

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

**June 7, 2022
9:32 a.m. – 3:53 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201**

Attendance

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

Paul N. Casale, MD, MPH, PTAC Chair (Vice President, Population Health, NewYork-Presbyterian, Weill Cornell Medicine and Columbia University)
Lauran Hardin, MSN, FAAN, PTAC Vice Chair (Senior Advisor, Illumination Foundation and National Healthcare and Housing Advisors)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Lawrence R. Kosinski, MD, MBA (Founder and Chief Medical Officer, SonarMD, Inc.)
Joshua M. Liao, MD, MSc (Associate Professor, Medicine and Director, Value and Systems Science Lab, University of Washington School of Medicine)
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
Terry L. Mills, Jr., MD, MMM (Senior Vice President and Chief Medical Officer, CommunityCare)
Angelo Sinopoli, MD (Chief Network Officer, UpStream)
Bruce Steinwald, MBA (President, Bruce Steinwald Consulting)*
Jennifer L. Wiler, MD, MBA (Chief Quality Officer Denver Metro, UCHealth and Professor of Emergency Medicine, University of Colorado School of Medicine)

PTAC Members in Partial Attendance

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

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

Lisa Shats, PTAC Designated Federal Officer
Victoria Aysola
Steven Sheingold, PhD

***Via Webex Webinar**

List of Speakers and Handouts

1. Presentation: Best Practices in Care Delivery for Population-Based Total Cost of Care (TCOC) Models

Soujanya Pulluru, MD, Preliminary Comments Development Team (PCDT) Lead*

Handouts

- Agenda
- Population-Based TCOC PCDT Slides
- Population-Based TCOC Environmental Scan Supplement

2. Listening Session on Assessing Best Practices in Care Delivery for Population-Based TCOC Models (Part 1)

Debbie Zimmerman, MD, Corporate Chief Medical Officer, Lumeris*

David Kendrick, MD, MPH, Principal Investigator and CEO, MyHealth Access Network*

Yi-Ling Lin, Healthcare Actuary & Financial Strategist, Terry Group*

Shari M. Erickson, MPH, Chief Advocacy Officer and Senior Vice President, Governmental Affairs and Public Policy, American College of Physicians; (*The "Medical Neighborhood" Advanced Alternative Payment Model [AAPM] [Revised Version] proposal*)*

Handouts

- Listening Session on Population-Based TCOC Models Day 1 Slides
- Listening Session Day 1 Presenters' Biographies
- Listening Session Day 1 Facilitation Questions

3. Listening Session on Assessing Best Practices in Care Delivery for Population-Based TCOC Models (Part 2)

David C. Grossman, MD, MPH, Interim Senior Vice President, Social and Community Health, Kaiser Permanente*

Ali Khan, MD, MPP, Chief Medical Officer, Oak Street Health*

Dana Gelb Safran, ScD, President and Chief Executive Officer, National Quality Forum*

Adam Weinstein, MD, Chief Medical Information Officer, DaVita, Inc.*

Handouts

- Listening Session on Population-Based TCOC Models Day 1 Slides
- Listening Session Day 1 Presenters' Biographies
- Listening Session Day 1 Facilitation Questions

4. PTAC Member Listening Session on Issues Related to Population-Based TCOC Models

Angelo Sinopoli, MD, UpStream

Handout

- PTAC Member Listening Session Slides

5. Stakeholder Responses to Population-Based TCOC Request for Input (RFI)

Victoria Aysola, ASPE

Handout

- RFI Presentation

***Via Webex Webinar**

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available on the ASPE PTAC website located at:

<https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>].

The [ASPE PTAC website](#) also includes copies of the presentation slides and other handouts and a video recording of the June 7 PTAC public meeting.

Welcome and Overview

Paul Casale, PTAC Chair, welcomed members of the public to the June 7-8 public meeting. He explained that in March, the Committee began a three-meeting series of theme-based discussions on population-based total cost of care (TCOC) models. Chair Casale noted that the March public meeting focused on definitions of population-based total cost of care, as well as issues and opportunities related to developing and implementing population-based TCOC models.

Chair Casale previewed the two-day June meeting as focused on the design of care delivery under population-based TCOC models. He noted that the meeting will include lessons learned from the public, subject matter experts (SMEs), and stakeholders who have previously submitted proposals to PTAC.

Chair Casale provided an overview of topics that will be covered during the two-day. He noted that the meetings will specifically include discussion of:

- Learning from strategies that have led to some organizations' success in bearing financial risk while managing care for patient populations with different needs;
- Incorporating specialty care innovations into TCOC models;
- Evaluating and measuring performance of TCOC models;
- Integrating episode-based or condition-specific models within a population-based model and, at the same time, managing complexity of these models; and
- Strategies to meaningfully address equity under these models.

Chair Casale previewed the focus of PTAC's September public meeting, which will address payment considerations and financial incentives that can encourage the care delivery practices that would be discussed during the June meetings.

Chair Casale referred audience members to background documents intended to summarize important issues and prior research related to the topics that will be covered, including an [environmental scan](#) prepared prior to the March public meeting, a [supplement to that environmental scan](#) prepared following the March public meeting, and other background materials available on the [ASPE PTAC website](#). He noted that after the September public meeting, PTAC will issue a report to the Secretary of Health and Human Services (HHS) with the Committee's comments and recommendations related to TCOC models.

Chair Casale provided an overview of the June public meeting agenda. He noted that today's agenda focuses on presentations that describe the vision and experiences of SMEs that will help the Committee assess best practices in care delivery for population-based TCOC models. The presentations will be followed by a Committee discussion.

