know, we represent a large group of nephrologists that are in a variety of practice conditions. Some are part of large health systems. Many are independent practices that work in communities throughout the United States.

Some practices are as large as 30 to 70 if not more nephrologists. Most practices are between four and seven nephrologists

39 End-stage kidney disease

delivering care in a variety of settings from rural to urban. The problem with kidney disease is that it is a continuum of care that requires ongoing monitoring. We have really good ways to keep track of people's kidney function using creatinine clearance or the estimated glomerular filtration rate, which then breaks out into stages of chronic kidney disease.

When someone has somewhere early Stage 3 to mid-Stage 4 kidney disease, they are in a window where we can do the most to mitigate risk and avoid potential expensive costs. As people's kidney function begins to fail further, and they enter late stage 4 or Stage 5 and as they enter end-stage kidney disease, we know this to be the period in which their medical complexity is high, and the costs associated with the care can be very high if upstream work, that is work in that period of greatest potential for risk mitigation, is not taken.

There's a series of jobs to be done. Things that nephrologists as the quarterback of care, especially for Stage 3 and beyond

patients, can be doing to either slow progression and/or prepare patients appropriately for what's called an "optimal start," which is a period where they can start dialysis or get a transplant with the least amount of cost and the most amount of medical support.

The biggest problem we have in the world of nephrology is that it takes a lot of colleagues in other domains to care for these patients. So irrespective of how good a nephrologist is, you're only as good as the community of providers that are working with you. Nevertheless, the nephrologist is in fact the best quarterback for managing this particular disease state, since it's what we do. It's our bread and butter.

And so no matter what payment model that we are participating in, and in the appendix to this deck, I've included what is 17 years of numerous payment models that nephrology has been participating in in one form or another, the nephrologist has to be at the center of it to make it work.

Next slide, please. So I think it's

important to talk about why kidney disease as a disease state rather than a population works well as a total cost of care model. There's a number of features about nephrology care and really kidney disease patients that lend themselves well to this kind of payment scheme.

Number one, there's obvious significant financial incentive or savings to be had when care is delivered appropriately and optimally for our patients. Dialysis, as you know, is very expensive, and transplants are less expensive, especially if done preemptively. Moreover, when patients have to start dialysis, if done in a way that is planned and thoughtfully executed, there's significant cost savings to be had, as well as quality of life for the patients.

Numerous, tens of millions of patients have some degree of chronic kidney disease, and these patients are typically diagnosed years before they enter that window of highest cost and highest complexity. Our patients are easily defined by lab data, and there's administrative data to keep track of their progress, both in the form of claims, as

well as CPT[40] and ICD[41]-10 codes.

There are measurable and cost-effective solutions that can slow the progression of kidney disease, and of course we understand at least some set of best practices that keep patients healthy on dialysis and getting transplanted. And lastly, attribution is relatively simple, though not perfect. But we have a numerous tock marks on the timeline that I displayed on the previous slide that allows us to link patients to physicians and other care providers in the communities in which they live.

Next slide, please. So I probably should have termed this slide "the actors," rather than the ideal components. But I think it's important to see the list of people and stakeholders that go into caring for kidney disease patients. Obviously CMS and payers have a strong interest in ensuring patients get high-quality, optimally priced care. But patients and the caregivers, I think, are critical components of this.

40 Current Procedural Terminology
41 International Classification of Disease

Much of what we do in nephrology involves engaging patients in behaving different, taking medicines, a lot of the things my colleagues have discussed, but perhaps more so given the complexity of their renal disease. Nephrologists and providers, and more importantly their nephrology practices, are business entities.

These entities are built around fee-for-service medicine by and large, and most of the payment systems that have been put into place over the last 17 years carve out a small percentage of the practice, which I'll talk a little bit more in the next slide.

But really I think it represents the fact that when you're a nephrologist or nephrology practice participating in one of these programs, that you're being asked to take a subset of your patients, think and work differently about that subset while you're still caring for the rest of your practice in the more traditional fee-for-service model.

There's a new entrant in the kidney care space, which are kidney care companies. Some of these are dialysis organizations like

the one I work for, DaVita. Some are independent organizations that are helping nephrologists and nephrology practices take on the logistics of managing patients and population health, as well as bearing some of the financial risk in the newer models that have come out.

And lastly, we interact heavily with other specialties and health systems. Within the kidney care payment systems, these folks have often been neglected, really. They are marginally incentivized, and while they're critically important, our patients are hospitalized quite frequently, they're often not as involved in the processes that need to be put in place to be to reach maximum success.

And if you could go to the next slide and my last slide, please. I want to close by talking about where the features that have been most successful have come from over the last 17 years. I think you're going to hear a lot of the same themes that my colleagues talked about, and I'll start with the nephrologist and the nephrology practices.

For independent nephrology practices

really, you know, these are the folks that want to be the quarterbacks and provide the most frontline care, and we're asking them to flex, flex into population health activities, flex into delivering care between office appointments. That means they need to have IT that works well and integrates with other community members. It means they need to have the right tools and data available.

For them, meaningful rewards financially, as well as quality of care rewards, are important. Most nephrology practices are willing to take moderate risk but are not really capable of putting up investment up front, and are really dependent on simplified reporting and accountability burdens to be successful.

The kidney care organizations, that is the newest entrants in this market space, really have started to fill some of the gaps, but are not quite there yet. They are more willing to take on risk and invest up front. They are willing to provide the IT and analytics that most small and moderate-sized practices can't provide, and they really need

to take the time to contract with all the other entities in this space.

Health systems and payers are still not fully engaged in the nephrology care space for capitated and at-risk payments, but really they are critical for providing data such as ADT notifications and partnership for delivering care through some of the subspecialties that are so critical for our patients.

And lastly, I think you've heard numerous comments about what patients and care providers want, and certainly our patients are no different than I think many of the patients represented amongst my colleagues here. We really look to be able to incentivize and work with patients differently within these care models.

I'll close by saying that I think the most common word I heard today amongst all of our presentations is time, and I would say that from the perspective of a kidney doctor, all of these things take time to develop. And so no matter what care models are developed, they need to be thought about in five- and 10-

year increments, not one- and two-year increments.

They need to be thought about as laying out a set of boundaries that are adhered to for a number of years, so that you can build IT systems that cross all of the entities in these communities, as well as give time for the practices to adjust their workflow, as well as to engage patients in what is really lifelong behavior changing that's necessary to successfully navigate one of the new payment models that might come down the line.

So with that I'll stop. I will refer you to the fact that I have a few slides in my appendix that might add some extra value, and likewise I am happy to take questions as part of the question and answer. Thank you.

VICE CHAIR HARDIN: Thank you so much, Dr. Weinstein. It was very interesting. I want to thank all of you for sharing your experiences and your unique knowledge with us today. Now we're going to open it up to Committee members to ask questions. If you'd like to pose a question, please tip your name tag straight up, and I want to open it up to

the Committee. Angelo.

DR. SINOPOLI: Yeah. My question is for David Grossman. So I heard about the automated mechanisms for sending referrals to the community-based organizations. I was wondering how you partner with them to hold them accountable for actually delivering services and outcomes?

DR. GROSSMAN: Yeah, thanks so much for that question. I think that's a, that's a work still in progress for us. Our first order of business is actually to create the incentive and the means by which to get these community-based organizations actually even to be part of the network and involved.

I think a secret to success there is to try to work in collaboration with the rest of the community, and not make -- and not have this be seen as necessarily a delivery-specific background, but one in which we can try to recruit other delivery systems and plans to be part of the same network.

I think that enhances the ability for us to be able to have that level of accountability and expand the accountability to

be not just from a single delivery system or plan, to a broader community level of accountability. As we, as you well know, the issue around those services and how these types of community resources may be converted into coverage benefit, will probably play a role in terms of how the accountability process evolves.

But for now it's really, you know, as we unfold this process and engage our partners in the community, I think that the process will involve giving feedback and providing statistics and data at the level of engagement -- referrals have been -- the percentage of the referrals that have been accepted, the percentage of information that comes back into the record, as starters, just in other words, these process outcomes to make sure that in fact these services are actually being delivered. It's going to be a little more difficult challenge to assess quality in terms of those services, and I think that's something that we as a community are going to have to really think hard about. Thank you.

VICE CHAIR HARDIN: Thank you so

much, Dr. Grossman. Paul.

CHAIR CASALE: Yeah, hi. A question for Dr. Khan. Thanks for the great presentation. You know, on your Slide 10 when you talk about the value-based models, under population health interventions, you list integrated specialty care. You know, we talk about under these total cost of care models, amongst the Committee, about how to engage specialists, how to think about how specialists fit into the total cost of care model.

And so I'd just be curious to hear more around how, how you engage with the specialists in general and, you know, I know some of this is virtual but then, you know, how much is virtual versus in-person and how you work that into your care delivery model?

DR. KHAN: That's a great question. Thank you for it. I've actually probably have a -- well, a bunch of points of resonance about what Dr. Weinstein put out, because from a ground level perspective, a lot of this comes down to, you know, what is the kind of connectivity that we're getting, right, how do we drive towards bidirectional communication,

and are the specialists that we're working with, you know, nephrology is a good example, are they like -- are those individual nephrologists, you know, excited about what we're trying to do, aligned from that perspective and eager to dig in, right?

Because I think we do see across lots of specialties heterogeneity, in terms of whether some folks are really excited by the idea of robust generalism, and you know, bringing hopefully higher-quality consults, things that are more worked up, things that are more focused, and some are not, right, like in terms of the traditional fee-for-service system.

Even when those -- there are those that are, right, traditional methods of communication, traditional methods of information transmission, stuff like that, will often stymie, right? I can spend 15 minutes writing a beautiful consult on a very specific thing that I want, that I need a kidney biopsy for, and if that gets transmitted as CKD-3, everything is lost, right?

