Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

March 3, 2025
9:33 a.m. – 5:07 p.m. EST
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attendance

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

Terry L. Mills Jr., MD, MMM, PTAC Co-Chair (Chief Medical Officer, Aetna Better Health of Oklahoma, and Owner, Strategic Health, LLC)
Soujanya R. Pulluru, MD, PTAC Co-Chair (President, CP Advisory Services, and Co-Founder, My Precious Genes)
Henish Bhansali, MD, FACP (Chief Medical Officer, Medical Home Network)
Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Lauran Hardin, MSN, FAAN (Chief Integration Officer, HC^2 Strategies)
Lawrence R. Kosinski, MD, MBA (Independent Consultant)
Joshua M. Liao, MD, MSc (Professor and Chief, Division of General Internal Medicine, Department of Medicine, The University of Texas Southwestern Medical Center)*
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
Krishna Ramachandran, MBA, MS (Senior Vice President, Health Transformation and Provider Adoption, Blue Shield of California)
James Walton, DO, MBA (President, JWalton, LLC)

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

Audrey McDowell, PTAC Designated Federal Officer
Steven Sheingold, PhD

Via Zoom

List of Speakers and Handouts

1. **PCDT Presentation: Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation**
   James Walton, DO, MBA, Preliminary Comments Development Team (PCDT) Lead

   Handouts
   - Public Meeting Agenda

- PCDT Presentation Slides
- Trends in Traditional Medicare Spending and Outcomes in Urban and Rural Areas
- Rural Disparities Report
- ASPE Issue Brief on The Impact of Alternative Payment Models on Medicare Spending and Quality, 2012-2022
- Environmental Scan on Reducing Barriers to Participation in Population-Based Total Cost of Care (PB-TCOC) Models and Supporting Primary and Specialty Care Transformation

2. **Roundtable Panel Discussion: Perspectives of Chief Financial Officers (CFOs) / Chief Executive Officers (CEOs) on Reducing Barriers to Participation in PB-TCOC Models**

   Christopher Crow, MD, MBA, Chief Executive Officer and Co-Founder, Catalyst Health Group*
   Chase Hammon, MBA, Chief Financial Officer, Duly Health and Care*
   Jessica Walradt, MS, Vice President, Finance, VBC Contracting and Performance, Northwestern Medicine*
   Brock Slabach, MPH, FACHE, Chief Operating Officer, National Rural Health Association (NRHA)*
   Michael Barbati, MHA, Vice President of Government Programs, Enterprise Population Health, Advocate Health*

   Handouts

   - Roundtable Panel Discussion Day 1 Panelists' Biographies
   - Roundtable Panel Discussion Day 1 Introduction Slides
   - Roundtable Panel Discussion Day 1 Discussion Guide

3. **Listening Session 1: Reducing Organization-Level Barriers Affecting Participation in PB-TCOC Models**

   Clif Gaus, ScD, MHA, Past President and Chief Executive Officer, National Association of ACOs*
   David Johnson, MD, MPH, Assistant Professor of Urology, University of North Carolina, and Clinical Operating Partner, Rubicon Founders*
   Angelo Sinopoli, MD, Executive Vice President of Value-Based Care, Cone Health*
   Dan Liljenquist, JD, Chief Strategy Officer, Intermountain Health*

   Handouts

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

4. **Listening Session 2: Supporting Primary and Specialty Care Transformation**

   Elizabeth Mitchell, President and Chief Executive Officer, Purchaser Business Group on Health (PBGH)*
   Joe Kimura, MD, MPH, Chief Medical Officer, Somatus
   Robert E. Mechanic, MBA, Senior Fellow, Heller School of Social Policy and Management, Brandeis University, Executive Director, Institute for Accountable Care*
   Frank Opelka, MD, FACS, Principal Consultant, Episodes of Care Solutions (*The ACS-Brandeis Advanced APM* proposal)*

Handouts

- Listening Session 2 Day 1 Presenters' Biographies
- Listening Session 2 Day 1 Presentation Slides
- Listening Session 2 Day 1 Facilitation Questions

Via Zoom

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

Also see copies of the presentation slides, other handouts, and a video recording of the public meeting.

Welcome and Co-Chair Update

Lee Mills, PTAC Co-Chair, welcomed the Committee and members of the public to the March 3-4 public meeting. He explained that the Committee has been exploring themes that have emerged from proposals that the public has submitted to PTAC and releasing a public report to the Secretary of Health and Human Services (HHS) with its findings on each theme. Co-Chair Mills noted that topics of previous theme-based discussions included maximizing participation in population-based total cost of care (PB-TCOC) models, addressing the needs of patients with complex conditions or serious illnesses, developing and implementing performance-based measures, encouraging rural participation, improving care transitions, and improving care delivery and specialty integration within PB-TCOC models.

Co-Chair Mills indicated that the March public meeting would focus on reducing barriers to participation in PB-TCOC models and supporting primary and specialty care transformation. He shared that the Committee had received two stakeholder responses to the publicly posted Request for Input (RFI) for the March meeting and that the RFI will remain open for additional input after the meeting. Co-Chair Mills noted that the two-day meeting discussion, RFI responses, and public comments will inform a report to the Secretary of HHS on reducing barriers to participation and supporting primary and specialty care transformation in PB-TCOC models.

Co-Chair Mills invited Committee members to introduce themselves and share their experience with reducing barriers to participation and supporting primary and specialty care transformation. Following Committee member introductions, Co-Chair Mills shared that four PTAC members served on the Preliminary Comments Development Team (PCDT): James Walton (Lead), Henish Bhansali, Lawrence Kosinski, and Walter Lin. He introduced Dr. Walton, who presented the PCDT's findings from the background materials.

Presentation: Reducing Barriers to Participation in PB-TCOC Models and Supporting Primary and Specialty Care Transformation

Dr. Walton delivered the PCDT presentation. For additional details, please see the presentation slides, transcript, and meeting recording (00:11:12-00:37:43).

- Dr. Walton shared the objectives of the March theme-based meeting: identifying barriers to participation in PB-TCOC models and other Alternative Payment Models (APMs); understanding potential pathways to increase participation; examining approaches to support primary and specialty care transformation to drive more value and grow participation; and discussing opportunities for enhancing the sustainability and competitiveness of PB-TCOC models.

- Dr. Walton shared that the discussion during the meeting will greatly assist PTAC in developing a report for the Secretary of HHS, which will also support colleagues at the Center for Medicare and Medicaid Innovation (CMMI or the Innovation Center).
- Dr. Walton reviewed the Committee's working definition of an accountable care relationship, which is a relationship between a provider and patient that establishes the provider as accountable for quality and total cost of care (TCOC) for the patient's covered health care services.
- Dr. Walton reviewed the Committee's working definition of a PB-TCOC model, which is an APM in which participating entities assume accountability for quality and TCOC and receive payments for all covered health care costs.
- Dr. Walton reviewed the Committee's working definition of a viable health care business model, which is a model that allows a health care entity to provide health care services that meet patient needs and delivery value while ensuring financial returns to maintain business operations over time.
- Dr. Walton reviewed key findings from an issue brief posted by the Assistant Secretary of Planning and Evaluation (ASPE) that assessed the impact of APMs on Medicare spending and quality from 2012 to 2022. In the first 10 years of the Medicare Shared Savings Program (MSSP) and CMMI's work, select CMMI models achieved gross savings of $7 to $11 billion, and MSSP had savings of $23 to $31 billion. Reductions in spending were greatest among counties with high model penetration and participation. There is potential for greater savings in the future if barriers to participation are identified and mitigated, particularly in low penetration regions where Medicare beneficiaries have not had access to participating providers. The findings further showed that CMMI models and the MSSP delivered more care coordination services and improved the quality of care for Medicare beneficiaries in areas of high model penetration compared with areas with no penetration.
- Dr. Walton presented participation data for CMMI models and the MSSP from 2010 through 2020. Findings showed that participation plateaued around 2018 across all payers. Hospital and integrated delivery system (IDS) participation has declined; physician-led Accountable Care Organizations (ACOs) are growing; and specialty care physicians are less likely to participate in ACOs compared with primary care physicians.
- Dr. Walton noted that the PCDT examined the barriers to participation for hospitals and IDSs. The market share and resource capabilities of IDSs enable them to provide high-value and well-coordinated care. Dr. Walton presented two questions concerning trends in IDS participation:
    - Has there been a decrease in the number of IDS-led ACOs as accountable entities?
    - Are physicians and hospitals able to participate in ACOs if the IDS they are affiliated with is not participating as the lead organization?
- Dr. Walton explained that the analysis conducted to answer the two questions focused on ACO participation among large IDSs for the years 2016, 2018, 2020, and 2022. The analysis included the MSSP, the Pioneer ACO Model, the Next Generation ACO (NGACO) Model, the Global and Professional Direct Contracting (GPDC) Model, and the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model.
    - The Pioneer ACO Model had 62 percent of participating ACOs led by IDSs in 2016. The NGACO Model showed a decline in participating ACOs led by IDSs over the course of the model with 56 percent in 2016, 36 percent in 2018, and 39 percent in 2020. The GPDC Model had 23 percent of participating ACOs led by IDSs in 2022.
    - Although a large number of IDSs participated in Medicare ACOs (90 percent of large IDSs and 70 percent of small IDSs), the degree of IDS participation was low (only a small

percentage of the IDSs' affiliated hospitals and physician practices participated). Dr. Walton described a graph that displayed the percentage of IDS-affiliated hospitals and practices by large and small/medium IDSs. Small/medium IDSs showed a higher percentage of participating IDS-affiliated hospitals and physician practices compared with large IDSs (33-38 percent versus 22-31 percent).