He explained that tomorrow's meeting on June 8 will begin with opening remarks from Elizabeth (Liz) Fowler, Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS) and the Director of the Center for Medicare and Medicaid Innovation (CMMI; the Innovation Center), followed by a panel discussion with SMEs, a public comment period, and a Committee discussion. He noted that all items on the agenda are meant to inform PTAC about the latest knowledge regarding the development of population-based TCOC models in the context of Alternative Payment Models (APMs) and physician-focused payment models (PFPMs).

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

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

Presentation: Best Practices in Care Delivery for Population-Based TCOC Models

Dr. Pulluru indicated that the other four members who served on the PCDT were Lauran Hardin, PTAC Vice Chair, Lawrence Kosinski, Walter Lin, and Lee Mills. She noted that the presentation will address best practices, as well as trade-offs and barriers associated with adopting effective care delivery strategies under TCOC models.

Dr. Pulluru explained that PTAC is examining issues related to developing and implementing population-based TCOC models that encourage accountable care relationships. She echoed Chair Casale's introductory remarks that the March theme-based discussion focused on defining population-based TCOC models and that the current June theme-based discussion will focus on assessing best practices in care delivery under population-based TCOC models. She added that PTAC is particularly interested in how best to integrate care delivery innovations that are specific to an episode of care or specific health condition under an umbrella of a broad population-based TCOC model.

Dr. Pulluru explained that the objective of her presentation will be to provide useful background information and context for the discussions to follow, both today and tomorrow.

Dr. Pulluru offered specific priorities that should be addressed or considered as the health care system moves from FFS to a fully capitated integrated delivery model:

- An organization's acceptance of more financial risk should be accompanied by a significant improvement in care coordination, care integration, and clinical accountability, which will require increased infrastructure to support improvements in care that go beyond interactions between providers and patients during a medical visit.
- An increased emphasis for coordinating care should go along with greater flexibility for innovation, such as use of synchronous or asynchronous virtual and digital care approaches. This will encourage innovation closer to the level of the treating provider and to the level of provider-patient interaction.
- A recognition that the move toward greater accountability may encourage limiting beneficiary choice of providers. While there are clear downsides of limiting beneficiary choice, it is important to consider how there may be useful trade-offs in this area that can lead to higher quality, better outcomes, and greater provider accountability.

Dr. Pulluru stated that there is increased financial risk for the accountable entity as payment models move from FFS methodology to a fully capitated model, with the following implications:

- Increased risk leads to increased focus on improving value; the goal of improving value is embedded in every model deliberated by the Committee.
- Increased risk may lead accountable entities to establish differences in beneficiary cost-sharing obligations that encourage beneficiaries to choose coverage and provider options that emphasize value.
- Increased assumption of risk by accountable entities may reduce administrative burden for payment determination from health plans or CMS and increase administrative burden for different types of organizations that accept risk, including providers.
- Models that increase risk for different types of organizations should also consider how to maintain administrative simplicity, paying attention to the timing and administrative costs of financial reconciliation.

Dr. Pulluru highlighted four important areas of focus for supporting innovative patient-centered care delivery with accountability for delivering high-value care to patients with different needs. She noted that each of these areas is equally important.

1. Models should recognize that while patients, on average, rely on primary care providers (PCPs) for most of their care, some patients see specialists more often than their PCP. Models should consider where patients with different needs receive most of their care in assigning accountability for high-value care.
2. Models should encourage provider alignment and coordination around needs that vary from patient to patient. For example, some attribution methodologies may focus accountability on PCPs even if the majority of a patient's care is provided by a specialist. Models' technical specifications and rules should align with and leverage differences in patient needs for social services, long-term care, behavioral health, and other areas in ways that improve coordination and establish channels of care delivery consistent with any given patient's needs.
3. Models should identify ways for innovation to produce value by considering the settings and context in which care is delivered. This may occur through adopting advanced primary care; adopting team-based care platforms and strategies that enable providers to work at the top of their licensure; encouraging care delivery that encompasses both synchronous and asynchronous virtual and digital care to engage patients in their care more effectively; encouraging provider

systems to provide care consistent with tailored care pathways; and integrating community services to address SDOH.

4. As a foundation, models must provide the tools, resources, and infrastructure necessary to enable providers to access real-time data, to establish effective patterns of care, to increase and facilitate sharing between organizations and risk-bearing entities, and to encourage best practices regardless of geography, practice size, or patient population.

. Dr. Pulluru noted that such incentives driven by benchmarks and cost measurement methods may result in conflicting incentives between episode-based models and population-based TCOC models. She stated that the services included in or excluded from TCOC benchmarks may incentivize cost shifting, and consistent implementation of incentives may encourage participation in advanced payment mechanisms.

Dr. Pulluru discussed considerations for integrating specialty care into population-based TCOC models. She noted the following points:

- Nested models may offer opportunities to effectively integrate specialty care into population-based TCOC models without producing unintended consequences. Nested models are hierarchical; for example, an Accountable Care Organization (ACO) global budget model may operate as an umbrella for accountability—with other models to improve care and manage costs for different services and patients with different needs embedded under and implemented by an ACO being reimbursed under the global payment approach. The implementation rules associated with key model elements, such as benchmarking and shared savings calculations, must be designed so that nested models complement one another and the overall umbrella model.
- Carve-out models may also be a useful approach to including some specialty services into a population-based TCOC models. Carve-out models embedded within a population-based TCOC would transfer risk and accountability for specific services outside of the ACO and to a separate entity with incentives driven by benchmarks associated with the specific (carved-out) services.
- Mandating provider participation models (including specialist participation in population-based TCOC models) may be needed if population-based TCOC models cannot create sufficient incentives to engage specialists. This may be the case in markets with a limited supply of specialty care, particularly underserved and rural markets.
- Voluntary provider participation may result in less accountability, integration, and coordination than necessary to address quality and TCOC objectives.
- There are potential structural modifications of episode-based models that may facilitate easier coordination with population-based TCOC models. These include extending the duration of episodes that are part of bundled care payments; making it easier to incorporate long-term measures of long-term quality into provider incentives; and addressing perverse incentives when episode-based models and broader TCOC models are implemented simultaneously.
To improve care for patients who see providers participating in multiple models, it will be important to encourage coordination across accountable entities involved in population-based models and accountable entities involved in other models. This would incentivize coordination between accountable entities that accept different types of risk – for example, coordination between accountable entities involved in different ACO models, coordination between ACOs and entities with accountability under advanced primary care models, or coordination between accountable entities in episode-based models and ACOs.