So on that level, I think we deploy

a couple of things. So first, we do leverage electronic consultation in a couple of different ways through the partner organization that we have now acquired, RubiconMD. So asking questions, both highly specific and very general, in order to ensure that our primary care clinicians aren't worrying alone, in terms of just asking the question they want to ask.

Whether it's what's the next medication that I should add for this diabetic, to hey, I've got this patient who I think may have lupus nephritis, and I'm curious about whether you would start something versus just, you know, versus wait for biopsy, given sort of the family history and everything else that we're seeing, right?

That kind of spectrum in an eConsult platform is something that we're able to get back not in the like 10 or 11 weeks that it can often take for a patient of mine to get prior authorization from a plan, schedule, follow-up, and then, you know, actually see them then with those records back to me, but oftentimes it's four to six hours, right? That starts a conversation.

Now when we pair that with the legwork that we do in every city and every community that we enter, of going out, taking publicly available data, taking proprietary algorithms from folks like Care Journey and Garner and others, to try to identify who are, who are specialists that are potentially high-value practitioners, right, as defined by those proprietary agents. How do those -- how do their -- how do those patterns or those findings match up against the clinical experiences of me and my team, my colleagues in terms of who's good to work with?

Then we layer on a bunch of work in trying to build relationships with targeted foci, right? So I may go in Maryland to Dr. Weinstein's practice and be like hey, this is who we are. We'd love to work with you. We can do this in a couple of different ways, but again communication, rapid turnaround, and, you know, good engagement on both sides are going to be really crucial, to make sure that we're driving towards exactly that vision of, you know, potentially co-quarterbacking, passing the ball back and forth, so on and so forth.

When we do that work, we now are able also to say hey, we can preferentially put you all on this eConsult platform. If you'd like all -- a good segment of our volume can go to you, and so that way we're establishing the bidirectional communication necessary up front to that eConsult platform, where the specialists can then tell us hey, you know, it's time for this person to really go into a procedure, go to biopsy, start -- needs to come in to get listed for transplant, so on and so forth, and we can turn that around quickly.

So it is -- it's not one main solution, but it becomes this piece of how are we leveraging, you know, tools that we have today from a digital perspective, to democratize and speed up access to specialty consultation for patients that are often without, and then secondly, how can we use those tools plus good old-fashioned analog interaction and shoe leather to build the relationships necessary in any community health environment to actually get that piece of follow-through.

So those two together have been what

have been showing most promise for us, particularly as we get to scale in certain places, right, like here in Chicago where we take care of 60,000 lives. That's a much easier conversation to have than when we've opened up, you know, a few weeks ago in Phoenix, and we take care of 300 people. So some of that matures as we go along.

VICE CHAIR HARDIN: Josh.

DR. LIAO: Great. I want to thank all the speakers for great presentations. My question is also for Dr. Khan. I appreciated you sharing the data from the Acorn Network in the kind of fee-for-service space and comparing that to MA. You know for me personally, I think a lot about the key differences that might prevent someone from using the same thing on both sides.

So I'm wondering if you can comment on that slide that Paul referenced, Slide 9, where you're identifying time, specialization, support, technology integration. If you can kind of cover some ground mentally with me and say what are the things that you think you've seen from Oak can be done pretty similarly

across MA and fee-for-service, comparably, to see those benefits that you're showing on that slide?

What are the things that you've done successfully in both but really need to look different in delivery? And then what are those things that you say look, in an ACO setting, it's very hard for us. We found it's hard to do, and so we don't do those in that setting where maybe we could under MA or other things? So kind of -- if you could bucket it in those three ways, that would be very helpful.

DR. KHAN: Yeah, and I'll give the caveat of like easy to do it versus like financially sustainable to do it are two different things, right? I think from the context of the core of what we do, right, in terms of bringing a patient in, risk stratifying them, identifying the amount of primary --

Like the right bolus of primary care, building the longitudinal care management plan that integrates with that clinical care plan, right, and then setting the large, the core of the large team, particularly nursing,

community health workers, social workers, and the like, in addition to our primary care clinicians against that work, that is --

That, you know, it consistently works across both settings, right? We can do that over and over again, and that for us has seen similar results, as demonstrated by our performance in MSSP[42] around delivering -- like the delivering that consistent experience and that consistent pace of follow-up has worked for us on both sides.

I would say where we end up running into challenges is probably in the areas of when we start to layer on additional services, that we just financially can't -- like can't sort of take on further in a non-MA or non-capitated environment, right?

So for us, historically that's often been integrated behavioral health, where we are, you know, doing a lot of work to refer people out, but making sure that we can, you know, bring that in, where we are doing a lot of work in training of our own folks using

42 Medicare Shared Savings Program

national, urban and rural ECHO[43] programs with UChicago and the University of New Mexico, how to manage and treat SMI and primary care with our own internal consults at least from a curbside standpoint, how we leverage electronic consultation through Rubicon and others.

That's one area. Podiatry becomes another area. Some of the ancillary stuff that we do particularly on transportation, right, is often something that we can't gate, open the gate for from a Medicare fee-for-service perspective because the economics grow challenging. So I think it becomes the basic model, right, of like higher touch, higher intensity, proactive primary care using a large, team-based model can deliver a lot of good.

I think when we look at some of the aspects that we feel are core differentiators to driving the next level of value and integration, from a patient-centered perspective, particularly when we think about navigating the specialty world or navigating

43 Extension for Community Care Outcomes

just last mile challenges when it comes to transportation, medication delivery, financial support, that's a challenge, right?

Like for example, when I was in clinic yesterday, I had a new patient with, you know, recent asthma exacerbations, had lost her nebulizer years ago from the health plan that she had gotten it previously. She's on Medicare Advantage with a Blue, and for us since we're at full risk, I just go back, I grab the nebulizer, and I hand it to her, right?

Like and you know, we fill the script for the meds in a -- from a medication perspective -- in a pharmacy. She goes out, she's got that set up. I can't do that on Medicare fee-for-service today outside of Alternative Payment Model constructs, and that I think becomes sort of the typification of the challenge.

VICE CHAIR HARDIN: Larry.

DR. KOSINSKI: Like Josh, I'd like to thank all of you for excellent presentations. Your experience brings information to our Committee that's extremely

valuable for us in making our decisions. I have two questions. The first one is for Dr. Grossman, and I'm focusing both of my questions from the view of the specialist.

So if I'm a specialist inside Kaiser, and I obviously have an opportunity to work elsewhere other than Kaiser, what are the benefits to me as a specialist in working in this environment? Do I have some freedom from some of the preauthorization problems that exist in the private practice world? Do I realize more incentive payments from value-based care than I would in the private practice space? How do you keep your specialists on board?

DR. GROSSMAN: Thanks, Dr. Kosinski. I think that, and that's a -- obviously a really important question, how well does the model work to retaining the workforce and also making sure that it's a satisfactory experience? I think that, of course you know there's been kind of emphasis on primary care, medical home, and the potential rewards associated with an advanced primary care practice, perhaps less emphasis on sort of what

is the process for a specialist, and how does that keep them engaged?

I think that freeing specialists of the constraints of the fee-for-service is in and of itself rewarding, in part because Kaiser Permanente, the Permanente medical groups, do not impose volume requirements or -- although we do track our overall RVU[44] and productivity. We generally do not, mostly from the standpoint of setting minimum thresholds, we do not obviously incentivize the increased use of services or -- and do not put part our specialists under a hamster wheel to generate more volume.

I think the other issue is in trying to create a unified medical group and multi-specialty group, enhancing the relationship between specialists and primary care, much as Dr. Khan was just describing earlier, is super-important, I think, for our groups' overall levels of satisfaction. And specialists can also play a mentorship role, for example, in the region that I work for, the National

44 Relative Value Unit

Program Office of Kaiser Permanente, I recently moved from the Washington Permanente Medical Group over to the health plan side in Oakland, after 30 years' practice here in Seattle, and for example, our diabetic practice is radically different than what you might see in a traditional environment, where the diabetologist actually sees the more severe, complicated cases, and trains and actively supervises a cadre of internists and family physicians who are in a sense deputized to take care of the less, of the more, and including advanced-level practitioners, those that are less severe.

And that enables our practitioners and our specialists to practice to the top of their license, and really also enriches the practice mix for primary care physicians at the same time. So you know, the type of model that we use here, I think, is one that definitely does appeal to specialists in general. We have not -- we generally are very competitive in attracting applicants for specialty positions. I hope that's helpful.

DR. KOSINSKI: I think it is. I'd

like to address a slightly different twist on the question to Dr. Khan. Since you engage your specialists, and it sounds from your presentation like you have a tremendous relationship with select groups of specialists that see the world the same way as Oak does, what percentage of their business typically are they obtaining from Oak?

Are your specialist groups almost exclusive to Oak? Are they deriving a very significant percentage of their business from Oak? Please expand on that.

DR. KHAN: Yeah. You know, it's actually a good question and as Dr. Grossman was giving his answer, I was smiling to myself only because the idea of having the captive specialist network as he does would be such a gift.

You know, before my time at Oak Street, I spent a number of years at CareMore Health in California, a part of Anthem/Blue Cross/Blue Shield. But in a world in which, you know, even as a health plan and a clinical provider, we had the kind of relationships, Dr. Kosinski, that you allude to, where oftentimes

the percentage of volume that a certain specialist group might be getting from us at CareMore was running upwards of 45 percent, right, because of the strength of those relationships and the strength of those networks.

At Oak Street, I think because we are so geographically dispersed across 20 states, but even in our most dense market, right, still only serving 60,000 beneficiaries, there's not a single specialist that we work with today where we are probably -- where we represent anything more than 10 percent of the volume that they have, right?