- Dr. Walton summarized key takeaways from the analysis. The percentage of CMMI ACO models led by IDSs has declined over time. Despite large IDSs' high rates of participation in Medicare ACO models, the percentage of its providers participating has been relatively low.
- Dr. Walton described organization characteristics that may impact organizational participation and profitability in APMs. Organizations can be grouped by organization type, including physician-owned, hospital-owned, and payer-owned. Organizations can also be grouped by operational characteristics, such as management approaches, governance, clinical integration, electronic health record (EHR) consolidation, and other factors. Organizations can also be grouped by market characteristics, such as geographic location, Area Deprivation Index (ADI), and degree of Medicare Advantage (MA) penetration.
- Dr. Walton described important revenue concepts for accountable care participation, including:
    - The size of total annual revenue for the accountable entity, which contributes to the business model and its participation decisions in accountable care;
    - The mix of revenue sources for an entity; and
    - The revenue of ACO participants compared with the total spending for the assigned beneficiaries, split into low- versus high-revenue ACOs. For example, a large group primary care practice accountable for TCOC may have relatively high annual revenues but a relatively small share of total spending for the population. This would be defined as a low-revenue ACO.
- Dr. Walton noted the relationship between business model characteristics and accountable care participation. ACO revenues as a share of TCOC may significantly impact participation decisions. For example, improvements in care delivery and overall health status could shift demand for some organizations who provide certain services (e.g., inpatient care for a large IDS). The size of annual revenue for a particular organization may also influence its ability to invest in value-based care infrastructure and/or its willingness to assume financial risk.
- Dr. Walton discussed pathways for increasing participation in PB-TCOC models. He provided the working definition of pathways for incentivizing increased participation in PB-TCOC models as a grouping of health delivery organizations that might be treated similarly with regard to benchmarks, two-sided risk, and how performance measures affect payment within the context of other incentives.
- Dr. Walton described the various inputs that contribute to the creation of pathways to maximize ACO participation. Provider types and operational characteristics feed into organization types. Market and revenue characteristics contribute to potential participation pathways created for like groups of provider entities. The pathways produced have unique features and incentive structures and can potentially be incorporated into existing APMs. The ultimate outcome is to maximize the accountable care mix of entities.
- Dr. Walton explained that organizational business model characteristics are useful for pathway development because they help explain why organizations may or may not participate in APMs. Key business model characteristics (e.g., revenue, revenue source, management control) could serve as the pathway building blocks for grouping similar entities into pathways that best fit their business characteristics. Pathways might represent groupings of provider organizations for which

it is reasonable to apply similar payment approaches, such as benchmarks, two-sided risk, and performance measures.

- Dr. Walton noted additional considerations for developing pathways, including:
    - Pathways may recognize certain factors affecting outcomes that are not modifiable by the organization (e.g., ADI, geographic location);
    - Pathways may not recognize factors affecting outcomes that are modifiable and consistent with the accountable care vision (e.g., primary and specialty care integration);
    - Balance incorporating factors while avoiding complexity that would be difficult to administer and comprehend by stakeholders; and
    - Given the rising influence of aggregators, consider a different pathway acknowledging the role of value-based care enablers/conveners to manage beneficiaries in downside risk arrangements.
- Dr. Walton described the complexity associated with APMs and pathways for various types of organizations. He provided an example of a shift from a fee-for-service (FFS) system to a full TCOC risk-based payment. On slide 31, the dark red squares depict payment models, and the blue ovals depict payment options where participation pathways may be implied. The green boxes show organization types that may be attracted to participate in different offerings available based on organizational business characteristics and APM pathways.
- Dr. Walton described the intersection between participation pathways and payment considerations on slide 32. He noted that receiving subject matter expert (SME) input to develop the different pathways in this table is a goal of the public meeting.
- Dr. Walton explained that it has been difficult to increase participation of specialty care providers in accountable care. One key opportunity to improve primary and specialty care transformation is sharing patient data. He also noted that nested specialty episodes can encourage provider collaboration between primary and specialty care physicians.
- Dr. Walton described two approaches to using nested episodes to integrate specialty care in PB-TCOC models. The first approach is to assess the variation of costs in particular conditions, such as conditions with low-cost variation (e.g., gastritis). The second approach is to create specialty condition-based payment models.
- Dr. Walton indicated that there are policies that can help make APMs more flexible and competitive, including assessing factors that influence competitiveness (e.g., market consolidation, MA penetration), engaging beneficiaries (e.g., shared decision-making tools), addressing specialty integration (e.g., nested episodes); and providing waivers to promote model adoption (e.g., 3-day skilled nursing facility waiver).
- Dr. Walton summarized the public meeting focus areas: reducing organization-level barriers affecting participation in PB-TCOC models; supporting primary and specialty care transformation; enhancing the ability of PB-TCOC models to be competitive; and understanding how to maximize participation of beneficiaries in accountable care and improve the sustainability of effective PB-TCOC models.

Co-Chair Mills invited Committee members to ask questions about the PCDT presentation. Committee members discussed the following topics. For more details on the discussion, see the transcript and meeting recording (00:37:43-00:52:47).

- One challenge is related to the concept of low-revenue versus high-revenue systems. The greater the level of risk for a given organization participating in an APM, the more likely the organization is to fully participate and maintain participation in the APM.

- Data sharing continues to be a challenge, especially for specialty networks that use different EHRs than primary care networks.
- The business model of the entity must be considered in the transition from FFS to value-based care. Sustained adoption will be difficult if the transition to value-based care is not sufficient for the business model of the provider entity.
- One Committee member highlighted the plateau of participation in Medicare APMs and the trend in participation across payer types. Different tools and discussions may be needed to promote further APM adoption.
- One Committee member emphasized the importance of competitiveness.
- Organizations should participate in market offerings that make sense for the specific organization, whether they are APMs or other programs.
- One Committee member stressed the importance of the graphic on slide 31 of the PCDT presentation, which linked the Health Care Payment Learning & Action Network (HCPLAN) framework of increasing risk in a value-based payment concept to specific factors a business would consider taking to move toward full TCOC risk-based payments. These pathways are important for varying organizations (e.g., small physician-owned practices, independent hospital-led ACOs, fully integrated ACO models) investing in value-based care.
- One goal of this public meeting is to understand the experiences and lessons learned from the experts, including recognizing the savings and improvements that have been achieved in care delivery and quality of outcomes, as well as their vision for the future of value-based care.
- There are three levers that function to encourage participation: 1) the financial lever: how organizations are paid; 2) the operational lever: how organizations operate (e.g., interdependence, ownership, single specialty or multiple specialties); and 3) the interdependence between the financial and the operational levers that can influence participation.
- One Committee member inquired if the percent of revenue at risk for an organization is another lever and whether benchmark adjustments could be made to encourage participation.
- There are different phases of adoption of APMs (e.g., early adopters and innovators). The presentation slides represented the different approaches that have been implemented. Caution should be exercised when referring to organizations as early adopters because models evolve over time.
- The FFS payment structure is the largest barrier to participating in PB-TCOC models because organizations generate substantial revenue with FFS payments. FFS needs to be made increasingly uncomfortable for organizations to continue under this payment structure.
- There are certain organizations within certain sectors that are delivering high-value care within the FFS structure. Emphasis should be on creating alternative models to optimize value-based care for organizations and/or sectors where the lowest value of care is being delivered.
- One Committee member noted that a main goal of this meeting is to further develop the pathways and payment parameters table on slide 32 in the PCDT presentation.

Roundtable Panel Discussion: Perspectives of Chief Financial Officers (CFOs) / Chief Executive Officers (CEOs) on Reducing Barriers to Participation in PB-TCOC Models

SMEs

- Christopher Crow, MD, MBA, Chief Executive Officer and Co-Founder, Catalyst Health Group
- Chase Hammon, MBA, Chief Financial Officer, Duly Health and Care

- Jessica Walradt, MS, Vice President, Finance, VBC Contracting and Performance, Northwestern Medicine
- Brock Slabach, MPH, FACHE, Chief Operating Officer, National Rural Health Association (NRHA)
- Michael Barbati, MHA, Vice President of Government Programs, Enterprise Population Health, Advocate Health

Co-Chair Mills moderated the panel discussion with five SMEs offering their perspectives on reducing barriers to participation in PB-TCOC models. For additional details, please see the transcript and meeting recording (00:00:00-01:32:22).