Dr. Pulluru explained that timely data sharing is a crucial element for success in population-based TCOC models.

She noted that many Next Generation ACOs have stated that delays in information on financial performance and lags in receiving shared savings payments make it difficult to use the prospect of shared savings payments to encourage provider participation. Dr. Pulluru described how some Next Generation ACOs have left the model because they did not have enough information about their financial performance in the current year before the deadline for withdrawing from the model in the following performance year. ACOs noted that in some cases, end-stage renal disease (ESRD) Seamless Care Organizations (ESCOs) cite similar challenges.

Dr. Pulluru provided examples of innovative specialty care models, including:

- CMMI's Comprehensive ESRD Care model, which grants nephrologists, dialysis clinics, and other providers the ability to form ESCOs—a type of ACO accountable for clinical quality outcomes and spending on dialysis services.
- The Maryland TCOC Model, which provides diabetes outcomes-based credit and provides recognition to Maryland for investing in initiatives and programs to delay and prevent diabetes.
- Several previous PTAC proposals included innovative care delivery approaches with the potential to improve quality and reduce TCOC, such as primary care medical homes, specialty-based medical homes, and remote specialty care to support patients and staff in skilled nursing facilities (SNFs).

Dr. Pulluru discussed unaddressed issues in performance measurement and evaluation, which are important considerations when developing TCOC models:

- Identifying appropriate time periods for measuring outcomes associated with financial incentives; short-term cost and utilization measures may not reflect long-term patient care goals or patient-centered care.
- Sufficiently accounting for variation in patient populations served by participating providers, recognizing that performance-based payments may exacerbate health care disparities if measures do not sufficiently account for this variation.
- Standardizing data elements used in calculating performance measures and reducing variation in coding practices that can affect performance measure viability.
- Addressing issues related to selection, including adverse selection under models currently implemented or being tested, which may limit the extent to which results from these models can be generalized.
- Addressing the challenge in estimating return on investment (ROI) if the scope of the advanced payment methodologies is broad, if associated costs and savings cannot be readily captured, or if returns are experienced over a longer time period, giving organizations limited financial flexibility to make necessary investments up front.
- For models implemented in areas where the population or utilization of specific services is limited (e.g., rural or underserved areas), it is difficult to validly compare performance measures from a limited sample of patients and episodes to appropriate comparisons and benchmarks. This poses a substantial barrier to introducing performance-based payment in areas where it is needed.
- APMs must adapt to include new performance measures as emerging health issues occur.

Chair Casale invited PCDT members to share any additional insights.

- Dr. Kosinski noted that one major challenge for TCOC models is managing the complexity related to transferring risk from an accountable entity to individual providers. He explained that entities are willing to accept global risk; however, this will not achieve successful integration of primary and specialty care unless providers are also sharing in that risk. Dr. Kosinski noted that many of the current models focus on primary care capitation and continue to use FFS to pay specialists. To the extent that value-based payment arrangements from some models represent a percentage of specialist revenue, this percentage is not high enough to incentivize their commitment to the care model.
- Vice Chair Hardin noted that it is a challenge to determine where payments for addressing SDOH should fall considering that related needs are often addressed through partnerships with community organizations that are not part of the same accountable entity or integrated delivery systems participating in an APM model.

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

- Angelo Sinopoli noted that in addition to considering how to include independent specialty practices in TCOC models, it will also be important to consider how to incorporate specialists who are employed by hospital systems. He questioned whether the hospital should bear some of that risk, considering that hospitals typically control budget and resources that enable improvements in specialty care.
- Chair Casale highlighted the question of how to spread accountability from the accountable entity down to the provider level. He noted that the answer starts with attribution so that providers understand for whom they are accountable. Chair Casale emphasized the importance of risk adjustment. He noted that a shift of high-risk patients to health maintenance organizations (HMOs) may, in some cases, worsen health disparities. He noted that for providers to participate in accountable relationships, they should understand the patients for whom they bear accountability, the adequacy of the model's risk adjustment approach, and their level of accountability within the overall model.
- Joshua Liao noted the tension between offering accountable entities flexibility in their approach to care delivery model design and asking them to avoid limiting patient choice. He asked, on the one hand, whether offering more flexibility will lead to beneficial innovation and change in clinician practice, or whether it is more important to reduce unhelpful variation in practice by limiting flexibility. He also raised the issue about how trade-offs associated with offer flexibility for model participants relate to the challenge of effectively nesting or cascading accountability across different providers.
 - Dr. Pulluru noted some examples of clinician practice innovations, such as the use of synchronous and asynchronous digital technology and team-based care that focuses on making the most of coordination opportunities at every point that a patient "touches" the health care system.
 - Vice Chair Hardin noted observing practices that weave together different types of services in the same setting—for example, practices that offer behavioral health visits in a primary care office. She noted that integrating services to address homelessness services with delivery of health care can stabilize affected populations quickly, provide care in a place convenient to patients, and produce efficiency across providers.
 - Dr. Liao noted that the prior discussion and Dr. Pulluru's presentation helped him realize the importance of considering which services models should cover, how those services should be paid for, and trade-offs associated with these decisions. He also raised the issue of the trade-offs associated with coverage and payment for telemedicine services.