And I think therein lies a very key difference, where 10 years ago it was almost always outlier practices that were willing to engage in this way. Now we are seeing health systems and multi-specialty groups who want to become a little bit more forward-thinking. Like that shift has gone from like one percent now to maybe like 35 percent, or who see like hey, this is a great model for us to test out, to see what we can learn from, and then do we try to leverage something similar within our

own groups? Do we leverage across our -- work on MSSP, so on and so forth, right?

What they're willing to kind of prototype with us, and we bring sort of a prototype hypothesis over and over again into communities across the country. But where we haven't developed the kind of relationship where it's like, you know, we're the bulk of their business, I do think we are seeing this across the value-based space in certain places.

Particularly look at the large MSO[45] aggregators. So Agilon, for example, in Ohio, I was talking to their CEO, CMO the other day. They're able in a market like Akron to, you know, to bring 40 percent of membership in that region to a specialty group and be like hey, work with us because we control a pretty big chunk of change.

We're not that lucky, so we have to go a lot more on -- so we're focusing on the details and getting to programmatic excellence, to demonstrate that it's, you know, a good investment to work with us.

45 Managed services organization

DR. KOSINSKI: Thank you.

VICE CHAIR HARDIN: And Josh, did you have another question?

DR. LIAO: I did.

DR. GROSSMAN: I was wondering if I could just add one other comment to Dr. Kosinski's question, if that's okay. I just, two other issues. One is that I think it's important to recognize that because Kaiser Permanente is a nonprofit organization, we are somewhat constrained in terms of what we can do in terms of offering financial incentives, and our salary structure is actually competitive.

But clearly physicians that come to work for Kaiser Permanente don't come because it's the best-paying offers in the community. Instead, what they're doing is trading off a practice lifestyle and philosophy of practice, you know, that is rewarding to them but not necessarily the highest-paying offer in the community.

The second issue, I think the other big difference that I neglected to mention was the seamlessness with their integration of the health plan and the practice is really

important. The lack of needing to fight and appeal and go back and forth and bicker with multiple insurance companies I think no doubt also contributes to the level of satisfaction and is an attractive feature for someone working in the Permanente Medical Group. Thank you.

VICE CHAIR HARDIN: Very helpful. Go ahead, Josh.

DR. LIAO: My next question actually is for Dr. Safran, and thank you for reviewing kind of your experience with the AQC. I guess my question is, you know, within the context of a global budget and one of the themes I'm taking away from these sessions is that it provides some flexibility financially to do a number of things. I was struck by the fact that there were, as I understand it, additional PMPM quality dollars kind of regardless of what the budget deficit or surplus was.

I'm curious if you could just share with us, given that PMPMs are something that we're thinking about in these models, what are certain things that partners are able to do with those PMPM dollars maybe that they

wouldn't have been able to do without them? Or you know, based on those learnings, how might we think about PMPMs going forward in these TCOC models?

DR. SAFRAN: Yeah, Josh, thanks for that question, and I'll answer it in two ways. First what I'll say is that I think that PMPM dollars provided enormous opportunity to invest in those four different types of interventions that I highlighted in a slide that I only went lightly over. But new kinds of staff, new ways of engaging patients, information technology and data systems, and new ways of relating to others in the network.

Probably the least was invested in the latter of those four categories, but you know, new staffing models. I think you've heard quite a bit about that today, bringing behavioral health specialists into primary care settings, bringing pharmacists on staff, bringing social workers and others in sort of allied behavioral health specialties on staff, so staffing.

Patient engagement strategies that leverage those new kinds of staff, that

involve, for example, direct patient outreach in between visits, after a hospital discharge, really the things that have the care extend outside the clinical setting to provide the kind of support that I referenced, that I think contributed to that improvement in outcomes that we saw.

So that's one thing I would say. The other thing I would say is that the constraint of our model was that those dollars, those payments were generally made, you know, in the year following. They were a reward for performance in the last measurement period. And some of, I think, the attraction of models that are not a global budget but rather an actual capitated payment are that they address some of those cash flow issues and perhaps, I think, I don't personally know of any evidence that demonstrates that that does create a front-loading of those investments. But that's, I think, the intent. What we did as a kind of surrogate for that was especially in the early years, we created some infrastructure payments that were grants, if you will, but sums of money to help organizations invest in

electronic health records, because remember this was 2007.

It was still very early for many organizations to invest in other things that they needed and where we didn't want them to have to wait until a performance-based payment, you know, next year or two years down the road.

VICE CHAIR HARDIN: And Paul.

DR. KOSINSKI: I have a question for Dana, as well. Dana, it's nice to see you, and thanks for a great presentation. One of the topics we talk about a lot is accountability and level of accountability, you know, whether it's the entity level, and how do you cascade accountability. So when you think about quality measures, and you mentioned the advantages of outcome measures, often -- as I think about it, it's often challenging to think about what is the right level of accountability when it comes to outcome measures, as often it's hard to assign that to a specific provider.

And of course, it depends a bit on what the outcome measure is, but I know you've thought about this a lot. I'm just curious

about your thoughts in general.

DR. SAFRAN: Yeah. Thanks for that question, Paul. So what I'd say is that in the AQC model, the accountability was with the system, and the system, you know as you probably know, could include anything from a large enough primary care practice, meaning had at least 10,000 members, so we could compute actuarially sound budgets, and was willing to accept accountability for total cost of care across the continuum, even though they didn't have, you know, specialists or hospitals in their contract, all the way to, you know, a multidisciplinary practice or a system that had multiple hospitals and everything in between.

So accountability at that level for outcomes, and I would say that both with respect to ambulatory outcomes and hospital outcomes, that was kind of appropriate and fair. Where I think your question comes into play is what about for the individual clinician or the individual team who's actually directly involved with a certain episode of care and the outcomes from that?

That's where, you know, I would say

both the art and science of measurement that I've dedicated my career to, tells us that that's not a good idea. That, you know, the science part is we rarely have adequate sample size, especially for an individual payer. Yeah, an individual payer with an individual clinician or even team, to compute stable, reliable information about performance on a given measure.

But also from the perspective of art, it doesn't create the incentives that we really want to be creating now and that value-based payment I think is trying to drive, which is really knitting that fabric that is health care, that no single individual clinician or even any single team can provide. So I think by creating the incentives at the system level, that's appropriate.

The challenge, which I know you're aware, well aware of, but that I can't end the response without saying because it would be incomplete, is that how that institution cascades those incentives down to the individual clinicians matters, right? Because when that -- when the payment for the

individual clinicians is primarily based on RVUs, for example, you know, we are really living with, you know, a foot in two canoes.

It's very different from the sense that phrase is usually used. But you've got individuals incentivized completely differently from how the organizations incentivize, and I think that that gets us stuck and unlikely to see the progress that we want from value-based payment. So I think that it's important for organizations to cascade the right incentives down to the frontlines, but not by, you know, creating accountability for individual measures and the results of those measures. I hope that answers your question.

DR. KOSINSKI: Yeah, thank you.

VICE CHAIR HARDIN: Walter.

DR. LIN: I have a question for Dr. Khan around the flow of funds in the Oak Street model, both to the organization and then, as Dr. Safran was just mentioning, how Oak Street incentivizes the frontline primary care provider. So the first part of my question is just a kind of a real simple structural one. Does Oak Street Health have its own health

plan, or does the organization take delegated risk from incumbent Medicare Advantage Plans?

DR. KHAN: Great question, Dr. Lin. Always happy to take it from a fellow Yale internal medicine grad. By and large, so we are not a plan, first and foremost. We obviously, for the 120,000 or so members that we are at full risk for, we are in full like percentage of premium arrangements, with a variety of health plans, I think 40-plus around the country, including all six major nationals.

For a subset of those plans, we happen to be delegated for a partial set of functions, most often usually in care management utilization management. It is very, very rare that we are taking on network claims, you know, griveances, appeals, those sorts of features. So which, you know, creates a different locus of control and a different areas of focus, than necessarily what I enjoyed coming from the plan perspective at CareMore a few years back.

So by and large then, like occasionally there are upfront capitation payments included as part of those percentage

of premium arrangements, but that is the main structure, and then there are some plans from which we are in a primary care cap, with a small number of plans kind of across the country, often as a bridge towards driving towards full-risk arrangements for the following year.

DR. LIN: Thanks, and then the second part of the question is around how Oak Street incentivizes its primary care focused model to engage the frontline PCP to reduce ER utilization and patient hospitalization, total cost of care. What kinds of -- it doesn't have to be too specific, but in general compensation arrangements do you have, and how have you seen that change primary care provider behavior?

DR. KHAN: Great question. So I think similar to the Kaiser model we are -- we feel like we are offering, you know, competitive, above 50 percentile salaries from a primary care perspective across the workforce, which makes a difference.

It doesn't close it, but it does make a difference in terms of sort of the shifting of primary care reimbursement, and

thankfully, I guess for whatever reason, the Kaisers of the world, the Oak Streets of the world, and the Ioras of the world have induced somewhat of a sea change on the fee-for-service sidetowards better primary care salaries.

I say this as a general internist, although most of those prices those, you know, heavily are RVU-rated. For us obviously there is no RVU component. We do maintain a significant portion of total compensation in bonus eligibility, but those bonus measures are driven almost entirely by engagement, quality, and quality measures, right?

So how we've done from a panel perspective in terms of, at the individual level and at the center level, of you know, bringing all of our primary care patients back every year before -- either staying on, staying in programs, staying adequately at the annual AWV[46] and, you know, really having engaged in that way, right?