Panelists introduced themselves and provided background on their respective organizations. Full biographies and panelist introduction slides are available.

- Christopher Crow introduced himself as a family physician and Founder of Catalyst Health Group, a health care innovation ecosystem that includes one of the largest independent primary care groups in the Southwest. Catalyst Health Group focuses on improving health care access, performance, and outcomes in communities and believes that health care, education, and jobs are key pillars for a thriving community. Dr. Crow advocated for moving beyond FFS models to more sustainable, population-based health care with prospective payments or subscription-based primary care. For additional details on Dr. Crow's background and organization, see the panelist introduction slides (slides 2-4).
- Chase Hammon introduced himself as the CFO at Duly Health and Care, where he oversees a multi-specialty group with approximately 1,000 physicians across Chicago. Mr. Hammon noted that provider-led patient care leads to better outcomes and lower costs—20 percent to 30 percent lower than most systems. He emphasized the challenges smaller physician groups face in participating in value-based care initiatives, particularly related to participation burdens (e.g., reporting requirements) and uncertainty of value-based payments. For additional details on Mr. Hammon's background and organization, see the panelist introduction slides (slides 5-8).
- Jessica Walradt introduced herself as the Vice President of Finance, VBC Contracting and Performance at Northwestern Medicine. Northwestern Medicine is an Illinois health system that has participated in various value-based care contracts, MA, MSSP, and bundled payment programs. Ms. Walradt explained that factors such as risk adjustment, attribution methodology, and carve-outs influence decisions to participate in APMs. There must be a clinically feasible path to savings to encourage health systems to participate in APMs. She also mentioned challenges related to data, administrative burden, and implementation timelines. For additional details on Ms. Walradt's background and organization, see the panelist introduction slides (slides 9-11).
- Brock Slabach is the COO of the National Rural Health Association (NRHA) and a previous rural hospital administrator. Mr. Slabach highlighted that many rural providers are eager to innovate and improve care quality and cost-effectiveness; however, rural hospitals face significant challenges when implementing value-based care. These challenges include operating with negative margins; high MA penetration; the closure or reduction of services in many rural hospitals; limited leadership capacity to implement transformation; and the lack of capital for investment in new programs. Additionally, the frequent changes or terminations of value-based care programs add to the uncertainty for rural providers, and the lack of alignment between payers on payment incentives and quality metrics creates additional challenges for rural facilities. For additional details on Mr. Slabach's background and organization, see the panelist introduction slides (slides 12-15).

- Mike Barbati introduced himself as the Vice President of Government Programs at Advocate Health. Advocate Health includes over 13,000 participating physicians across multiple states, managing 2.4 million lives and more than 110 value-based care contracts. The organization has saved over $750 million in taxpayer savings across a variety of APMs and has distributed $1.4 billion in savings to participating physicians since 2015. Mr. Barbati highlighted the challenges of participating in value-based care, such as managing disparate geographies with different insurance regulations and needing significant investments in technology and infrastructure. Additionally, fragmented care plans, especially in specialty care, make it difficult to integrate care in value-based care models. Advocate Health focuses on embedding specialty care within its TCOC models. Mr. Barbati emphasized that nested care models are crucial for future success in population health. For additional details on Mr. Barbati's background and organization, see the panelist introduction slides (slides 16-24).

Panelists discussed key factors affecting health care organizations' decisions about whether and how to participate in PB-TCOC models.

- Different organizational structures (e.g., physician-owned, private equity-backed, nonprofit, academic) and settings (e.g., rural versus metropolitan) have varied perspectives and challenges. Smaller organizations, especially independent physician groups, face significant uncertainty about the financial impact of participating in PB-TCOC models. They face concerns about potential reductions in FFS profitability and delays in payments. Additionally, team-based care is critical to TCOC models but may be challenging for organizations that traditionally operate on a revenue-minus-expense model.
- For Northwestern Medicine, a primary consideration for participating in a TCOC model is the attribution methodology because its ACO includes a mix of 20 percent primary care clinicians and 80 percent specialists. Northwestern Medicine would be more interested in a model with attribution based on both Taxpayer Identification Number (TIN) and National Provider Identifier (NPI), as it would better align with its patient population than using TIN alone.
- Balancing multiple revenue streams within a health system is challenging. Health systems consider the financial benefits of participating in Medicare APMs, such as the financial incentives for reducing admissions and readmissions. However, independent physician groups struggle with cash flow, especially in models such as ACO REACH where they had to give up their guaranteed FFS revenue to take on capitation. Despite presenting potential revenue increases, only 30 percent of Advocate Health practices signed up for ACO REACH due to concerns about delayed payments. Organizational readiness is also an important consideration. For example, some organizations are more willing to take on risk or have more support from larger health systems.
- Rural hospitals and clinics face many challenges in participating in PB-TCOC models. Many of these hospitals are independent and have leadership that struggles to manage complex models due to limited resources. One potential solution is creating clinically integrated networks among independent rural hospitals. Rural facilities also struggle with assessing and managing risk, often focusing on short-term survival. A rural-centric approach that accounts for low patient volumes and the unique challenges these communities face is needed.
- Rural and urban communities require different approaches to health care. Incentives, alignment, ownership structures, and existing capabilities are important considerations for APM participation. Additionally, physicians are often hesitant to adopt new payment structures, even when the math shows potential benefits, making transitioning from FFS to value-based models more challenging.

- Payers, especially commercial payers, play a significant role in shaping health care decisions, particularly for physician groups. Payers drive physician groups into larger risk-based arrangements that they might not have otherwise chosen. Understanding the impact of payers is crucial when discussing the factors influencing groups' decisions to participate in various models.

Panelists discussed how to address the challenges of participating in value-based care models for rural hospitals with small patient volumes.

- The Pennsylvania Rural Health Model was a global budget model that required a rural transformation plan. The plan focused on improving access, care navigation, and chronic care management. It is important to preserve existing rural hospitals while exploring new models. Although the program ended in 2023, many of the participating hospitals continued with the model, demonstrating its potential success, despite not meeting CMMI's savings criteria.
- Panelists suggested that rural hospitals should be owned and managed locally, rather than by outside entities. They should use a global budget and function like community health centers, leveraging the strong local engagement and relationships among residents.

Panelists discussed the level of reward over risk necessary to participate in APMs (e.g., specific hurdle rates) and success stories related to value-based care implementation.

- On average, Medicare margins for hospitals are negative, and Medicare payments are decreasing. Therefore, the hurdle for participating in Medicare ACOs is decreasing. An example of a successful nested model is a nephrology group that participated in the MSSP. There was a 25 percent increase in kidney transplant rates and a 10 percent decrease in readmissions through better care management and support services such as transportation. Advocate Health has invested in building infrastructure and technology to support episode-based care, as it is a key component of the future of health care.
- Uncertainty in the broader health care system impacts organizations' willingness to take on risk in value-based care models. For example, concerns about telehealth regulations and physician payment can reduce appetite for risk. Successful models focus on solving specific problems, such as joint replacement bundles that aim to reduce post-acute care spending by standardizing the criteria for patient care after discharge.
- One panelist initially needed to offer performance surpluses at 140 percent to 150 percent of Medicare rates to convince a risk-bearing entity to utilize prospective payments. Over time, the clinical model shifted, with physicians focusing more on end-of-life care, heart failure, and early interventions for high-risk patients—areas typically neglected in FFS models. However, multi-payer alignment is crucial for scaling such models.
- Incentives are critical in shaping how care is provided. Global budget models are better suited to addressing the evolving needs of rural health care compared to traditional profit-driven strategies such as expanding service lines. The Pennsylvania Rural Health Model used a global budget and involved multiple payers, including Medicare, Medicaid, and large commercial insurers. This multi-payer approach aligned financial and quality incentives, making it easier for health care providers to work toward common goals.
- Although incentives are important, the real challenge lies in overcoming barriers. For physicians, the major barriers are related to data, cash flow, and managing multiple value-based care plans, each with different requirements. The focus should be on removing these operational barriers.

Panelists discussed APM characteristics or incentives that could attract health care professionals or organizations to help rebuild rural health systems that have collapsed or are collapsing.

- Rural communities have a higher density of Medicare and Medicaid populations in these areas, which can simplify options for health care models. Alignment with local entities such as school districts, cities, and counties could help create a unified budget model. However, success would require a long-term commitment to address each community's unique needs. A global budget and clear metrics would be essential.
- The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model and Geographic Direct Contracting ("Geo") Model aim to address rural health care challenges. One panelist suggested that a combination of these models, with a more direct focus on supporting struggling communities, could help organizations serving larger geographic areas improve health care in these regions.

Panelists discussed telehealth policy flexibilities needed to ensure success in PB-TCOC models.

- Panelists stated that it is critical to incorporate connected care modalities, such as telehealth, into value-based care models. Many providers are frustrated with the current FFS reimbursement rates for telehealth, particularly for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Payment parity is needed to ensure the sustainability of these services. Artificial intelligence (AI) has an emerging role in this space that will require careful considerations.
- Subscription models, where primary care is unbundled from insurance and becomes a regular, tax-deductible service, encourage ongoing relationships between patients and their primary care providers (PCPs). Under this type of model, care delivery can be centered around the patient's location preferences.
- Panelists also stated that telehealth is important in addressing shortages of health care providers in rural areas. However, the core doctor-patient relationship must be preserved and should remain local, as patients in rural communities are unlikely to want a remote relationship with a doctor far away.