- Dr. Lin emphasized that in the U.S., health care follows finance, which makes provider incentives in both quality and cost performance crucially important to health outcomes. He noted that often care delivery models are successful from a quality and patient care perspective, but they cannot last if they are not linked with an appropriate payment model.
- Chair Casale noted that many PCPs are still operating in an FFS- or Relative Value Unit (RVU)-based system. He noted that because they are so busy with patient care and administrative duties, they do not have time to think more broadly about their patient population.

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

SMEs

- Debbie Zimmerman, MD, Corporate Chief Medical Officer, Lumeris
- David Kendrick, MD, MPH, Principal Investigator and CEO, MyHealth Access Network
- Yi-Ling Lin, Healthcare Actuary & Financial Strategist, Terry Group

Previous Submitter

- Shari M. Erickson, MPH, Chief Advocacy Officer and Senior Vice President, Governmental Affairs and Public Policy, American College of Physicians; (*The "Medical Neighborhood" Advanced Alternative Payment Model [AAPM] [Revised Version] proposal*)

Chair Casale moderated the listening session with three SMEs and a previous submitter on assessing best practices in care delivery for population-based TCOC models. He noted that full biographies and presentations for presenters can be found on the [ASPE PTAC website](#).

Debbie Zimmerman presented on the TCOC model implemented by Essence Healthcare, a Lumeris-operated Medicare Advantage (MA) plan in Missouri and Illinois.

- Dr. Zimmerman shared that the Essence Healthcare model is focused on partnering with physicians to manage TCOC and balance the cost of care with quality and access outcomes. She indicated that Essence Healthcare evaluates outcomes across four domains:
 - Reducing per capita costs of care: Achieved a 26 percent reduction in costs compared to FFS Medicare when risk adjusted for age, gender, geography, and incidence of chronic conditions.
 - Quality: Averaged 4.5 stars from CMS's Star Ratings system over the past 12 years and received a five-star rating in 2022. Dr. Zimmerman noted that while the MA quality rating system is not perfect, it is a reasonable measure of quality of care and service.
 - Improving the consumer experience of care: Received a five-star consumer experience score in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and has seen low member disenrollment.
 - Increasing physician engagement: Physicians' incentives are well-aligned with the MA plan's goals to reduce TCOC.
- Dr. Zimmerman noted that Essence Healthcare conducted a study of patients, providers, and provider groups in the plan to determine the factors that drove improved performance when using TCOC as the outcome. She emphasized that care delivery transformation, particularly the delivery of accountable primary care, is the most difficult driver to achieve. Dr. Zimmerman also noted the difficulty of incentivizing providers to change their behavior, indicating that providers need to have a substantial number of their patients enrolled in a value-based TCOC contract to be motivated to transform their practice.
- Dr. Zimmerman explained the Essence Healthcare model and described best practices in its TCOC alignment. She noted that every patient in the MA plan is assigned to an accountable PCP; that

every accountable PCP belongs to a physician group; and that every physician group is in a value-based contract with the payer. All Essence Healthcare physicians have TCOC incentives that are balanced with health care quality and access. She indicated that the value-based contract provides transparency to ensure that providers and payers are aligned and understand how the value-based arrangement works.

- Dr. Zimmerman described the investment that Lumeris makes to manage TCOC. She noted that understanding the differences between a managed and an unmanaged population gives insight into what programs are effective and where the plan should focus its efforts. Dr. Zimmerman highlighted the importance of investing in low-risk patients. She indicated that medical groups are not successful in Medicare TCOC models if they do not see 95 percent or more of their patient population at least once per year.
- Dr. Zimmerman emphasized that the 26 percent reduction in cost is not spread evenly across all spending categories, but a shifting distribution of health care costs while reducing costs overall. She gave an example, where Essence Healthcare observed decreased spending for inpatient and specialty services, but the plan increased spending for primary care.
- Dr. Zimmerman discussed the alignment of payer and provider incentives and provider compensation.
 - She noted that for value-based incentives, there should be complete transparency and a balance of TCOC incentives with health care quality and access. The level of financial risk for providers should also be appropriate for the organization's maturity. Dr. Zimmerman noted that putting a provider group at full financial risk is not sustainable. Plans should instead invest in these provider groups and help with performance.
 - Dr. Zimmerman noted that Essence Healthcare does not control how physician groups compensate their physicians. She emphasized that Essence Healthcare works with its provider groups to implement a fair and equitable compensation model that incentivizes shared learning, accountability, and improvements in quality of care offered by all of its physicians. She noted that models should not just reward high performing physicians; plans should identify high-volume, high-opportunity providers and mentor them to improve performance.
- Dr. Zimmerman provided an overview of the primary care delivery transformation used by Essence Healthcare. She emphasized that care management programs alone would not achieve the 26 percent reduction in overall cost without care delivery transformation and changing patients' approach to caring for themselves. Essence Healthcare targets investments by identifying the activities and attributes most important to achieving better outcomes. Dr. Zimmerman highlighted that the plan hires staff committed to transforming health care practices at all levels (e.g., scheduling, pre-visit planning, and engaging advanced practice providers [APPs]). She also described rapid practice transformation, where the plan works with practices on transforming care, and an accountable care "boot camp" for providers.
- Finally, Dr. Zimmerman discussed the importance of giving providers the information they need to adjust care to produce better outcomes. She noted that providers must know how they are performing at the population level and have insight into the costs associated with the patients they see. She highlighted that physicians can access data at the claims level to see measures of overall cost for their patients. Dr. Zimmerman also explained that health systems must be able to use information at the population level to identify opportunities for the system and individual providers.

David Kendrick presented on lessons learned related to information, technology, and infrastructure for health care innovation.