We may look at like -- we may look at performance on stars measures across the

46 Annual wellness visit

panel, and how they're driving from that perspective in a risk-adjusted manner, right?

It's these kinds of measures, right, that we're really trying to drive towards. We did a couple of quarters last year where we really focused heavily on COVID vaccination or boosters, right?

So in terms of what we've seen is that in terms of driving primary care and team behavior, those same bonus measures cascade across the entire team, from our welcome coordinators who are checking in patients to our drivers who are providing transportation to our social workers, so on and so forth.

Different weights and measures, but by and large really optimizing on that aspect or patient experience and consistency or follow-through. So with that, we are able to derive a whole team kind of engagement in the pursuit of those measures, which I think unlocks -- we think unlocks a bunch of creativity at its best, right?

When a team is like you know what? The whole point of a model like this is to just -- let's just go to their house, and we can

block off two hours because that's the right thing to do, because we know like he's having trouble coming in, and we know this patient's hard of hearing, and he's got other challenges, right?

Or sometimes it can be what I did a couple of weeks ago, right, which is knock on a bunch of doors in a parking lot in a semi-abandoned mall out in the west side of Chicago, looking for a patient of ours with our social worker, who we knew had a pretty honking diabetic foot infection, but, and was in a gray Celica, that she thinks is a Celica, but she really only knows it's a coupe, right?

And so we're literally walking around this entire mall parking lot, trying to -- I try and see who's in every single one of these gray coupes, because that's the right thing to do from an engagement standpoint. So what we found is that that kind of approach can be very useful in starting to do the work of unlocking years of like reactive practice into doing something more, that feels very odd to our PCPs in particular.

But that is actually the work, I

think that Kaiser has exemplified this so well, of just getting out into the community and meeting people where they are.

DR. LIN: Great. Those examples were really vivid and I think well illustrative.

VICE CHAIR HARDIN: I think this is a perfect note to close this session. We want to thank you all so much for this excellent discussion. I have a feeling we could continue asking you questions for a good another hour.

We want to welcome you to stay on and hear the next presentation or listen to the rest of the meeting as much time as you have available. We'd love to have you on, and we want to sincerely thank you for sharing your time, expertise, and excellent thoughts about total cost of care.

*** PTAC Member Listening Session on Assessing Best Practices for Care Delivery for PB-TCOC Models**

Next, I'm honored to move into our PTAC Member Listening Session, and we have one of our very own members presenting based on his experience with many delivery system models.

Angelo Sinopoli, Committee members, will be presenting and members, please have your questions ready for Angelo after his presentation. Angelo, please go ahead.

DR. SINOPOLI: Thank you, Lauran, and I appreciate the opportunity to talk today, and right now I am the chief network officer for UpStream, but I want to emphasize that this presentation is not really about UpStream, although I'll highlight some characteristics of UpStream to fit into the discussion here.

What I'm really trying to bring to the table today is kind of a series of experiences working with very large, integrated delivery systems, large networks and companies, consulting with other networks particularly across the Southeast and other areas, and then my more recent experience with UpStream, and kind of identifying -- I think you're going to hear repeated messages from today. I think we're all on the same page in terms of where things go in and what needs to happen.

So I'll just walk through this and kind of highlight these things as we go. So if you can go to the next slide. So this is just

a pyramid that I always like to look at, because it does represent all of the building blocks that are necessary for a very high-functioning integrated network. And I will tell you that from my experience, with notable exceptions, some of those that just presented today, these don't exist in most clinically integrated networks, okay.

But ideally, these are the things you'd want to have active participation in, in every one of these building blocks. If you're missing some of these building blocks, you're not going to be the Kaiser, you're not going to be some of those that we think about day-in, day-out. But it still is useful to look at these building blocks as you're building your pyramid to understand where you need to be.

Because I'm going to talk just a couple of minutes about this, and talk about some of the more important pieces, at least from my perspective, and some areas where I think historically we've kind of missed the boat a little bit. And so obviously physician leadership is the single more important building block of this pyramid. You've got to

have engaged physicians who understand what needs to happen, and I think there's been a tendency in the past to not appreciate the importance of primary care.

I think that is rapidly changing over the last few years, and I think appropriately so. Primary care has been seen mainly as where attribution occurs, and where referrals come from, and a way to grow the network and grow a volume. But it's not been really seen as that's where the patients get managed, and that's where the cost containment and the quality improvements occur. So that, that is changing, and I think we need to emphasize that.

The next layer up is after you get that physician engagement, you've got to have appropriate care models that are informed by data and analytics. And again, I've built a large data and analytics company, but I'll tell you again that most places do not have adequate data and analytics, and most entrants into the market trying to get into value-based care typically will rely on their hospital systems for data, and they'll rely on payer reports.

Those two things are okay for a beginner set, but they're not good enough to really get you to that next level. The expertise within hospital systems aren't focused on the kind of things we're going to talk about, and their analysts, their data scientists, et cetera, are a different breed than what we need from a value-based component standpoint.

And then developing the delivery network. I will mention UpStream here. I think one of the differences in UpStream compared to some of the value-based companies is that we take all comers, okay. Just as compared to trying to aggregate patients into a center, we partner with every primary care patient (sic) that sees Medicare patients, and our goal is to bring all of them up.

Some of them have lots of Medicare patients; some of them have only a few. But we partner across the board, and we treat them all the same. We isolate them in terms of their quality and outcomes, and so if you're in a given network, and you have one practice across the street that's doing poorly but the other

one across the street is doing great, we incentivize the practice that's doing great, okay.

So as practices, and I'll talk about the model in a minute. As practices improve, they see that reward immediately as opposed to 18 months down the road. We'll talk about that. I think developing a financially sustainable model, in my personal opinion, I think this is where we've fallen down a lot too, because we are so timid to get into risk arrangements that we fail to recognize that if you don't have enough upside potential, you can't generate enough money to cover the expenses.

The secret to success in these models is data and it is expertise. This kind of expertise doesn't come cheaply, and so you can't -- as somebody said to me "If you think expertise is expensive, wait till you hire inexperience." So you've really got to go after those people that know how to do this work and invest a lot of money up front.

But I'll show you that there is money out there. I'm not talking about private

equity money; I'm talking about money from CMS that can cover these things.

So next slide. So this is just a layout. You've all seen this slide, the continuum of care. The only reason I put it up there is to point out a couple of things. Number one is you do have to think about and address the entire continuum of care. You're not going to be successful in Medicare if you don't have a great post-acute program, for example. So you've got to do that.

But the other thing that this continuum of care slide represents to me, which it's supposed to represent the continuum, what it also represents to me is the fragmentation. So you can even see from this slide that there's multiple boxes, there's multiple entities within each box. They all have great initiatives going on, but even coming from integrated delivery systems, they're still fragmented.

The fabric that we heard about before is the ideal thing that we're all striving for. But it's hard to obtain that fabric seamlessly across every aspect of the

organization. The other thing that I would point out is that primary care, in that left lower box, has been again traditionally ignored as a site of where the actual care occurs.

And when I say "care," I don't mean the care from the physician, but the team, and we'll talk a little bit more about the team, creating a team focus there in that practice, and creating what we refer to as linear integrity.

And so that primary care practice with the right support systems and the right team, can be that mini-care management company, that for its patients is deriving that linear integrity across to the hospital, across to the post-acute systems, across to the community-based organizations and driving very direct care in a relatively low technology standpoint of their risk stratification and data analytics.

Next slide. So again, just reemphasizing this is that changing how we think about primary care, it is the first contact that patients have. It's the first opportunity to do risk stratification. It's

the first opportunity to intervene. I think primary care has been a missed opportunity in general to intervene, and go to the next slide, and we'll talk a little bit more about that.

So transforming primary care to really -- rather than being the old PCMH[47] model, being a true primary care transformation model, okay. And that requires an embedded care team with multiple resources, and interestingly enough, the money is out there today to cover that. Most people don't utilize it. I think when we did our own study, we realized that chronic care management fees were only charged about 14 percent of the time, okay.

That's a huge missing opportunity for primary care docs. So if you add up the chronic care management opportunities, the transitional care management opportunities, the remote patient monitoring opportunities, the annual wellness visit opportunities, there's a significant amount of dollars there that can transform a primary care practice into a care

47 Patient-Centered Medical Home

management hub that can identify or risk stratify those patients, manage those patients through the primary care practice, and create great outcomes.

Now that team that is supported through those revenue flows needs to be very specific, and so it can't just be that you're hiring anybody, just another nurse to put in the practice. You've got to really think through what you're hiring. Again, that team. So we had a doctor present at the APG[48] meeting last week in San Diego, and he stood up and said, okay, I'm a primary care doctor, and I just saw a patient who had five chronic medical problems. They're on 12 medications. They had side effects from medications. They had transportation problems. They had social determinant problems.

Tell me how I'm supposed to strategically decide which one of those problems to address in a 15-minute visit? The answer was you shouldn't have to, you know, prioritize any of those at all, and if you had

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a team around you, number one, that would have not occurred to begin with, because they're cycling in the back addressing those things before you come, before that patient gets in to see you.

When you see the patient, you already know what's going on with that patient and what's being done for them. The other thing that team can do is what our team does, is that before those visits, is we have every patient come in and see that care management team, which includes a clinical pharmacist, and they're specifically trained to do certain things.

But that team will reach out and get medical records from every specialist that that patient has seen, because although it sounds reasonable that you would expect that those would get sent to you, they don't; that you can retrieve them electronically, you can't. My previous clinically integrated network had 83 different electronic medical records, okay, and you never got anything from the ophthalmologist.

And so this team serves to aggregate

all that data, bring the patient in. They'll spend as much as 90 minutes with a patient, going through all those reports, going through how they're doing, listening, trying to understand what the patient needs are, what their expectations are, and what we've seen is that once those patients come in and see that care management team, that there's almost 100 percent retention rate in that model.