Panelists discussed higher-value, lower-lift changes that can be made in organizations to help move toward PB-TCOC and improved patient outcomes.

- Panelists suggested that the Centers for Medicare & Medicaid Services (CMS) could improve the adoption of new models by offering longer implementation timeframes. For example, CMS provided a year of lead time before the Transforming Episode Accountability Model (TEAM) started. This advance notice helped organizations assess gaps and resources needed to meet the model's requirements while dealing with competing priorities. The lead time before implementation was beneficial and should be replicated in future models.
- Simpler designs are often more effective, such as the global budget AHEAD Model. This model also has a 10-year horizon, allowing for a longer period to assess success. Providing technical assistance for the implementation of models is crucial, especially for rural, independent facilities. Offering consultants to guide these facilities through complex application processes would also be highly beneficial.
- Panelists stated that for value-based care to truly succeed, the government needs to fully commit, similar to the push for electronic medical records (EMRs) in 2004. One panelist stated that despite initial resistance, the government made a decisive push which led to widespread adoption within a few years. A similar all-in approach is needed for value-based care. Without this full commitment and national infrastructure, progress will continue to be slow and fragmented, as has been the case with value-based care since 2006.

- Panelists suggested that managing multiple quality measures and contracts for primary care across different payers is inefficient. Moving toward a multi-payer model with standardized methodologies, risk adjustments, and quality measures could streamline the process and improve care. By consolidating efforts into a single model, resources currently spent on managing various individual contracts could be better used to focus on patient care and improvement efforts. While this shift would be a significant undertaking, starting with incremental changes, such as a multi-payer database or multi-payer methodologies, could help move toward this goal.
- Reducing the risk associated with the first-year patient cohort could be helpful. This cohort tends to be more expensive and has a larger financial strain. Adjusting risk for this group could encourage more organizations to join. As patients progress through care management, profitability improves. Reducing the initial year's risk could provide significant benefits.

Panelists discussed how to distribute shared savings from a value-based care model to the frontline clinicians in a way that sustains their continued change in behavior.

- At Northwestern Medicine, financial incentives are tied to quality measures and risk-adjusted benchmarks similar to classic shared savings models. However, the organization also recognizes the value of infrastructure investments that help physicians practice at the top of their license. Examples include AI scribes and additional support staff such as social workers and pharmacists in clinics. These investments aim to ease physicians' daily workloads, improve patient care, and contribute to the success of value-based care contracts. Additionally, physicians are financially recognized for tasks that may seem burdensome but are necessary for patient care, such as extra administrative work.
- Panelists stated that it is important to bridge the gap between value-based care and FFS models, particularly in how physician compensation is structured. As models evolve, physician incentives and compensation often shift, creating complexity. Duly Health and Care is considering how to align care for both value-based care and commercial patients. It is exploring a standardized approach that could work across both models, potentially using subscription-based services for commercial patients, similar to the care provided to value-based care patients.
- At Catalyst Health Group, 70 percent of revenue is directed to physicians, a model it has maintained for over a decade. It is important to address physicians' priorities, including time and money. Physician education has been crucial in helping physicians understand how the clinical model affects the financial model, especially in transitioning from FFS to value-based care. There are ongoing challenges related to cash flow delays and the need to align financial incentives with important clinical activities, such as managing high-risk patients and addressing end-of-life care.
- Panelists suggested that rewards should be distributed among the entire care team, including the advanced practice providers and other staff supporting PCPs. The future of care may shift toward managing patient panels as a whole rather than individual patient encounters, requiring a new way of thinking about value-based care.

Listening Session 1: Reducing Organization-Level Barriers Affecting Participation in PB-TCOC Models

SMEs

- Clif Gaus, ScD, MHA, Past President and Chief Executive Officer, National Association of ACOs
- David Johnson, MD, MPH, Assistant Professor of Urology, University of North Carolina, and Clinical Operating Partner, Rubicon Founders
- Angelo Sinopoli, MD, Executive Vice President of Value-Based Care, Cone Health

- Dan Liljenquist, JD, Chief Strategy Officer, Intermountain Health

Dr. Bhansali moderated the listening session with four SMEs on reducing organization-level barriers affecting participation in PB-TCOC models. Full biographies and presentations are available.

Clif Gaus presented on approaches for determining and improving predictability of benchmarks.

- Dr. Gaus provided an overview of the National Association of ACOs (NAACOS), an association that is member-owned and member-governed.
- Dr. Gaus indicated that the ACO model has grown over time. He noted that although the ACO model has not achieved the savings people anticipated, ACOs have saved Medicare $28.3 billion in gross savings since 2012.
- Dr. Gaus described challenges with adopting the ACO model, including misaligned incentives; the investment required to transition to value-based care; burden associated with quality reporting; and inadequate budgets (i.e., benchmarks) to manage certain patient populations.
- Dr. Gaus explained several benchmarking challenges that have stalled participation in ACO models, including using historical spending to determine the baseline; adjusting for differences in patient-level factors; and accounting for changes in spending patterns once benchmarks are set. He suggested that different methods can be used to adjust for changes in spending patterns, but the methods are not flawless.
- Dr. Gaus noted two major programs in accountable care: the MSSP and the ACO REACH Model. He explained that there has been a focus on leveling the playing field between value-based care programs (i.e., MSSP, ACO REACH) and MA. Evidence suggests that Medicare's dominant program is the MA program due to its subsidies. He highlighted the long-term changes needed to level the playing field for both patients and providers.
- Dr. Gaus described challenges with three different components of benchmarking: setting benchmarks; accounting for changes in spending with trend factors; and risk adjustment.
    - Regarding challenges with setting benchmarks, Dr. Gaus indicated that the use of historical spending can lead to a ratchet effect where accountable entities are penalized for successful performance. He noted that the MSSP program has updated its policies to adjust for changes in spending.
    - Regarding challenges with accounting for changes in spending with trend factors, he mentioned that prospective trends create certainty but can be inaccurate, and that inaccurate estimates may harm ACOs.
    - Regarding challenges related to risk adjustment to account for patient population factors, Dr. Gaus indicated that risk adjustment methods differ between MA and ACOs. Although both programs use Hierarchical Condition Category (HCC) risk scores, MA does not have caps on accountable entities and rising scores.
- Dr. Gaus summarized key takeaways from his presentation: making benchmarks more predictable and stable; allowing for adjustments when predictions fail; providing ACOs a level playing field with MA by adopting an improved risk adjustment model and rewarding quality; improving the ACO business case to grow the beneficiaries and preserve the traditional Medicare option for beneficiaries; and until administrative benchmarks are implemented, increasing the inclusion of past savings in new benchmarks to avoid ratcheting down benchmarks.

For additional details on Dr. Gaus' presentation, see the presentation slides (pages 2-12), transcript, and meeting recording (00:01:04-00:11:44).

David Johnson presented on the role of conveners in increasing participation in PB-TCOC models.

- Dr. Johnson defined the term convener in PB-TCOC models as an organization or entity that engages multiple stakeholders to facilitate the implementation and execution of value-based care models. He noted that a convener is typically the risk-bearing contract holder with the payer in value-based care agreements. Payers can include MA plans, CMMI models, and at-risk PCP groups. He explained that conveners partner with provider organizations and can provide support with care delivery and aligning financial incentives. He also noted that patient engagement can depend on several factors, including the type of provider group with which the convener works; the services provided by the convener; and the contract terms.
- Dr. Johnson explained that although the principles he is presenting today can apply to primary care models, his presentation is focused specifically on how conveners can enable specialists to participate in risk-based models.
- Dr. Johnson explained that specialists are trained to deliver reactive, episodic, transactional, face-to-face, hands-on care, and the systems in which specialists practice are set up to facilitate that type of care. He suggested that meeting the basic requirements for taking on accountability for costs and outcomes can be challenging for provider organizations, and that conveners can make participation feasible.
- Dr. Johnson noted that PB-TCOC models require a large population to achieve actuarial stability. He shared that providers are increasingly taking on risk for narrow populations. These populations are sometimes defined by an entire specialty service line (e.g., cardiology) or by specific clinical conditions (e.g., inflammatory bowel disease). Conveners aggregate risk across multiple practices, geographies, lines of business, and payers so that physician practices can participate in the models. Dr. Johnson suggested that the actuarial exercise to set benchmarks is challenging, and typical specialty practices lack the actuarial expertise needed to understand different risk models. Conveners can identify cost variation, look for savings opportunities, and project future expenditures to validate the viability of the risk models for specific populations and provider groups.
- Dr. Johnson indicated that cash reserves and financial capital are needed for care transformation investments when participating in risk models. Conveners can help shield provider groups from downside risk and maintain adequate cash reserves to meet statutory requirements for two-sided risk contracts. He also explained that significant up-front investments are required to deliver on population-based outcomes, particularly when implemented in the reactive, transactional FFS environment. Conveners can help with investments to support clinical infrastructure, high-value clinical staff, and technology (e.g., population health management tools, technology to collect and act on patient-reported outcomes, and performance dashboards for quality reporting).
- Dr. Johnson emphasized the importance of having a complete and real-time view on patients outside clinical settings. Conveners can make investments in real-time aggregation of both clinical and claims data, as well as collect and identify other barriers (e.g., social determinants).
- Dr. Johnson suggested that specialty providers who wish to successfully manage TCOC must shift toward an upstream approach of early detection and prevention. Conveners can support this shift by helping to integrate high-value care models into clinical practice.
- Dr. Johnson explained that not all conveners are the same. He listed different factors providers should consider when partnering with a convener: the services and functions offered by the convener; the convener's business model; how the convener's services will integrate into core clinical operations; how the convener will impact patient experience; alignment between the practice and convener's care delivery vision; and alignment with financial incentives.