- Dr. Kendrick introduced the MyHealth Access Network (MyHealth), which is the health information exchange (HIE) for Oklahoma.
- Related to model design, Dr. Kendrick discussed the consequences of multi-payer models. He noted that in CPC Classic, there were multiple payers and a high proportion of patients participating in the model at each practice. This motivated improvements to the care delivery infrastructure, but it placed a burden on establishing community-level governance and convenings to help commercial payers work with a large federal agency.
- Related to model execution.
 - Dr. Kendrick explained that most claims data cover a use of a wide scope of health care services provided by different providers but do not always provide sufficient context on the care delivered.
 - As an HIE, MyHealth helps to ensure that the full picture of each patient's data is available to providers. Dr. Kendrick emphasized that patient data are fragmented: more than 90 percent of patients seen in Oklahoma have data in more than one clinical location. Data fragmentation persists when providers use the same EHR vendors, including Epic and Cerner.
 - When accounting for chronic diseases, data fragmentation increases; nearly 100 percent of patients with two or more chronic diseases have fragmented clinical data. A 2007 study that found that the average PCP must coordinate care with 225 providers across 117 organizations.
 - Furthermore, 20 percent of commercially insured patients change payers every year, which represents a death and birth data event from the payer perspective. Providers in Oklahoma also see patients who have received care throughout the U.S. in the prior 2-3 years. As a result, it is essential for providers to have a national view of patient data.
 - MyHealth serves as a health data utility by collating clinical, claims, and social needs data from the more than 1,400 statewide health care and social service facilities and other sources into a common resource that is available for patients and providers. This is critical because looking at only EHR data is not sufficient to adequately understand the greater than 110,000 clinical encounters that happen every day in Oklahoma.
 - Dr. Kendrick noted that patient attribution is a difficult concept for providers, and EHRs do not have internal analytics that account for attribution. He explained that each payer may use a different logic to attribute patients to providers. Dr. Kendrick explained that if the EHR does not analyze patient data according to the same attribution logic as each payer's system, providers will not be able to use their own systems to view quality measure results for their attributed population.
 - Dr. Kendrick highlighted the importance of using data such as MyHealth for interventions that alert providers of sentinel clinical events. He explained that care fragmentation alerting resembles Admissions, Discharge, Transfer (ADT) alerting and notifies a provider within 24 hours when their patient receives any health care services, regardless of where the services were performed. Dr. Kendrick noted that 30-day readmission monitoring immediately notifies providers when their patient registers for care at any location with an impending 30-day readmission.
 - Dr. Kendrick explained that as a trusted third party for measurement, MyHealth mediates information exchange between payers, providers, and social service agencies to ensure that the most relevant and recent data are used to calculate quality measures. He noted that MyHealth uses the most recent result for each patient, uniquely calculates their status for a specific quality measure (e.g., Hemoglobin A1c for diabetic patients), and uses the appropriate attribution logic to determine quality performance based on surrounding

- community data. Dr. Kendrick observed that payers, providers, public health officials, and employers have engaged in the MyHealth quality measurement process.
- He emphasized that the infrastructure developed during these model demonstrations allows for real-time quality measurement. He also suggested that it is important for payers and practices to access expenditure data reported by service line.
- Dr. Kendrick noted that MyHealth studied the process of making patient referrals across providers in the community and observed that thousands of referrals were dropped due to complexity in the referral process. Dr. Kendrick added that referrals within the MyHealth population may be made across 25 unique states. He shared a vision where an electronic hub would monitor the status of referrals, and providers would send and receive referrals to coordinate the referral process and “feed it back” to the EHR system.
- MyHealth demonstrated significantly improved rates of referral loop closure by using technology to track referrals, rather than labor-intensive phone calls between providers. Furthermore, Dr. Kendrick stated that electronic consultations are critical to enable specialists and consultants to triage cases, especially for practices assuming financial risk. He highlighted data that showed a \$130 per-member per month (PMPM) decrease in spending for Medicaid patients who received an electronic consult as part of their referral visit when compared to patients who did not receive an electronic consult.
- Dr. Kendrick emphasized that social needs and SDOH data are also highly fragmented. He described MyHealth’s mobile screening system as part of the AHC model that attempted to defragment social data. Dr. Kendrick explained that a screening questionnaire is sent to the patient’s mobile phone when they register for care; the patient can complete the screening in less than five minutes, and MyHealth technology immediately scores the results. He noted that if the patient demonstrates a social need, the technology sends a tailored referral back to the patient’s phone based on MyHealth’s database of nearly 5,000 community services throughout Oklahoma, and that the data are also relayed back to the practices for awareness. Dr. Kendrick noted that this system allows MyHealth to identify where social needs exist at a granular level (e.g., sites of care, payer type).
 - Dr. Kendrick observed that to date, MyHealth has provided more than 2.8 million offers for social needs screening, received more than 500,000 responses, and identified and referred over 100,000 social needs for assistance. He added that this process was sustained throughout the COVID-19 public health emergency (PHE) because patients used their phones during telemedicine appointments.
- Dr. Kendrick emphasized that combining clinical, claims, and SDOH data results is essential for maximum improvement. He noted that MyHealth is dedicated to sustaining its social needs program even as the models it was developed for are ending. Dr. Kendrick noted that CPC+ practices that participated in the AHC model and utilized the SDOH screening tool demonstrated significantly reduced cost trends and emergency department (ED) utilization compared to the practices that did not implement the screening tool.
- Finally, Dr. Kendrick noted that the longer practices are involved in value-based payment, the more they benefit from their experience. He presented data showing that practices that participated in CPC Classic before transitioning to CPC+ had reduced ED utilization and total expenditures when compared to practices that participated only in CPC+. Dr. Kendrick emphasized that all practices could achieve positive results if they have more exposure to these alternative models.
- Dr. Kendrick concluded his presentation by suggesting that CMMI models are a suitable laboratory for a rapid start-up of data infrastructure, a space for quick evaluation and rapid iteration on the evaluation results, and a channel through which to disseminate the results.