So they begin to recognize those ancillary support team members as their team members, and they become very attached to those. They're available to them 24-7, and they -- we embed those in every primary care practice, and those patients will call that pharmacist or call that nurse care manager for any kind of problems they have. That takes a lot of workload off the primary care doc.

They also handle all of the pre-auths from the pharmacies, from the insurance companies, et cetera, so the primary care doctors love it. And they work to close all the gaps in the practices. They bring those patients in and they look at where those gaps are. They schedule their mammographies, they

schedule their colonoscopies, et cetera.

Next slide. So it does have to be the right combination though, and they do have to be trained. So you can't just get a pharmacist and stick him in there. So we put our pharmacists through something called UpStream University, and they're actually trained in motivational interviewing. They're trained to listen. They're trained to look for these very specific indicators of health outcomes and to document those and to address those issues, to address those social determinants.

These embedded teams, although we say embedded, we have some that wrap around the practice too, and as you heard earlier, they'll go out to the laundromat and meet them, or they go to the home and meet them, and those are unlicensed but trained professionals that go out and do that. And so it's varying the levels of expertise in that model.

The other thing that we do that we -- that I think has been a differentiator, because one of my issues has been, even for our -- my previous network, is that from a doctor's

standpoint, you're working all year long.

You really have very little line of sight of how well you're doing. And then at the end of the year, the end of the year closes, and then you're at another eight months, and you cross your fingers and see if you're going to get any shared savings.

So after a while, that becomes a little demotivating, particularly if you go some years where you're not creating shared savings. So in an UpStream model, they're confident enough in their model that they know they're going to make shared savings. So they're actually paying the physicians up front, but we don't pay them for shared savings. We pay them for quality.

So we actually have a star rating system for quality, based on all the typical metrics you would think of, and as their quality improves, then we pay them more. So they get paid a certain PMPM for this level of quality, but as their star ratings go up, they can actually see their monthly income going up.

And so that motivates them to participate in a team, to close those gaps, to

drive quality. It's not about utilization. It's about driving quality. The team is addressing utilization by managing those referrals, managing the hospitalizations, managing the post-acute, but that encourages the doctors to work with that team.

And so the docs see immediate reward, we're seeing great returns on the back end with this, with this model. So we take all the downside risk, and we guarantee the upside risk, and that clinical embedded team is what drives all the outcomes. It's amazing that just a handful of embedded team members compared to a telephonic model, drives dramatic improvements in quality and shared savings, okay.

Next slide. So again you've heard a lot about data and analytics, and obviously it's important. Most people don't have the access to kind of data you've heard today. We had a fairly sophisticated data system at the previous organization I worked for, but even that was relatively unusual. And so but you do need that. I mean that is the ultimate goal, is to develop that level of data integrity and

data abilities, because you've got to aggregate.

Again, it goes back to one of the problems is in our network, we had 83 different EMRs[49], and so developing the processes to get that data, to centralize it, to aggregate it, to scrub it, to normalize it, to match it with claims, to do all that is a huge, huge undertaking. Then to use all that to risk stratify patients, both from a cost standpoint and a clinical quality risk standpoint, and we're now rebuilding that at UpStream, a similar model.

So that is a very difficult task, and something that's very expensive. Again, I think relying on hospitals is probably one of the disservices that most organizations do, because they're depending on that kind of data, and hospitals just aren't equipped to do the things that I just mentioned.

So you've really got to either build your own, or reach out to a partner or some other data company to help bring that data to

49 Electronic medical records

the table. If you do that, then I think many more primary care practices can get into the value-based arena than we've seen get into it in the past. You know, the barriers have been that upfront expense, you know. It's just too expensive for primary care docs to get into the value-based arena.

They don't have the capital to take downside risk. Even $5 million organizations don't want to take that much downside risk, because that hurts their bond rating. They could afford to lose it, but it hurts their bond rating, and then the data and analytics. Those three things really are barriers.

So next slide. So again, as I think through what the barriers have been that I've been exposed to that have really prevented us as a country for moving more rapidly into value-based care, has been, you know, a reliance on hospitals to help drive this. Again, it's not that they don't necessarily want to; it's just not their business model if they don't have enough patients in their system for it to become important for them to make the appropriate investments that they need to do,

again with notable exceptions.

We all hear about the great organizations that are doing this well, but I'm talking about through rural Southeast United States. That just doesn't happen very often. Lack of the upfront investment. Physicians don't receive real-time incentives, unable to take the downside risk, not enough volume. Those are the barriers.

So next slide. And my last slide was just really, so how do we get past this? I think developing enablement resources or partnering, and I think the good thing that I'm seeing in the market is that more of these companies are developing, that can at least bring data to the table that's appropriate data the practices and networks can use.

I think there's opportunity to make those upfront investments if we educate our practitioners. How do you build chronic care management, transition care management, you know, educate them on the importance of the annual wellnesses, et cetera? All of that are huge drivers to success, and they pay for themselves if you learn how to manage those

correctly. The real-time incentives is a problematic thing. There's not many companies that pay up front, real-time, but I think that's becoming more recognized as a need to do that.

And then enough to embrace enough risk, and what I hear constantly in conversations is that we've got to move the downside risk. That's a little bit of a negative tone for me, because it's not that I -- I want to go to -- all of a sudden I want to start taking downside risk. What I want is I want lots of upside potential, and to do that, it will take some downside risk.

And so but you're never going to have the money to invest in the things you need to invest in unless you're willing to take that upside risk, and the odds are that you're not going to have to pay on the downside. Scale does matter, and so you know if you're managing 15,000 patients, your year-to-year variability is significant.

But if you're scaled and you're managing a million patients, then that, that kind of evens out over the years, and you may

have one network that does poorly but another one that does well, and so your risks even out. And so I think, you know, scaling across the country with various organizations is another important aspect of how we're going to spread this across the U.S. more quickly than we have in the past.

So I think that was my last slide. So it's really open for questions.

VICE CHAIR HARDIN: Go ahead, Bruce.

MR. STEINWALD: Thanks. It's a two-part question, so wait for the second part please. I guess you mentioned, I was thinking of volume. What's the minimum that you can get something going in the direction of value-based care in a given market? Is it based on the number of patients?

DR. SINOPOLI: That's a great question. So we look at it in two ways. We look at it per practice, and we look at it per micro-geography. So in a micro-geography, we need 4,000 patients, and in a single individual practice, it doesn't make sense for us to embed pharmacists and care management staff if they have under 200 patients.

And the way that we do that, so we use that 4,000 patient supports an entire team. That includes a clinical pharmacist, a nurse care manager, and a concierge team of non-licensed people that surround, surround those three individuals, and they cover 4,000 patients. And so if you've got two practices, each that have 2,000 patients apiece in them, then they're splitting half of their time between those patients, those practices.

But they're available to those practices 24-7, and they're available to those patients 24-7. But when it gets down to a single practice that has under 200 patients, it's not very productive to have that model in place. But we do that sometimes, because we may have a network that has 50,000 patients, and there's a few rural practices in there that have 200. And so in the bigger scheme of things, we provide that service anyway.

VICE CHAIR HARDIN: I'm going to jump in.

MR. STEINWALD: As I was listening to Dr. Khan, and some of the statistics he cited where it seems like they're in many, many

markets, but the market penetration in any given one is pretty low. And even to the point of saying well, there's no specialist organization that derives more than 10 percent of their income through their presence there. Would you pursue a strategy like that? It sounds like it's successful, but is that the exception rather than the rule?

DR. SINOPOLI: Yeah. We actually take the opposite strategy, in that we -- and there have been a lot of delivery systems that are trying to move towards senior clinics, you know, that kind of model. After talking to us, they're reversing their strategy, and they're going to go with us because it's, it's -- our strategy is to allow patients to see the practitioners they want to see, you know.

Don't take patients away from doctors who have long-standing relationships. Let's embed the resources. Let's give the doctors the time, the resources, the patients, the resources, and we've proven that we can -- we can drive utilization down 45 percent a year, year over year, and create, you know, savings of 10 percent a year with this embedded

model.

And so -- so yeah. So ours is a much broader footprint, more scalable than trying to create, you know, individual practices.

VICE CHAIR HARDIN: I have a question for you about social determinants and addressing equity. So you have the perfect scenario. You're not only with one payer or one population, you've got everyone. So I'm curious. What have you found to be the most impactful investments for addressing health-related social needs, and then in relation to that, what partnerships or revenue shifting are you needing to build in order to meet the demand that you're finding as you're proactively addressing that with large populations?

DR. SINOPOLI: From a social determinant standpoint?

VICE CHAIR HARDIN: Yeah.

DR. SINOPOLI: Yeah, yeah. You're right. Since we do all -- all of our contracts are global risk, and even on the fee-for-

service side, either a DC[50] model and now REACH going into this coming year and MA global contracts, and what we're finding is -- so I'll start from the top -- huge educational opportunities.

Patients come in, and they don't know how to access the system. They're on multiple medications. They don't understand their medications. One of the things that we do is that we synchronize their prescriptions, so that they're getting all their prescriptions filled on the same day of every month, because otherwise they're trying to get to the pharmacies multiple times a month, and they miss them.

Because the number one driver has been transportation. They cannot get to their doctor's office, they can't get to the pharmacist. They can't -- even if you refer them to a community-based organization, they can't get there to talk to them. And so the transportation's the issue, and we have partnered with cab services, with EMS[51], with

50 Direct Contracting
51 Emergency medical services

others to help drive those outcomes.

That solves the vast majority of problems, because if you can transport them somewhere, you can get most of their issues taken care of. It's just the transportation.