- Dr. Johnson also listed factors payers should consider when working with conveners: why a convener is better suited to provide the services or functions than the practice; the degree of practice integration and provider buy-in required for success; the attractiveness of the convener's model to network practice; the appetite for outcomes-based reimbursement; and alignment of the convener's business model with payer goals.

For additional details on Dr. Johnson's presentation, see the presentation slides (pages 13-20), transcript, and meeting recording (00:12:05-00:21:32).

Angelo Sinopoli presented on incentives for clinical integration and health-centered care.

- Dr. Sinopoli defined clinical integration as the structured collaboration among physicians, hospitals, and care teams to improve quality, efficiency, outcomes, and affordability. He suggested that key elements of clinical integration include but are not limited to physician leadership; coordinated care delivery; shared data and technology platforms; and aligned financial incentives.
- Dr. Sinopoli explained that the goal of health systems is to clinically integrate all assets (e.g., community resources, retail pharmacy, mobile clinics, hospitals) to make patients' experiences seamless. This integration requires a data and technology system that spans the entire set of assets that drives data and patients across the system seamlessly. Integration also requires a horizontal care coordination group.
- Dr. Sinopoli noted that a medical neighborhood approach can integrate care across all geographies by having health care assets reach out into the community.
- Dr. Sinopoli explained that many health systems and physician practices function in a hybrid financial environment where they operate in both FFS and APMs. A hybrid approach can make it difficult to transform care until approximately 40 percent to 50 percent of the practice's patient panel is under an APM. He noted that research evidence suggests that the APM start-up cost is approximately $1.8 million.
- Dr. Sinopoli recommended addressing this challenge by extending beyond the MSSP and ACO REACH programs to include patients in other types of risk arrangements (e.g., MA, Medicaid, commercial payers, provider-owned health care, and direct to employer contracting). Including patients in other types of arrangements will help to transform care away from FFS. He suggested that once 50 percent to 60 percent of patients are under a payment model, the financial investments in tools and infrastructure will be justified.
- Dr. Sinopoli described enablers of clinical integration: a critical mass of APM patients; proper governance and physician engagement; adequate financial incentives and payment models; technology and data-sharing enhancements; care coordination and patient navigation; patient engagement and digital health tools; and contractual and legal mechanisms.
- Dr. Sinopoli explained that there are more restrictions at lower levels of risk. Practices that take on more downside risk (e.g., global risk arrangements) will have more flexibility to pay physicians for care coordination and pay for technology. He noted that the 2020 Office of Inspector General (OIG) final rule allows for this flexibility.
- Dr. Sinopoli outlined additional restrictions that were covered in the 2020 OIG release.
- Dr. Sinopoli recommended stronger incentives for specialists to participate in value-based care. He mentioned that bundled payments have provided gainsharing opportunities for specialists within the ACO.
- Dr. Sinopoli explained that small ACOs have limited risk pools and large statistical variability. Small ACOs typically need to focus on high-impact interventions, leverage partnerships (e.g., partnerships with conveners), and share resources to achieve integration and financial risk.

- Dr. Sinopoli noted that practices and systems need to shift toward being more fully involved in APMs to justify the expenses required.

For additional details on Dr. Sinopoli's presentation, see the presentation slides (pages 21-34), transcript, and meeting recording (00:21:48-00:31:54).

Dan Liljenquist presented on reducing organization-level barriers affecting participation in PB-TCOC models.

- Mr. Liljenquist provided an overview of Intermountain Health and noted its mission of helping people live the healthiest lives possible. Intermountain Health aims to avoid waiting until patients are chronically ill to provide care.
- Mr. Liljenquist described Intermountain Health's strategy, which focuses on taking on full clinical and financial accountability for the health of more people; partnering to keep those people well; and coordinating to provide the best possible care. Intermountain Health aligns incentives to take on full clinical and financial accountability.
- Mr. Liljenquist mentioned that Intermountain Health has two major system initiatives to advance its strategy:
    - The first initiative is focused on simplifying care for caregivers, patients, and members. He suggested that health care is complex and confusing for patients, and that everyone who works at Intermountain Health is considered a caregiver. Mr. Liljenquist also indicated that Intermountain Health is working to reduce confusion for patients and be more situationally aware of patient conditions in real time.
    - The second initiative is focused on expanding proactive care. Mr. Liljenquist noted that collapsing Intermountain Health's payment levels to the Medicare payment levels among the states in which they operate would shift the organization from being one of the healthiest health systems in the country to losing $1 to $2 billion per year. Mr. Liljenquist emphasized the importance of creating proactive care models that work for commercial populations. He described the missed opportunity to impact lives by waiting to treat patients for metabolic disease until they are 65 years old. Patients should be treated in their 30s, 40s, and 50s.
- Mr. Liljenquist expressed concerns about the focus on payment models only within Medicare. He suggested that this focus misses an entire generation of people and the chance to avoid crises.
- Mr. Liljenquist noted supply and demand concerns. One quarter of Intermountain Health's doctors and nurses are retiring in the next five years, yet demand is increasing as the baby boomer generation grows older.
- Mr. Liljenquist summarized key takeaways from this presentation, including the importance of adopting cutting edge technology; enriching consumer experience; reimagining their work; growing at-risk payments to align the system with meeting patients where they are; moving toward preventive care measures to keep people well; and creating and expanding proactive care models.
- Mr. Liljenquist emphasized the importance of building trust with providers, which is facilitated through communication and action feedback loops. Being highly engaged in physicians' experiences can help reduce burnout.

For additional details on Mr. Liljenquist's presentation, see the presentation slides (pages 35-42), transcript, and meeting recording (00:32:06-00:43:36).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and meeting recording (00:43:37-01:29:11).

Dr. Johnson discussed best practices for making payments to conveners in specialty-based models.

- There are two main issues concerning payment flow between conveners and partner practices. First, it takes a long time to change the health of a population; generating savings can take a long time as well. Second, providers must wait a performance year plus time for reconciliation once savings are generated. Conveners have difficulties with keeping providers engaged when providers do not see the results in savings for their work on value-based payment contracts in a timely manner.
- He suggested considering different payment flows that occur during the year that can be passed to the provider partners. Conveners are backed by financial institutions because much of the up-front investment is required before payments can flow back to partners.
- One best practice includes ensuring that payers understand the need to front payments as cash flow.
- Another best practice includes having a reasonable ramp to two-sided risk that allows time for shared savings to materialize.

Presenters discussed the role of a convener in an Administrative Services Only (ASO) model, where health plans may not wish to renegotiate contracts with each self-funded employer client.

- Broader payer infrastructure for value-based payments can help include convener-based models.
- The Medicare population has many needs, and there has been a rationing of care. One presenter's organization uses sub-capitation models for primary care with a corresponding guarantee for same-day access. Large employers agree to cover costs to increase access.
- Creating a value network to make it easier for payers to contract for certain types of services is a challenging and costly undertaking.
- Individual employers can be offered a spectrum of services, from minimal services (e.g., same-day access, sub-capitations) to total risk with risk quarters. This effort has been on an individual, large employer-by-employer basis. A mechanism to do this through a payer has not yet been found.

Dr. Gaus discussed potential solutions for private practices to improve their risk-based coding, as private practices are compared to hospital-based systems.

- Coding practices and inequities in coding underlie the problems in benchmarking and reconciliation. Conveners bring new coding technology, which can help place individual private physician practices on a similar level as hospital systems.
- This problem does not have a simple solution.
- Dr. Gaus confirmed that there is no financial incentive for a doctor to improve their coding. Doctors will be paid the same, no matter how they code, unless they are in a risk-based contract.

Presenters discussed different types of physician compensation arrangements that may be most effective to change the physician mindset for caring for a population while balancing individual physician needs.

- As networks initially enter APMs, they are limited in what they can provide for practices. Physicians' base salaries are linked to fair market value. Shifting toward more global risk allows leeway for other types of support. Shared savings are not always predictable, and networks

cannot rely on shared savings as an incentive. Once a certain level of risk is reached through the 2020 OIG rules, there are ways to pay physicians for care coordination efforts, process improvement projects, or in-kind services (e.g., ambient listening devices that embed notes into the EMR). Clinical integration is driven by taking on a level of risk that moves the practice past the 2020 OIG regulations.