Yi-Ling Lin presented on population-based TCOC models from an actuarial perspective.

- Ms. Lin shared that she works with hospital systems, physician groups, payers, and employer groups as a consulting actuary.
- Ms. Lin described how an overreliance on historical data leads to value-based measures anchored to past performance, rather than set to achieve a desirable future outcome. She also noted that using historical data penalizes organizations that perform well in TCOC arrangements by establishing lower targets for subsequent performance years. Ms. Lin explained that as a result, organizations are incentivized to barely achieve value-based targets to prevent the implementation of more challenging performance targets the next year.
- Ms. Lin acknowledged the challenge of using a one-year time horizon for TCOC contracts, noting that health care organizations must answer financial questions, such as ROI estimates, on a one-year time horizon. Ms. Lin explained that a one-year time horizon is necessary to support annual financial planning but impedes long-term progress toward servicing the population of interest and improving health care. She added that a one-year time horizon encourages a lack of planning for unpredictable years.
 - Ms. Lin explained that insurance companies have more sophisticated financial management systems than health care provider groups and are able to manage reserves for years when health care spending among their covered population is unpredictably high. She noted that if spending is lower than anticipated in a specific year for an insurance plan's covered population, the plan may release some of the reserved cash and reduce premium costs for the subsequent year. At the same time, in years when spending is unexpectedly high, the insurance company may siphon money from the reserve to cover the spending that exceeded prediction. Ms. Lin observed that provider organizations do not have the same capacity and reserves built up over many decades of insuring patients, but should be encouraged to become more sophisticated in their management of their financial reserves over long windows of time.
 - Ms. Lin highlighted how the COVID-19 PHE demonstrated the importance of planning for unpredictable years, citing the impact of supply chain-related difficulties and the situation where medical inflation is less than the Consumer Price Index (CPI). She added that the full long-term impact of the PHE on health, including mental health and social trauma, is not yet understood.
- Lastly, Ms. Lin discussed the use of risk scoring, or risk adjustment, a mechanism invented to predict how much each beneficiary will cost in a given performance year. She emphasized that risk scoring was developed mathematically to predict cost, not to measure a patient's health needs. Ms. Lin observed that in some cases, risk scores are being used for unintended purposes, such as to inform the allocation of care management resources and to identify populations for targeted outreach. She added that risk scores are being used to determine payments to health organizations when they assume financial risk for a population.
 - Ms. Lin noted that risk scores may be artificially low for populations not using preventive services or addressing chronic conditions because the scoring algorithm will predict lower costs for patients that have not historically used these services. She noted that predicting what a patient's health care will cost in the future is different than predicting the cost of care that the same patient will need in the future.
 - Ms. Lin cautioned against risk scoring algorithms incorporating proxy measures for SDOH (e.g., race, income, zip code). She explained that proxy measures are not suitable to identify individual patient needs or to allocate care management tools and interventions.

- Finally, Ms. Lin emphasized the importance of investing in developing risk scores for all patients, not just those whose care is paid for under APMs or value-based contracts.

Shari Erickson presented on assessing best practices in care delivery for population-based TCOC models in the context of *The "Medical Neighborhood" Advanced Alternative Payment Model [AAPM] [Revised Version] (MNM)* proposal to PTAC.

- Ms. Erickson stated that the *MNM* proposal was submitted to PTAC jointly by the American College of Physicians (ACP) and the National Committee for Quality Assurance (NCQA). She explained that ACP represents 161,000 general internal medicine physicians, as well as subspecialists, interested in advancing payment models that incorporate primary and specialty care. Ms. Erickson noted that the *MNM* proposal was identified by PTAC as meeting all the Secretary's criteria for PFPMS and was recommended to the Secretary for testing.
- Ms. Erickson described *MNM*: The *MNM* process is initiated when a patient and their physician agree that a specialty referral is necessary. After the specialty referral is submitted, the specialty practice pre-screens the referral and accompanying documentation to ensure that it is appropriate. The pre-screening step eliminates potential administrative challenges related to inappropriate referrals. If the referral is deemed appropriate, the specialty visit triggers an active phase of attribution to the model. Ms. Erickson noted that the specialty practice role may vary from co-managing treatment to serving as the primary manager of treatment.
- Ms. Erickson highlighted best practices for engaging clinicians in accountable care arrangements that ACP identified during development of the *MNM* and continues to promulgate in its recommendations to CMS and other payers.
 - Focus on the development and implementation of a limited set of measures that are patient-centered, actionable, appropriately attributed, and evidence-based for public reporting and payment purposes. In addition, identify mechanisms for supporting the use of clinically meaningful measures for internal quality improvement to allow for greater innovation opportunities and to engender trust between practices and payers.
 - Maintain safe harbor opportunities that allow practices to engage in innovation. While the safe harbor opportunities evolve, Ms. Erickson recommended moving toward measurement at a practice level, as opposed to the individual clinician level. She added that ACP reviewed internal medicine-relevant measures for validity and recommends prioritizing those measures, along with others focused on prevention (e.g., cancer and substance use screenings).
 - Provide performance targets to clinicians and clinical care teams in a prospective and transparent manner. She advised that such performance feedback be accurate, actionable, and timely.
 - Recognize that appropriate patient attribution and benchmarking are critical for successful performance measurement. Ms. Erickson noted that voluntary patient attribution is the gold standard, and use of patient relationship codes is also a promising method of attribution. She said that without use of one of these mechanisms, attribution should rely on robust case minimums. Ms. Erickson recommended that benchmarks should be fixed across all participants and be set prospectively using the most current data available.
 - Encourage primary care and specialty practices to work collaboratively and establish a care plan that is customized to individual patient and family circumstances and preferences. She noted that this collaboration leads to more meaningful patient engagement and subsequently improved health outcomes. Similarly, she emphasized the value of care coordination agreements between the two types of practices.