VICE CHAIR HARDIN: Thank you. I wasn't paying attention because I was so excited about my own question. Who was first?

DR. MILLS: We'll just say it was me. So first of all, Angelo, I'm going to say fantastic and hip-hip hooray. In a fit of convergent evolution, I had exactly the same experience in private practice in Kansas that came with the very same lessons learned, which was such modest investment in primary care of about half an FTE[52] nurse care manager, one extra medical assistant per physician, one LPC[53] per clinic site, and a tiny smidge of a clinical pharmacist, you can get what you need done, and you laid out the revenue sources that cover it.

DR. SINOPOLI: Yeah.

DR. MILLS: It makes perfect sense.

52 Full-time equivalent
53 Licensed professional counselor

These are two follow-up questions just to see what your experience was in parallel to my experience, which was first, two parts.

One with your providers. The biggest sticking point is often just getting the time and attention of the individual docs to engage, and trust their team to do the amazing stuff behind the scenes while they're in an exam room. So what did you find to be the magic tipping point for your docs, doc by doc?

And secondly was we actually had more resistance in the management level of most of the clinics than the docs. Managers, of course, being trained to maintain homeostasis and keep the bus moving smoothly, as opposed to a leadership mindset of what's the potential for the future. So we actually had some retraining at a management leadership level to make huge difference. So if you can comment on those two aspects.

DR. SINOPOLI: Yeah. No, I would agree with you. I think -- and one of the ways that we train our staff is we tell them. So your primary responsibility is to the patient.

Your secondary responsibility is to the doc in that clinic, and you're not there to disrupt his workflows. You're there to partner with him, to help make his workflows more efficient. Even with that to your point, it takes about four months before the doc begins to trust that these staff know what they're doing, that they're not there to disrupt his day and make his day, and it's interesting.

You know, as we're talking to potential new partners, that's always the number one things that comes up. They're saying what kind of abrasion am I going to get when you embed your team in my practice, and we're going, this is your team, you know. We're training them, we're hiring them, but they're your team and this is what they're going to do for you, and you've got to be willing to work with them to let them do that.

But even with that, there's that tension and resistance. But typically after about three or four months, they're like, oh yeah. In fact, I had one of the -- so this is a country doctor. You've got to understand his language. So I had a doc call a primary care

practice out in a rural area to describe the lack of abrasion that you're talking about.

He called me up afterwards, and he said yeah, I talked to Doctor such and such, and he said, he said I'm glad my office staff wasn't in the room. I'm like uh-oh. I said well, what did he say? He said if my office staff had been in the room, they would have wrestled me to the ground and put a choke hold on me until I signed the contract with you, because they took so much of the administrative burden off the staff, and that's what gets the staff bought in.

Because all of the sudden now they're freed up to spend time with the patients too, and they're not answering all these pharmacy calls and all these other things. And so it takes a number of months for them to kind of recognize that's what's happening. So good question, thank you.

VICE CHAIR HARDIN: Jay.

DR. FELDSTEIN: Angelo, do you hire -- does your company hire the team for the doctors' office?

DR. SINOPOLI: We do, we do.

DR. FELDSTEIN: Do they have any input into those decisions?

DR. SINOPOLI: Yes. They have hiring and firing rights. We train the teams. We bring the teams to them, but they get to meet them, make sure they're a fit culturally, and if at any time during the course of their employment there they get sideways with the docs, the docs can fire them, and we have to bring in another, another team. But they do, they do participate.

DR. FELDSTEIN: And are they on the physicians' payroll, are they on your payroll?

DR. SINOPOLI: They're on our payroll.

DR. FELDSTEIN: And is it part of the package?

DR. SINOPOLI: Part of the package. So we cover all the costs for all the teams, as well as paying the docs that monthly PMPM.

DR. FELDSTEIN: And when you say "embedded," do you mean face-to-face action, or just it’s owned by the physician practice? So if they have to do telephonic, it's still part of the practice, or it just has to be face-to-

face? I'm very curious about that.

DR. SINOPOLI: So we have both of those. So we have actually physical bodies in the office. We have a clinical pharmacist and a nurse care manager actually in the practice, and they may not both be there the same day. You know, the scenario I gave you where they might be covering two practices, and one may be in one and one in the other.

But somebody's there most every day, and they're interacting with the docs. They've got a space where they can see the patients. They do the intake, so to speak, of those patients and meet with them and manage them. We also have a -- we do have some telephonic care management services. We found that they're really only useful for follow-up issues. We don't like to use them as a primary resource for care management.

It's if somebody just needs to be checked on to see if something happened or if they got their prescription, then we can call them, and we can call them from a central office. But we want them to have that relationship with that pharmacist and that

nurse care manager, that they feel like that's my pharmacist and my nurse care manager so --

We also, you know, those that we are seeing so intently, it averages to be about 30 percent of the entire Medicare population. Those are the ones that we're really seeing in the office and intently. That other 70, we have a team that's outside the office just following up on those, because what you heard from somebody earlier today, that 70 percent is actually what drives a lot of the gaps in care, because we're paying attention to those top 30 percent and trying to fill those gaps.

There's 70 percent with rising risk and those quote, you know, "well patients," they aren't getting their colonoscopies done, but they're not sick, and they're not utilizing you yet. So we've got another team that addresses those, and make sure that those gaps are being filled.

DR. FELDSTEIN: Thanks.

VICE CHAIR HARDIN: Jennifer.

DR. WILER: Thank you for describing your organization and your previous experiences. I think there's a lot of themes

that we continue to hear, not only today but in our other sessions. So it strikes me that in fee-for-service, a balancing measure that was created out of that system, is utilization management, right, to restrict access.

And yet we had a number of speakers, including yourself, today talking about number of touches being a process measure, to validate interactions, which improve outcomes. So we heard today about a ratio of a PCP to specialist/consultant, and one of our speakers said a one to one ratio was where they were, they were focusing.

And if I took notes appropriately, Dr. Zimmerman said that the goal was to have 95 percent of patients being seen once per week, which is obviously really high. So again, you just described high touch and also 24-7 access. So can you talk a little bit about how to operationalize that, especially as we're thinking about workforce issues and folks who are, you know, leaving the specialty because of emotional stress?

And yet we're, you know, this is creating potentially an unintended consequence

of unfettered access of patients to resources. Are you finding it difficult to find staff who want to have 24-7 accessibility to patients, number one, and then number two, what are the metrics that you're following around validating that there's a high touch?

DR. SINOPOLI: So we've not found it difficult to recruit staff. So there's an abundance of pharmacists out there right now, and a lot of new graduates who are having difficulty finding jobs, and then because of this model, a lot of the pharmacists are tired of counting to 30 every day.

So they are looking for these kind of jobs, and so -- and we pay very well. And so for every open spot we have, we typically have at least five great applicants for them. We have to decide between those five which ones to put in a practice. So nurses are a little bit harder to find, but this is such a unique job again, that we've not had problems so far of finding enough good nurses. But just because of the nature of the work. It's what they went to nursing school for, and so, so we've not. They love the interactions, they

love being available, and they don't really get that many calls at night.

You know, they are available 24-7, but if they're doing their job, those things are taken care of during the day, and there's not many night time calls. And so -- and we are measuring touches. We measure how much time each of our staff spends with patients. They average about 7-1/2 hours per year actually, you know, directly conversing or meeting with the patient.

It doesn't sound like a lot, but that's actually a lot of time compared to nothing, and that intense structured time with them is really what's driving the outcomes. So we do measure that, and we measure patient experience and get feedback from patients about it too.

VICE CHAIR HARDIN: Walter.

DR. KOSINSKI: Walter?

VICE CHAIR HARDIN: I mean Larry.

(Simultaneous speaking.)

DR. KOSINSKI: Angelo, I can't tell you how much I enjoyed listening to you and how much I relate to the environment you're

building, because it's so similar to what we're doing. Touches. Touches are such an important concept. They supersede the difference between PCPs and SCPs[54], because really what you're doing, what you're calling primary care is proactive engagement with patients, and we call it touches because it can be in multiple different fashions.

But a specialist managing a condition that has a very high ratio of disease-specific cost to total cost, those touches are equally as important, and I think we heard that in the renal disease piece earlier today. So one of the things we've done with touches is we've -- I hate the word "automate," but I'm going to use it.

But we automated them. They are, they're a part of the technology platform, and we're in an environment today with patients where patients want to engage in the way they want to engage, and we have to adapt to that. We can't retrofit it. I know we heard a story about trying to find a gray Celica, you know,

54 Specialty care providers

to get a diabetic patient. That's obviously the extreme, but you know, you have to figure out a way of engaging with those patients where you can proactively avoid the deleterious effects that happen with poor engagement.

You're right. We found out that 200 patients was the minimum. But on the other side, that nurse care manager or care manager, it doesn't have to be a nurse, but that care manager can handle a lot more than the 200. So you build a lot more efficiencies as you bring in more patients.

We really don't have an upper end to that established yet because there is a lot of elasticity there in how many patients you can encounter there. So you're doing great things, and I think there's a science. We've heard some things today that have permeated multiple presentations.

To me, what I'm coming away with is that engagement is so critical, because we heard that in just about every successful story up there, and whether that engagement's being done by a PCP, an under-appreciated PCP I should say, or a specialist, I think we have to

get to the patient before the patients need, realize that they need to be encountered.

DR. SINOPOLI: Thank you.

DR. KOSINSKI: Oh, one more point, one more point.

VICE CHAIR HARDIN: Okay. Only one.

DR. KOSINSKI: I forgot. My team, I emailed my team because you mentioned CCM[55] and PCM[56] codes. One of the things that's a problem today, these are not first dollar codes. A patient gets a deductible every time we use them. So if they're, if they're realizing that we're doing something for them, they can accept the fact that they have a hit to their deductible and their copay.