- The current environment is unpredictable for providers. Even large, sophisticated IDSs can be on the wrong side of a contract. Plans can shift risk onto providers. Many MA plans are trying to keep their quarterly earnings without risk adjustment or HCC uplift; they are denying claims and shifting risk by adding benefits and using contracts against providers. This has reduced individual providers' willingness to participate in value-based care, especially risk-averse providers with low capitation. There is a need to create clear rules and be comfortable with what the shared savings are for providers.

Presenters discussed how their organizations use AI.

- Doctors across all settings have been offered DAX Copilot, an ambient listening tool. The tool has saved doctors between 90 minutes to two hours of provider administrative time every day.
- Another time-saving AI tool one organization uses drafts response notes to patient inquiries.
- Intermountain Health currently has approximately 70 different AI projects. Most of the projects are back office-oriented (e.g., reducing time to complete a claims denial letter appeal). One project uses ambient listening for nursing. The organization works with Microsoft on a nursing pilot to reduce coding time per patient per nurse. The goal of this project is to increase bedside time for nurses, which could allow nurses to take one to two more patients per shift. This project aims to proactively address nursing shortages.
- One organization has not used AI tools for physician copilot work, such as tools that provide physicians real-time advice. The organization hopes to use these types of tools in the future.
- An ambient listening tool has been implemented across most employed practices in one organization. This tool has decreased provider time spent on administrative tasks and has improved documentation. One challenge the organization faces now is implementing ambient listening tools in independent physician practices. This is a challenge because independent practices have a variety of EMRs where the tool needs to be integrated.
- One organization is beginning to implement a Care Everywhere tool that allows patients to describe their symptoms over the phone and receive instructions on the best site of care based on the symptoms.
- One organization uses Care Guides to provide PCPs with guidelines.
- The University of North Carolina is currently implementing ambient scribe pilots for clinical purposes.

Presenters discussed essential clinician roles, technology, and practices to successfully deliver anticipatory symptom and disease management.

- The biggest transition will need to happen in specialty practices that are not integrated and do not have primary care doctors, advanced care planning (ACP), or palliative care services.
- Regarding clinical roles, this type of care (e.g., goals of care, ACP, anticipatory care) is important but not always part of residency training. It is key to have individuals whose clinical focus considers patient preferences.
- Regarding technology, AI can help with stratifying patients and creating cohorts of high-risk patients. Bringing together clinical data, outside records, and information on social determinants is important to ensure that the right resources are used for the right patients.

- Financial incentives could be designed so that there is a business model to hire individuals with this type of clinical focus and invest in useful technologies. Time spent on high-margin procedural activities could be replaced with conversations that are aligned with patients' goals of care.
- Anticipatory symptom and disease management needs sophisticated data analytics and AI.
- Organizations want to be able to predict risk on an individual patient level. However, predicting risk in communities using a broad population-level approach is also important.
- One challenge in dealing with population-level risk is regression to the mean; patients either die or they get better. One organization is focusing on identifying rising risk, which should be observed in real time, not retrospectively. The organization has 138 clinical systems that feed data into more than 2,500 data tables. Because there are no current data standards, people manually work with the data tables to understand patient situations. The organization collaborates with Graphite Health, a nonprofit organization that is developing a semantic and syntactic data standard to create a translation engine inside the organization's firewall that reduces the number of data tables from 2,500 to three in real time. The clinical systems are fed into the data model, and then algorithms can be run on the data. The industry is missing a standard for retrofitting clinical systems to a data standard. The organization calls this engine the Next Right Action Engine.
- The Next Right Action Engine is focused on the next right action to take given an episode of care. Models have not been developed to determine the next right action for 30-year-olds. The organization is known for its quality, but quality has been episodically focused, not longitudinally focused. There is a need for a broader mechanism that creates awareness across both episodes and the longitudinal pathways for patients.

Dr. Gaus discussed best practices for improving the predictability of ACO benchmarks and how to effectively address the ratchet effect.

- It is challenging to adjust for future factors.
- The Accountable Care Prospective Trend (ACPT) was an effort to bring predictability to future benchmarks in the MSSP program. ACPT provided a risk-adjusted prediction for the total cost over the course of the five-year contract. CMS projected a 3.9 percent cost growth for 2024, which served as a component of the benchmark for ACOs in 2024. However, spending was close to 9 percent to 10 percent in 2024. CMS will need to adjust for the inaccurate estimate or else ACOs will lose nearly $100 million in potential earnings through the shared savings.
- There is not currently a predictable, stable, future-oriented benchmark. AI has potential to bring more predictability of trends in spending for ACOs and/or at the national and local levels.

Mr. Liljenquist discussed what AI could miss or undervalue due to potential bias in data among people who have utilized the system disproportionately more compared with other people, as well as how to mitigate this potential bias.

- There are significant asymmetries in information. For example, healthy people are underrepresented in the data. It is difficult to engage and interface with a patient who is relatively healthy but entering the beginning stages of metabolic disease. There is a need to create ways to maintain an ongoing relationship between a health system and a patient so that providers can encourage patients to receive health care services at the beginning stages of disease.
- There are concerns with biases in data. This issue was particularly evident during the COVID-19 pandemic. One organization uses a higher level of scrutiny on tools and results that could drive the bias. The datasets are imperfect. The organization wants to expand datasets so that

providers can effectively engage with people in the early stages of disease and then refine the datasets to specific populations. The next right action aims to use the best knowledge available on the particular individual, including their genetics, makeup, social determinants of health (SDOH), and other factors to provide adequate care for the patient.
- One organization considers AI bias checks and balances when selecting tools. One difficult aspect of using AI is the ability to achieve replicable answers, which may be largely due to the underlying structures of datasets. When results are provided, it is difficult to tell how much bias is inherent in the system and how much bias is being reinforced by AI.

Listening Session 2: Supporting Primary and Specialty Care Transformation

SMEs

- Elizabeth Mitchell, President and Chief Executive Officer, Purchaser Business Group on Health (PBGH)
- Joe Kimura, MD, MPH, Chief Medical Officer, Somatus
- Robert E. Mechanic, MBA, Senior Fellow, Heller School of Social Policy and Management, Brandeis University, Executive Director, Institute for Accountable Care

Previous Submitter

- Frank Opelka, MD, FACS, Principal Consultant, Episodes of Care Solutions (*The ACS-Brandeis Advanced APM* proposal)

Dr. Kosinski moderated the listening session with four SMEs on supporting primary and specialty care transformation. Full biographies and presentations are available.

Elizabeth Mitchell presented on supporting primary and specialty care transformation.

- Purchaser Business Group on Health (PBGH) consists of 40 members, including private employers and public agencies, collectively spending over $350 billion annually on health care.
- Investing in primary care is one of the few strategies that both lowers costs and improves outcomes, yet only 4 percent of U.S. health care spending is allocated to primary care. The lack of investment leads to negative consequences, including longer wait times and higher TCOC.
- On average, PBGH members allocate 7 percent of their health care spending to primary care. The Office of Health Care Affordability (OHCA) in California aims to raise primary care spending to 14 percent of total health care expenditures.
- Advanced primary care (APC) includes expanded access options (e.g., extended hours, virtual visits, and asynchronous messaging), interdisciplinary care teams (e.g., nutritionists and community health workers), integrated mental health services, a focus on broader outcomes (e.g., SDOH and patient relationships), and informed referrals to other health care services.
- The APC measure set is simple, evidence-based, and focuses on outcomes and prevention (e.g., blood pressure control), patient-reported outcomes (e.g., depression screening and remission), patient safety, patient experience, and high-value care (e.g., reduced emergency department [ED] visits and hospital utilization). From a purchaser's perspective, TCOC is a non-negotiable measure as the goal is to pay for appropriate care and avoid unnecessary spending on poor-quality care.
- A significant barrier to implementing APC is the payment structure as providers are not compensated for collecting quality measures under a FFS system. Prospective, population-based

APMs are needed to give providers the flexibility to implement APC effectively. This includes paying for specialty referrals based on quality data; however, many PCPs lack the necessary information to identify high-quality specialists. APM payments should compensate APC providers for managing care, performing data analysis, hiring interdisciplinary staff, and integrating mental health and physical therapy services.

- Due to the lack of alignment across health plans, employers engage in direct contracting, particularly for APC. Direct contracting allows employers to standardize contracts, quality measures, and payment models for primary care across regions.
- Multi-payer alignment is crucial for the transformation of primary care. Three health plans in California are collaborating on an aligned payment model through 2025, featuring consistent quality measures, shared performance incentives, increased investment in primary care, and technical assistance for transformation. The three value-based payment models are: 1) FFS plus (a combination of capitation and FFS); 2) per-member-per-month (PMPM) payments; and 3) performance-based payments based on the APC measure set. The goal is to scale this model to at least 30 practices across California.
- A common reporting platform is essential for multi-payer payment reform.
- Ms. Mitchell urged health plans and Independent Physician Associations (IPAs) to align their payment models and their pay-for-performance (P4P) incentive programs with the APC measure set.
- Purchasers should maintain regular dialogue with health plans to understand the barriers and requirements for engaging in multi-payer collaboration and alignment. This includes addressing the challenges posed by legacy FFS systems that discourage multi-payer collaboration.