- ACP recently released updated guidance on referrals and effective care collaboration between primary and specialty care practices. Critical elements of care coordination agreements include delineated communication and data sharing protocols; mechanisms for prioritization of notifications; clarification of when handoffs between providers should occur; and internal plans to define who is responsible for clinical and care coordination tasks.
- Ms. Erickson discussed best practices to engage specialty providers in APMs or TCOC models.
 - She noted that one challenge to specialist engagement is the limited ability to scale prior models to various specialties. She described how the *MNM* is built on a scalable framework that ensures the model is understandable and predictable for participating primary care and specialty practices.
 - Ms. Erickson reiterated the importance of clear communication, information sharing, and care coordination agreements. She emphasized that the specialty practice or clinician should be involved in pre-screening all referrals and maintaining the accompanying documentation.
 - Related to the payment methodology of these models, Ms. Erickson described how the reimbursement structure should support specialist engagement and reduce the administrative burden of unnecessary and duplicative work. Efficiencies may be gained through interventions such as triaging referrals and pre-screening. She noted that TCOC models also need to use incentives (e.g., transportation and copay waivers) that encourage patients to engage with participating specialists.
 - Ms. Erickson confirmed that evaluations could look at TCOC both at the practice level and at the patient-population level, looking at cost across both primary care and specialty care practices.
- Ms. Erickson described how to operationalize these best practices by reviewing critical elements of a referral and the subsequent referral response. She noted that these elements are elaborated on in the recent ACP position paper.
 - She described critical elements of a successful referral: a patient who is educated up front to ensure that they are aware of the appropriate next steps; available information on patient demographics; scheduling preferences, and special considerations (e.g., language needs); clear specification of relevant clinical questions as rationale for the referral with supporting data; and a method for tracking the referral.
 - Ms. Erickson described critical elements of the referral response: a clear answer to the clinical question; an agreement over the role of the specialist in the immediate and long term; confirmation of any new, existing, or changed diagnoses; notification of medication or equipment changes; a summary of any testing results, procedures performed, or patient education completed or recommended; notice of any secondary referrals made; and recommendations for services that could be completed by the PCP or patient-centered medical home (PCMH). She explained that the referral response should also provide a clear indication of what the specialty care provider is going to do, what the patient is instructed to do, and what the original referring physician needs to do and when. All this information should be easily accessible in the response note.
- Moving beyond the subject of referrals, Ms. Erickson discussed the integration of behavioral health with primary and specialty care. She highlighted that the Collaborative Care Model (CCM)—a model that allows patients to be seen by PCPs and evaluated for behavioral health issues in consultation with psychiatrists—is a good start to enabling integration, but CCM is not supported by the current primary care infrastructure. Ms. Erickson noted that existing codes and payment mechanisms are not sufficient to cover the up-front cost that primary care practices will incur in order to build the

necessary infrastructure. She posed the question of how to integrate a model such as CCM with the MNM.

- Ms. Erickson further highlighted the need to address health equity and the social drivers of health. She emphasized ACP's recommendation to prioritize the inclusion of underserved patient populations in all APMs. Ms. Erickson also described the need for creating validated methods for measuring the cost of care for patients that experience health care disparities and inequities based on their personal characteristics or for those who are disproportionately impacted by SDOH. She emphasized the importance of safe harbor opportunities for health care practices to engage in innovative approaches to address these issues. Ms. Erickson noted that ACP will be releasing a paper on this issue soon.

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

- Dr. Mills asked Dr. Zimmerman and Dr. Kendrick to comment on the complexity of the measurement process and the importance of timeliness for data reporting and financial accountability in a TCOC environment.
 - Dr. Zimmerman stated that CMS provides MA plans with more than 40 quality measures that impact star ratings. She added that Essence Healthcare includes between 10 and 15 quality measures in its physician contracts, some from CMS and some proxy measures (e.g., access to care, readmission rates). She noted that Essence Healthcare uses standard measures where applicable and proxy measures when needed.
 - Related to the timeliness of data reporting, Dr. Zimmerman emphasized the importance of partnering with an HIE and leveraging the availability of real-time ADT feeds. She noted that while many health systems claim to have a lot of information about discharges, many of their patients may be discharged from providers outside of their health system. She supported the concept of a nationwide HIE.
 - Regarding the timing of data, Dr. Zimmerman noted that using claims payments for cost of care is retrospective and not timely. She noted that physicians are more interested in identifying future opportunities to improve care and reduce costs, as opposed to looking back at claims that have already happened. Regarding risk adjustment, Dr. Zimmerman supported Ms. Lin's recommendation to use a future-oriented perspective when setting benchmarks or performance targets; however, she noted that retrospective claims payment for TCOC can be useful for identifying opportunities for improvement and overall trends in outcomes or cost of care.
 - Dr. Kendrick noted that with the current approach to measurement and available data, providers are using workarounds, such as proxies for SDOH. He emphasized the need for patient-centric, community-wide measurement to allow for the critical use of service-level patient data across all data sources.
 - He added that during his tenure as the Chair of the NCQA board of directors, the organization shifted its focus to certify and validate the datasets used for measurement, as opposed to certifying and validating the measures themselves. He suggested that if the data can be certified to contain accurate data from all aspects of the patient record, in addition to all the data within a community, then experts can adopt the measurement approach accordingly. Dr. Kendrick also highlighted the importance of real-time or more rapidly available clinical and cost of care data. He suggested that live clinical data can drive predictive cost.
- Jennifer Wiler asked Dr. Kendrick to comment on the capital investment needed to build data infrastructure that gives access to real-time data to help influence physicians' decisions and, as a result, patient outcomes. She noted that there is a risk in building infrastructure with a delayed

opportunity to evaluate its performance and underscored the value of providing time to allow outcomes to be achieved. She also asked Dr. Kendrick to comment on the sustainability plan for maintaining infrastructure described throughout his presentation.