But if we're using it proactively, and maybe they don't realize they're getting that much benefit, it would really accelerate the use of these if they were first dollar and --

(Simultaneous speaking.)

DR. SINOPOLI: So if I can make a comment about that, is that so when we reach

55 Chronic Care Management
56 Principal Care Management

out to patients, we always describe that to them so that they're aware of that. We only get about a 70 percent uptake, because they're worried about their copay. Of the 70 percent who decide to take it, and sometimes their copay is covered by their supplemental or whatever, that's where we have a less than one percent attrition rate.

But as we move into REACH, REACH actually has a waiver, so that as long as you do it for everybody, you can you waive the copays for these client care management fees? So that's our intent, is just to waive the waiver because it's so valuable to get those patients in so --

VICE CHAIR HARDIN: So fantastic presentation.

DR. SINOPOLI: Thank you.

*** Stakeholder Responses to PB-TCOC Request for Input**

VICE CHAIR HARDIN: It's really great to see you weaving together the themes and the depth of knowledge and experience from having done this and best practices. We've heard some fantastic themes today, really great

dialogue and discussion, and now we're going to turn it over to Victoria, an analyst with ASPE, to update us on the request for information and input that we issued in March. Victoria, please go ahead.

MS. AYSOLA: Hello, excellent. Thank you so much. So I'm here to give a quick plug that PTAC has released a Request for Input, or RFI. The RFI is an important part of the Committee's work on population-based total cost of care models, and the RFI is still open. So members of the public are asked to submit by July 20th for the Committee's consideration as part of the series.

And as a quick disclaimer, I'm not speaking on behalf of PTAC, and right now I am also not endorsing specific comments or policy positions. So if we could go to the next slide, please. Excellent. So throughout the Committee's history, at least 10 of the physician-focused payment models that stakeholders have proposed discussed the use of total cost of care measures or other related elements, which led the Committee to plan and hold this theme-based discussion series.

The purpose of the RFI is to gain additional stakeholder insights that can then inform the Committee's review of proposals, as well as recommendations provided to the Secretary.

I think the Chair noted this morning that the Committee is going to draft and release a report to the Secretary of HHS on this topic after the series concludes in September. So this RFI is a great source of stakeholder input to lead to those recommendations.

So if we could go to the next slide, please. Great. So seven different organizations have responded so far, and I'll leave this up for a moment so that our audience can get a sense of who has submitted. The public comments that have been received so far are available on the ASPE website, and as you can see, we've heard from a few different parts of the health care system.

Next slide, please. Great. So here are some of the topics that the Committee asked about in the RFI. I do want to share some brief highlights of what has come in so far,

but note that this is not a comprehensive look at the responses. I think a lot of these will sound familiar, based on what you have all been hearing throughout the day.

So I'll note that for defining total cost of care, there has been a variety of ideas about which services should be included when calculating total cost of care. In terms of the design and implementation of these models, several respondents suggested incorporating a wide array of providers and entities that can potentially contribute to reducing total cost of care.

That was also a care delivery best practice that people wrote in about. Some respondents also said that using clinical workflows and data analytics can help facilitate innovative care delivery. In terms of accountability, respondents tended to favor setting accountability for total cost of care at the entity level, rather than at the individual provider level.

And for provider participation, stakeholders who responded shared that being able to manage total cost of care does vary by

many factors such as specialty, data availability, provider's history of prior participation with value-based care arrangements, patient's health status, and so on.

Respondents said that to improve coordination between primary and specialty care providers, there are several factors that tend to be important, including access to timely and accurate data, expanding payment opportunities to all necessary services in real time, as well as expanding regulatory flexibility when possible.

And for that last category, I'll note that some respondents wrote in that while incorporating and embedding episode-based payment models into or within a population-based total cost of care model can be useful, this requires a very clear definition of the episode, as well as transparent rules about the accountability.

Great, and next slide, please. Great. So that was just a sample, and the full RFI and stakeholder responses are available online, and members of the public are welcome

to submit by July 20th for the Committee's consideration as part of the series. Thank you. Back to you, Lauran.

VICE CHAIR HARDIN: Thank you so much, Victoria. At this time, we're going to take a short break. The PTAC Public Meeting will resume at 3:30, with Committee discussion about themes and things noted from today. So from 3:15 to 3:30, we'll take a break. Thank you all so much for joining.

(Whereupon at 3:14 p.m., the above-entitled matter went off the record and resumed at 3:30 p.m.)

*** Committee Discussion**

CHAIR CASALE: Welcome back. So now the Committee members and I are going to discuss what we've learned throughout the day from the various presentations and Q and A sessions. We still have more presenters in a panel discussion tomorrow, but I want us to reflect on what we heard today.

After we conclude this series in September, we will submit a report to the Secretary of Health and Human Services on population-based total cost of care models.

Our reflections at these meetings will help shape our findings in that report. So for Committee members, I'm going to ask you to find the Potential Topics for Deliberation document. It's in the left front pocket of your binder.

To indicate that you have a comment, again just please flip your name placard. So we're now going to open it up for comments for the Committee members. The potential topics are listed on the slide, but you can also see those in your handout. So I'll turn it over to the Committee for comments. Larry.

DR. KOSINSKI: So we heard models described in fully employed situations. We heard about primary care models. We heard about how specialists interact with the primary care models. There's -- to me, there was a single best practice -- if we're talking about best practices, there's a single best practice theme that permeated just about everything, and that's high touch, proactive patient engagement.

To me, that's almost a must after listening to everybody today. We have to be proactive. We have to have a lot of touches.

Whether it's a primary care doctor or a specialty care doctor doing it, I don't know if that environment is different. So I mean that's, that's I think one of my biggest takeaways from today.

CHAIR CASALE: Lee.

DR. MILLS: Yeah. A really rich discussion today. I think I was just reflecting on some of the themes we've heard, and some of Angelo's recent comments I think really highlight that. One is the importance of thinking and recasting primary care. It just has to be done differently, and that includes resourcing that is real, but it's not as hugely overwhelming as it sometimes is feared to be.

It can be fairly modest. Focused resourcing makes all the difference in the world inside a different model. That model pairs with some compensation changes. Again, you can't keep doing the same thing and expecting different results. I think all of us have lived through that.

The centrality of data that has be polysourced, it has to be bigger than any one

practice, one doctor, one EMR, frankly even one system or one payer. So I think Dr. Kendrick spoke powerfully to those challenges and opportunities.

And then lastly, to take up what Larry just pointed on, that we heard sometimes I oversimplify and say it's just doing the job. But it's just the high touch, get where the patient is and find out what, what they need, and that's not -- that's not rocket surgery, but it is something that doesn't happen in the traditional model of medical practice, and that's the secret sauce to everything we've heard about today.

CHAIR CASALE: Yeah, thanks. I mean I'll add to that. Particularly on the data, I thought Dr. Kendrick, I mean that was really -- you know, I know the data that I work with, and I think it's okay. I know it's not great, but when I saw that map of the country and Oklahoma and where all the patients are getting their care, I mean that's really powerful, to realize that, you know, how -- you know, we tend to very centered on our either health system or community or state.

So the data piece, which is really challenging but so important, is certainly one of the takeaways I was thinking about. And the other thought again around these high touches, which I think you brought up, was around the culture change that's needed. I can tell you my organization, I have, you know, quite a few primary care doctors who sort of want help, but then they want to control.

And so I'm sure, Angelo, in your model, I'm sure you've come across that, and it is a culture -- any of these things require a culture change from, to move to a new model and how best to do that.

VICE CHAIR HARDIN: I'll just build on that. I think some really interesting themes that I've seen in my work and also in partnership with other sites is really the concept of case finding. So utilizing data to find people with needs or really a longitudinal relationship, where you're looking in your population for people with needs before they have them. And then another theme I thought was really interesting and teased out is the cultural change in the kind of training.

So Angelo talked about this, but it was true across the other models as well. It's very different to do a longitudinal relationship and build that sort of full knowledge, comprehensive across settings and EMR. What is that patient's story, and how does it integrate? That's a different kind of work and culture than proactively light touch reaching out in that 70 percent of rising risk.

Different people like to do those things, and the training's different. But they're both necessary to get total cost of care, and then I think tomorrow we'll have an opportunity to go even deeper on some of those social determinants of health, investments, and opportunities, and also the populations that aren't intersecting with primary care. So what's happening with them, because they're also in that total cost of care equation.

But we did hear some great themes about reaching out to where the people are and the importance of transportation, as well with social determinants. So lots of rich dialogue.

DR. SINOPOLI: One other -- sorry. One other point I'd like to make is that either

we have to make it easier to migrate to global risk, and/or create a lot more waivers that are easy to get, because we're -- we have our hands tied frequently because of our inability to do things because of regulatory issues.

If we can get past those waivers, it'll make things a lot easier. So identifying those and addressing those I think is useful.

DR. WILER: I think what struck me most, and this has come out in a number of these sessions that we've done, is that the care delivery itself at the patient level may be a simple intervention. But the incentives and payment programs around it are extremely complicated. I appreciated hearing these disruptions and innovations.

But a couple, back to a couple of other themes. There's still a disproportionate amount of employed physician practice where the biggest innovations are happening, which may or may not be replicable. This big data strategy is one that absolutely works, but again the question around feasibility is one that I think I appreciated the comment that, again if I'm remembering correctly, that there's 25 nodes

across the U.S. that potentially could be linked, which I think is really an opportunity for CMMI to be thinking about how do we incent leverage of that data.