For additional details on Ms. Mitchell's presentation, see the presentation slides (pages 2-37), transcript, and meeting recording (00:00:52-00:20:16).

Joe Kimura presented on developing team-based attribution methods and aligning specialty payment mechanisms and performance measures.

- Somatus is a specialty value-based care organization accountable for TCOC for patients with chronic kidney disease (CKD).
- Enhanced collaboration between primary and specialty care involves clinical care teams working closely with patients and families, clearly defined roles and responsibilities within the care team, timely and productive communication, and effective data sharing.
- To foster effective collaboration within a care team, all members must agree on clinical best practices; use a standardized EHR and decision support system; maintain frequent and timely communication; and transparently share process and outcome metrics to increase accountability. Additionally, financial incentives must align with these practices.
- Team-based attribution is easier to implement in fully integrated systems as they have control over the entire spectrum of care. Although more challenging, team-based attribution is still achievable in less integrated systems, such as Somatus.
- Team members across specialties must align on the ultimate goal of prioritizing the patient's best interest and how to achieve it. Collective discussions, where team members can clearly see the decision-making process, help ensure that everyone is receiving the same information. This transparency in decision-making fosters a sense of justice, which is essential for high-functioning teams.

- High levels of burnout present a significant challenge to effective teaming and communication and cannot be addressed solely through financial incentives. Efforts to reduce provider burnout include minimizing administrative burdens.
- The Complete Care Program implemented protocols for managing 26 chronic conditions across all care settings and specialties. The program aimed to enhance the value of every patient interaction across all provider types, maximizing the scope of the care team. Over six years, the Complete Care Program outpaced national HEDIS (Healthcare Effectiveness Data and Information Set) performance improvement.
- The SureNet Program automates follow-up procedures for team-based kidney care. The care team agrees that if a patient's lab results show abnormal kidney function and no action is taken within 90 days, the patient should automatically be scheduled for follow-up. Of those who followed up in the program, most were confirmed to have higher-stage CKD.
- The Ask-a-Doc Program's e-consultations streamline communication between primary and specialty care. This program has significantly reduced ED visits and unnecessary physician office visits.

For additional details on Dr. Kimura's presentation, see the presentation slides (pages 38-48), transcript, and meeting recording (00:20:16-00:42:16).

Robert Mechanic presented on strategies for improving alignment between PCPs and specialists in ACOs.

- Mr. Mechanic stated that there are several ways CMS could nest episodes in ACOs, including:
    - Mr. Mechanic suggested that CMS could provide data to encourage ACOs to develop their own episode-based protocols and incentives, also known as "shadow bundles."
    - Mr. Mechanic also suggested that CMS could require ACOs and their providers to join bundled payment models, as many ACOs do not voluntarily participate in these models.
    - Additionally, Mr. Mechanic suggested that CMS could set condition-specific benchmarks. However, Mr. Mechanic questioned whether nesting episodes in TCOC would allow for net benefits, as some providers may lose while others gain.
    - Furthermore, Mr. Mechanic suggested that CMS could explore medical home approaches with incentives for longitudinal specialty care management, similar to the Guiding an Improved Dementia Experience (GUIDE) Model, which provides additional resources for qualifying programs without additional risk.
- Mr. Mechanic noted that a key question moving forward is how to reconcile bundled and shared savings payments.
- He indicated that the mechanics of nesting episode payment models in ACOs are complex.
    - When episode performance is measured with low volumes, random variation can distort performance measurement, leading to inaccurate and potentially unfair payments.
    - Risk adjustment is challenging; it is more effective for procedural episodes than for acute medical or chronic condition episodes, where predictive power is lower.
    - Provider attribution is difficult, especially when identifying the correct specialist for attribution.
    - It is unclear how to define longitudinal episodes for patients with co-occurring conditions. For these patients, capitated payments or carve-outs could be considered.
- Mr. Mechanic stated that ACOs should support PCPs to make better specialist referrals, engage specialists in value-based care, and foster effective collaboration between PCPs and specialists through improved data sharing, cultures supporting transformation, efficient workflows, and aligned incentives.

- Mr. Mechanic also stated that implementing episodes in ACOs is challenging for several reasons, including the fragmentation of care; the fact that most specialty care for ACO patients is provided by outside specialists; low episode volumes; and limited resources for making transformative changes.
- Mr. Mechanic stated that barriers to specialist alignment in ACOs include a lack of quality data; dominant FFS incentives; insufficient bandwidth within ACOs to engage specialists; lack of specialist interest; and uncertainty about financial incentives. Notably, financial incentives for high-quality specialists could reduce shared savings for PCPs.
- Mr. Mechanic suggested that CMS should consider sharing more episode data with ACOs, ideally including all Medicare data.
- Additionally, Mr. Mechanic stated that specialists and hospitals can also play a role in engaging ACOs rather than placing the full responsibility on ACOs to engage specialists.

For additional details on Mr. Mechanic's presentation, see the presentation slides (pages 49-61), transcript, and meeting recording (00:42:16-00:58:22).

Frank Opelka presented on primary and specialty care transformation.

- PCPs often have difficulty with helping patients navigate specialty care. Patients have questions about their treatment options, how to find a quality specialist, and the out-of-pocket costs associated with specialty care.
- Meaningful transparency is crucial for informing high-quality specialist referrals. This includes transparency related to the cost of care, clinical outcomes, patient goal attainment (beyond clinical outcomes, such as SDOH), and STEEEP (Safe, Timely, Effective, Efficient, Equitable, Patient-Centered) metrics. Care pathways should also adhere to certified and verified clinical care standards.
- Value-based care should be defined by whether patients reach their goals of care. These goals should be highly personalized, reflecting the patient's wishes with guidance from their PCP and specialists. Coordinated care occurs when PCPs and specialists work together to achieve the patient's goals. To achieve value, PCPs, specialists, and patients must share clear goals, identify the true outcomes of care, and be transparent about goal attainment and associated costs.
- Too much time is spent tracking payers' adverse event metrics, which show limited variation across specialists. Rare adverse events are not particularly distinguishing and do not measure whether a patient's goals were achieved. Although these events are costly, they should not dictate referrals. High-quality referrals should be based on the patient's goals of care.
- Patients seek a bundled price for an episode of care, including all clinical services delivered by a single team. The unit of analysis for optimal value lies in key performance indicators (KPIs) within an episode of care, focusing on safety, goal attainment, clinical outcomes, access, affordability, and patient risk profiles.
- Dr. Opelka used the analogy of a football team composed of exceptionally talented individual players—quarterbacks, running backs, tight ends, and linemen—to explain that even the most talented individuals are not a team until they collaborate, measure success as a unit, and hold themselves accountable for both individual and collective performance. Unfortunately, in health care, care is often fragmented, and providers tend to work independently, contributing to burnout.
- Patients and PCPs need a digital platform for shared knowledge with openly available information on STEEEP factors.
- Dr. Opelka provided a simulated example of an episode of care finder for a cholecystectomy procedure, based on ZIP code and maximum travel distance. The search engine showed two

hospital options, detailing each hospital's average cost, infection rate, readmission rate, average patient risk score, and patient rating. He also provided two additional examples related to knee replacement procedures. The search results included hospital certifications, common care pathways, timelines, historical volumes, patient goal attainment metrics, and knee score progress. An episode-level search engine such as this should be available to patients and PCPs to facilitate informed decisions about specialist referrals.

For additional details on Dr. Opelka's presentation, see the presentation slides (pages 62-77), transcript, and meeting recording (00:58:22-01:19:24).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and meeting recording (01:19:24-01:40:12).

Dr. Kimura discussed best practices related to data sharing between specialists and PCPs.

- Every practice has its own system for data collection, which leads to confusion. While tools are improving, with more sophisticated organizations using advanced filters and logic, it will be essential to standardize data collection systems across specialists, many of whom are in smaller practices with less advanced infrastructure. Smaller practices often struggle to process the data they receive and integrate the data into their workflows. Technical vendors should evolve their standards to promote better interoperability. Investments are needed to develop standardized reports that can support smaller practices in managing data effectively.

Presenters discussed proactive e-consultations as a model for integrating primary and specialty care.

- E-consultations are a practical way to move toward primary and specialty care transformation. Some health systems have internal mechanisms that allow PCPs to use e-consultations to ask specialists questions as needed. However, one presenter had not encountered a model where specialists proactively review the EMR to identify opportunities for involvement. A key challenge with e-consultations is ensuring that they occur in a timely manner, ideally while the patient is still in the office. An important question to address is how these e-consultations would be financed.
- It is critical to assess the appropriateness of specialty procedures. Referrals should not be linked to incentives for conducting the procedure, making e-consultations with a third party a valuable option.
- PCPs should not be the only providers monitoring the dashboard; specialists should also track patients' progress and conditions. Additionally, predictive analytics powered by AI should be used to identify the most appropriate types of care.
- The relationship between a PCP operating in a capitated model and specialists working under a FFS model can be challenging, especially when services overlap. As a PCP, one presenter encouraged proactive collaboration with specialists and emphasized the importance of specialists providing timely feedback to PCPs for this approach to be effective.

Ms. Mitchell discussed inflation rate targets and guardrails to protect from rationing care under a TCOC model.

- Most PBGH members aim for flat or low trend increases. Many are experiencing annual TCOC increases of 1 percent to 3 percent, while the OHCA of California has set a target of 3 percent. It is challenging to directly translate these TCOC increases into an inflation rate, as some members have shifted spending from services such as ED utilization to primary care. The APC measure set helps to prevent underutilization of care, particularly the use of access and clinical outcome

metrics. Its goal is not to restrict care, but to ensure that more people receive the right care at the right time.

Ms. Mitchell discussed strategies for encouraging other regions of the country to move toward multi-payer alignment, similar to what California has implemented.

- Building relationships is crucial for payers to recognize the mutual benefits of multi-payer alignment, as many view it as a competitive disadvantage. The dominance of FFS is entrenched, and change takes time, making it challenging to convince stakeholders that multi-payer alignment will be effective. Funding is needed for regional or community infrastructure to support collaborative efforts. California stands out by having established groups such as the California Quality Collaborative to foster this type of collaboration.

Ms. Mitchell discussed the role of integrators—entities that facilitate collaboration between providers, payers, and the community while addressing gaps in community needs—in the transition to value-based care.

- Historically, funding sources for integrators have varied, and there is no clear funding structure in place. Payers could contribute, as they stand to benefit from collaborating with one another to develop models.

Dr. Opelka discussed how to integrate patients' goals of care into quality measurement for value-based care in a standardized and fair way.

- Quality measurement can be repetitive, with patients often asked the same questions by multiple providers. The National Committee for Quality Assurance (NCQA) recently released a goal of care measure for primary care that uses a brief survey. This measure should also be adapted for specialty care, such as assessing patient goals of care before, after, and at multiple follow-up points after surgical procedures. Measuring patient goals of care would provide more meaningful insights than the current focus on adverse events. Measuring the right qualities can help reduce burnout and should be prioritized for investment.

Committee Discussion

Dr. Lin opened the floor to Committee members to reflect on the day's presentations and discussions. The Committee members discussed the topics noted below. For additional details, please see the transcript and meeting recording (00:00:00-00:26:00).

- For rural providers to achieve success in PB-TCOC models, key themes from today's meeting included the importance of conveners; a networks approach; community hospitals serving as community centers and the need to share resources across sectors to build integrated teams; and creativity for how care is delivered, which is particularly important for all-payer models.
- Additional key themes that emerged from today's meeting included the integration of AI for broader, predictive work; the need for proactive, anticipatory disease and symptom management; and identifying needs, pathways, and roadmaps for rising risk populations. AI may be able to promote efficiency as the number of older adults increases and the workforce declines.
- One Committee member emphasized that businesses will step forward to make changes if existing structures cannot achieve the desired changes.
- Multi-payer alignment is critical for success. There is a need to consider what the critical mass is for patients. Having between 40 percent to 60 percent of patients in at-risk arrangements is needed to make participation more profitable in these types of arrangements.

- In multi-payer frameworks, considering how multi-payer Electronic Clinical Quality Measures (eCQMs) can help streamline the administrative burden in participation in value-based arrangements is critical.
- There is a need for technical assistance to participate in models.
- There is a high degree of burden of first-year patients where solutions will be needed to overcome this challenge.
- Consider new ways to adjust for the ratcheting effect.
- Tactical suggestions include increasing implementation timelines regarding payment demonstration projects in the future and reducing the time between performance and payment.
- Attribution can be improved by considering the level of the TIN and NPI instead of solely the level of the TIN to avoid attribution by specialty care alone.
- One general theme that emerged was simplicity; keeping measures simple, lowering the barrier for entry, and aligning models.
- Consider "the last mile" to ensure that incentives make it to the doctors in a way that keeps providers engaged in the process, especially because reconciliation is delayed.
- Models need lead time to prepare for participation.
- There is a need for more robust investment in primary care, especially when considering the return on investment (ROI) for primary care. There is a National Consortium of Health Outcomes Management that states the positive outcomes for different interventions. Measurable, quality metrics should be focused on positive outcomes.
- ACP should be a fundamental part of all value-based care models and considered a core quality metric.
- These models are complex, and the inertia is entrenched. Financially, participants must be far beyond the tipping point (e.g., 75 percent) to change how they practice.
- Rural providers typically have a low volume of patients and will need their own set of standards as risk is higher in these settings.
- The MSSP is considered a successful Medicare model, but it lacks the ability to demand utilization control upstream or utilization control in the organization as a way to reduce waste and unnecessary cost.
- How downside risk is mitigated or controlled is considered more important than how much gain is possible.
- In multi-payer alignment, a margin of 40 percent or 50 percent of a practice's entire panel is needed before considering changing the practice's operations.
- NAACOS has generated solutions to benchmarking, risk adjustment, and trend adjustment that are worth consideration.
- Physician leadership takes a "mad man" to move to value-based care.
- Innovation is difficult when the ship has holes in it. The U.S. has trouble with expanding and creating pathways to increase participation in value-based care so that the benefits of value-based care accrue to vulnerable populations. There is momentum growing in large environments; however, there is a group of people that will be left behind. Critical Access Hospitals (CAHs) and rural providers are at a disadvantage regarding market forces, organizational structures, and business models that could affect participation decisions. There is a need to consider pathways for rural communities.
- One Committee member noted interest in considering a measure of a patient's goal attainment and aligning performance measures across multiple payers.
- MA has an advantage. Evidence suggests that business is moving from FFS to MA. However, evidence also suggests that FFS value-based care saves money and increases quality in the MSSP

model. Consider policy-related recommendations related to minimizing MA's advantage regarding risk scoring and ratcheting effects that are adversely affecting FFS value-based care.

- There must be a feasible, visualizable path to savings.
- The time between performance and payment must be reduced.
- Up-front payments must be part of the model.
- There is not enough participation from specialists.
- FFS should be less desirable for specialists and more desirable for PCPs.
- Hybrid FFS capitation models should be investigated.
- The 40 percent rule regarding risk may promote participation. Enough revenue should be at risk.
- Risk-reward analysis should be realistic and consistent with the business model of the practice.
- Multi-payer alignment could be a game changer for participation.
- Nested Patient-Centered Medical Homes (PCMHs) could create cascading accountability for chronic medical care.
- Using global budgets for rural hospitals could help to rescue some of the hospitals that are needed in those specific areas.
- PCPs have a Stockholm syndrome when it comes to FFS. Consider making the primary care payment tax deductible for the patient because the ROI on primary care is 13 to 1. Additionally, also consider a carve-out payment as a mechanism for a prospective payment to support PCPs.
- Technical assistance to implement programs is important. Consider avoiding inadvertently incentivizing consolidation of organizations due to people not being able to access data or technical assistance.
- Actuarial stability in benchmarking is important. There is a need to consider ways that providers can achieve actuarial stability in benchmarking and a reconciliation process that is quick so that providers can access money when they fall short.
- The 2020 OIG rules regarding flexibility and waivers need more attention. Consider why people were not using this program and how to make this part of the connective tissue in how care is delivered.
- PB-TCOC models can and should be improved in a technical way to be one key offering in the market; however, there are other important models in the market.
- There have been many recommendations provided. As a next step, the Committee members should consider which ideas no longer serve us so that they can be taken off the table. There are trade-offs with some of the recommendations provided. For example, multi-payer alignment is important for many reasons, but it requires simplicity. The simplicity required has a trade-off; simplicity can be achieved with primary care and ambulatory measures, but there is difficulty with investment in primary care. How can the simplicity be brought to specialty care when every specialist, context, and load is different? Simplicity is further challenged by integrating sub-specialists. If organizations scale up, they are accepting complexity. Complexity is a feature in the system, not a defect. Embracing complexity, however, means some degree of simplicity must be set aside.
- Participation among ACOs in PB-TCOC models has plateaued. The viable business models that thrive under FFS are a challenge to increasing participation in value-based care.
- ACOs are held to a stricter performance expectation without approaches such as networks or utilization management. TCOC models do not have the tools that MA plans have to help the models succeed. There should be additional considerations over time to add tools to the PB-TCOC model toolbox to help the models be more successful.

Closing Remarks

Co-Chair Pulluru adjourned the meeting.

The public meeting adjourned at 5:07 p.m. EST.

Approved and certified by:

//Audrey McDowell//
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Audrey McDowell, Designated Federal Officer
Physician-Focused Payment Model Technical
Advisory Committee

4/18/2025
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Date

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4/18/2025
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4/21/2025
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Date