And then I was also struck by multiple examples of how to get care teams to want to participate, either with, you know, a carrot or, you know, balking at it, a disincentive. And so we heard a number of 30 to 50 percent of total comp at risk for performance, and a couple of -- and there was all kinds of micro-examples at the clinical staff person or provider level, absent contracting because we heard a lot of, I thought, interesting ideas around contracting, about how to make this work.

I'm also struck by the fact that a health system strategy for which I work is unlikely to be the right model, and these private-public partnerships are the ones that appear to be the most successful.

DR. LIN: Yeah. So just following up on that comment on incentives, I believe Kaiser lore has it that one of the co-founders of Kaiser, Sidney Garfield, a physician, was found

nailing nails down in a construction site to prevent an infection from a tetanus wound from these construction workers, who were seen in clinic.

And similarly, you know, we heard Dr. Khan today talk about a really vivid example of going out to, it sounds like a trailer park, looking for a woman with a diabetic foot ulcer in a Celica, along with a social worker by the way, so the care team, to prevent or treat a diabetic infection.

What you can say, which I assume is implied, is that he was doing that to prevent a downstream worsening of infection, potential hospitalization with weeks of IV antibiotics, post-acute care, preventing a 15 to 30,000 dollar stay in the inpatient and subacute areas of health care. And he was doing that with a simple physician visit along with the social worker.

So I think, you know, as I'm thinking about total cost of care, how this Committee can help maybe think about a payment system that incents that kind of really profoundly innovative primary care. How do we

-- how do we incent, create the right incentives to substitute low-cost, high-value care for much higher-cost care downstream? I think we had some great examples of that today.

And I think we'll have some more tomorrow too, as I look forward to tomorrow's subject matter experts.

MR. STEINWALD: May I go?

CHAIR CASALE: Other comments?

VICE CHAIR HARDIN: Bruce.

MR. STEINWALD: Yeah, I have one. You know, as I keep telling you, I've been around a long time, and the notion of being, of doing more and as a result of doing more, spending less has been around for a long time, but it's kind of when you want to have an actuary in your pocket to come out and say, oh yeah, well what's the evidence of that.

And I -- actually I guess I'm thinking of in particular the presentations by Drs. Zimmerman and Kendrick, who are now at a decent-looking time series where it does appear that the upfront patient engagement approach yields downstream less spending. I'm going to give them the benefit of the doubt that their

methods are up to snuff, but that cynicism about doing more and spending less has got to be still there somewhere. I'm not sure I've done away with it myself.

CHAIR CASALE: Thanks, Bruce. Josh.

DR. LIAO: Yeah. I think lots of things to chew on and reflect on today, and I think setting aside the data piece others have I think articulated really well, and putting aside high-level actuarial considerations for the moment. I think, you know, I at least quickly kind of found seven things that I'm taking away for today, and what I've --

The through line for this is to be thinking about how to me under certain arrangements like Medicare Advantage, people either said or indirectly imply that they don't have to worry about certain things. So I'm cognizant that there are certain activities, delivery activities where they can do it, and not have to mind those things, and I'm thinking how if possible can we translate to a world where people do often mind those things?

And there may be some trade-offs there, but how do we do that? So the first was

around kind of removing barriers, you know. Angelo talked about the services that can like create the financial proposition for it, take away patient copays. I think he also mentioned waivers as that kind of bridge that's maybe not the end state, but that is one way we could think about operationalizing that.

The other is to think about maximizing opportunities to reframing downside, is actually the ability to take upside. I think it's fair to say that as we think about TCOC models, one of the limitations I think historically has been there hasn't been a lot of upside there, and that rationing effect of benchmarks just like further dampens that.

So just a very concrete design thing is if we don't expand that some way, I don't think we can get that analog to what Angelo's talking about. The team-based approach and the kind of touches, but maybe not coming from each team member, kind of like distributing the work among team members, is a good idea. Again, under certain models or approaches, you don't need to count those.

I think in some fee-for-service

arrangements you do, and so I think thinking about how we define eligible professionals for different services and also how we think about access. So for example, in the forthcoming REACH model there is that element around expanded NP[57] access. So to be determined. But there are, I think, practical things we can do to begin fitting different activities to different people in an incremental way.

I really was struck by something Angelo said and Dana Safran said around quality, which is that often I think we incentivize clinicians and physicians in particular to work on utilization. It's not surprising to me and then seeing, you know, letters response about if you engage clinicians in quality, it motivates them.

Someone's got to mind the utilization, but it doesn't have to be them, and Dana had that element in AQC where they just pay people on quality like no matter how you did, you know, on the spending. And so how do we think about that? The models that I'm

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aware of in the more restrictive fee-for-service world tend to gate on quality, but they don't reward on quality. So I think there's probably a revisiting there that can happen, to get closer to those things.

I'll buzz through the last couple quickly. I think we heard from Dr. Zimmerman about maturity, and I think we say "glide path" a lot. I don't know that our models have had the glide paths that we, you know, can see, and I think it's -- but it's doable in my mind. So I'd love to see more of that.

You know, Shari Erickson talked about what is a high-value referral, and there are a lot of bullets there. I think what I took away from that was you do have to mind the details in some ways. And so if some of the codes and the services we're talking about do have those details, and they can be frustrating, but they also help ensure that it's not just like "I coordinated care and that was good."

And so I think we'll have to kind of grapple with how specific we want certain things to be, and then finally, you know, what

I took away from the kidney model presentation was that there are these other non-primary care realms in which these things can be applied. I do think issues of accountability and culture need to be addressed. But I'm hoping that some of the learnings from this we can use as a way where I think it fits a task in primary care often. Not so much in others, but I'm hoping we can move in that direction.

So in each of these, I do think there are little things we can do, but in the spirit of trying to say how do we capture the spirit of all the things we've heard today, but also acknowledge like the reason they're so gripping is because they can be done in a world where there's more flexibility. So --

CHAIR CASALE: Yeah, I appreciated all those comments. Just picking up on the quality one, yeah, I was looking at one of the topics around addressing unintended consequences. I always think about that whenever we think about total cost of care, and you know, to the point that if, you know, focusing on quality, there's always worry on the other side, you know.

Could you be stinting on care, and so you need to counterbalance measures to be sure, and that's really hard to do, to be honest with you. And so when -- having the physicians or clinicians focused on utilization can sometimes exacerbate some of those unintended consequences around potential stinting of care, where if you really have them focused on quality and quality measures and outcomes, one, it's a scenario they feel, you know, passionate about and very comfortable obviously, and also, you know, I think enhances that relationship with the patient, because it's all about the quality of care that you're trying to get to.

DR. LIAO: And I'm going to say in a follow-up, I think many of us are clinicians and, you know, a lot of us think about financial incentives. One thing that also came up about giving trophies, which I don't get many of, Dr. Zimmerman, but that idea of what like motivates people is not all money.

I mean that is one thing, but it's not everything, and speaking as a general internist and having many colleagues in primary

care, I think people do things and they spend the time and they work on the EHR because it's the right thing, not because they're thinking about that bonus. So I think that the alternate is not like -- there's harms, you know. There's like errors of tying too much I think to utilization. It creates these potentially twisted incentives that we don't want so --

CHAIR CASALE: Yeah, and I was also thinking about, and I'm sorry, I forgot which presentation talked about risk adjustment, you know, the problems around our currently doing risk adjustment, which really focuses often on cost but not necessarily on needs. I thought that resonated with -- in my thinking, as well as -- you know, we always think about that as an issue about a current risk adjustment methodology, but where does that need to move so that it really does think about the patient, you know?

DR. WILER: Yeah, I agree. I think what I heard in that same comment, we focused a lot on risk adjustment and how to get credit for taking care of complicated patients. But I

think what our speaker said today was think about payment adjustments for taking care of complicated patients, all right, rather than trying to create a homogenous benchmark essentially.

And I think that's a really interesting way to create incentives, to actually want to focus on that patient population. That said, the other comment I'll make is I do wonder currently many of the models or the innovative care delivery programs that we've heard about it -- from a total cost of care perspective, the winners have disproportionately focused on high-cost utilizers.

Which is no surprise, but it assumes a couple of things. One, that the mean will never get better, right? So that you can always beat a rate by just focusing on those patients. And even in the renal care model, it really doesn't incent what we have, you know, what's been described is probably being value-added, and that's back into that preventative care space.

And so the question is, you know, is

that a sustainable model, only focusing on -- and in the renal care model it was broken up into fourths, where basically the patients who had accelerated all the way to the end of transplant, nothing you can do about it. But in that sort of progression of disease space, there was the most opportunity.

We're definitely hearing a theme of these groups, right? That's where the biggest revenue generation is. And so it's creating potentially disparities in focusing on these high-cost patients.

CHAIR CASALE: Yeah. Yes, Larry.

DR. KOSINSKI: It's also assuming that the high-cost patient of last year is going to be the high-cost patient of next year and the year after, and that that is a flawed assumption.

CHAIR CASALE: Right.

DR. KOSINSKI: And the vice, and the opposite of that, that your low ones are going to be low-cost going forward too.

CHAIR CASALE: Yeah. Other thoughts, comments? Bruce, anything else. No, you're okay. Okay, okay.

*** Closing Remarks**

So I want to thank everyone for participating today, our expert presenters, my PTAC colleagues, and those listening in. We certainly have more to cover as we alluded to related to care delivery for population-based total cost of care models.

*** Adjourn**

So we'll be back tomorrow morning at 9:30 a.m. Eastern. Liz Fowler, the CMS Deputy Administrator and Director of the CMS Innovation Center, will deliver opening remarks. So we hope to see you all then. Thank you. This meeting is adjourned for the day.

(Whereupon at 3:53 p.m., the above-entitled matter went off the record.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

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was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

Neal R Gross

Court Reporter