- Dr. Kendrick noted that substantial infrastructure already exists, with 75 organizations similar to MyHealth that have levels of sophistication, throughout the U.S., covering between 290 and 310 million lives. Dr. Kendrick commented that the organizations were built in response to the promotion of interoperability by the Office of the National Coordinator for Health Information Technology (ONC) and supported by investment dating back to the American Recovery Act of 2009 and the 2011 implementation of meaningful use standards for EHRs. Dr. Kendrick noted that prior to federal involvement in data infrastructure development, there was community-level involvement and support of development, governance, and trust in this process. Dr. Kendrick emphasized the appropriateness of the term “health data utility” to refer to this technology, rather than “health information exchange,” to indicate that such infrastructure is essential for every community.
- Dr. Kendrick discussed how health data utilities are generally built as nonprofits to prevent the tension that arises when asking communities, especially with underserved populations, for their data when a profit motive exists. He noted that the major funding for these nonprofits expired in October 2021, and many of the nonprofits are now trying to figure out how to sustain their models. Dr. Kendrick explained how MyHealth used CMMI models as “steppingstones” to expand the functionality of their technology. However, progress and research may stop when a model ends, and MyHealth must pull back on its resource investments and delete valuable data. He noted that important research had to stop when CPC Classic and CPC+ program data had to be deleted.
- Dr. Kendrick discussed the sustainability plan for the SDOH screening tool developed under the AHC model. He noted that MyHealth put the tool on the marketplace in Oklahoma with the prediction that it could be used for 25 cents per screening.
- Jay Feldstein asked Dr. Zimmerman whether Essence Healthcare has sustained its cost and utilization trends over multiple years. He also asked Dr. Zimmerman to comment on the plan’s approach for pharmaceutical cost management.
 - Dr. Zimmerman noted that Essence Healthcare consistently has a significantly lower spending trend than the industry (when excluding 2020 and 2021 data, which may be irregular due to COVID-19). She cautioned that analyzing health care cost trends is more complicated than looking at the overall trend because the distribution of medical costs has changed over time. As an example, Dr. Zimmerman observed that inpatient medical costs no longer compose the majority of medical spending and that ambulatory pharmacy costs have increased significantly. Regarding pharmaceutical cost management, Dr. Zimmerman noted that California physicians, who are typically considered experienced in taking on financial risk, do not include pharmacy in their TCOC arrangements. She noted that Essence Healthcare includes pharmaceutical costs in TCOC calculations because the organization considers it important to help patients adhere to their pharmaceutical regimen to manage overall costs. She described how Essence Healthcare works with pharmacy benefit managers (PBMs) to establish preferred networks; engages in activities to balance medical and pharmacy costs (e.g., zero copay insulin benefit); allows for prior authorization; invests in technology and programs to improve medication adherence; and engages with providers (e.g., oncologists, rheumatologists) to maximize the effectiveness of the care they are providing as a means to manage the plan’s pharmaceutical costs.

- Dr. Liao agreed with Dr. Zimmerman's observation that providers with limited experience in value-based payment arrangements should not assume full risk. He asked Dr. Zimmerman to expand on how incentives should be used for providers who are new to risk-based arrangements to engage in population health management, and how should incentives or supports evolve over time and experience?
 - Dr. Zimmerman emphasized that this is an important area of learning for Essence Healthcare, which was started by a group of physicians who had the infrastructure, data and analytic capabilities, and case management programs needed to manage TCOC. She described how plans must understand the six drivers from her presentation and what it means to deliver accountable care. Dr. Zimmerman noted that contracts should make sure to include an actuarially appropriate number of patients across which to spread risk and should consider a provider group's experience before implementing downside risk for TCOC.
 - Dr. Zimmerman recommended five activities that should be implemented in the first year of a TCOC arrangement in an MA population:
 - Accurately document the chronic disease incidence for the population, which is essential to receive an accurate premium.
 - Identify quality metrics for a one-year performance period to assist in the development of the collaboration, leadership, shared performance, accountability, and incentives that are essential to achieve reduced cost.
 - Increase access to primary care to ensure all patients are seen by a PCP, and the sickest patients are seen more frequently by PCPs, as well as specialists. Dr. Zimmerman noted that Essence Healthcare encourages PCPs to see patients at least as frequently as the patient requires a specialist visit. She recommended a primary care to specialty care visit ratio that approaches one for the sickest patients.
 - Follow up with patients after discharge, including follow-up that lets patients know about changes in the providers responsible for their care that may occur following a discharge. Dr. Zimmerman also mentioned that follow-up should include sharing information about the patient's own accountability for their care.
 - Identify high-risk patients and manage them appropriately. This involves identifying high-risk patients where providers can change the disease trajectory and implement complex case management or interventions that pay close attention to care transition.
- Dr. Liao asked Dr. Zimmerman to confirm whether the demonstrated results for Essence Healthcare were achieved at the stated goal of 30 to 50 percent compensation rates for providers. He also asked Dr. Zimmerman to elaborate on whether these results track with increasing compensation rates, or whether a threshold for achieving these results exists.
 - Dr. Zimmerman stated that physician groups with 30 to 50 percent compensation rates performed better than the groups with lower rates. She cautioned that providers respond to more than salaries, such as by how resources are devoted and where information is shared. For example, Dr. Zimmerman described a contest where the top three physician groups received medals on the basis of clinical outcomes. The silver medal team was motivated to improve and earned the gold medal the next year.
- Dr. Lin noted that MA plans have a narrow network comprising higher-quality, lower-cost providers. However, CMMI value-based demonstrations generally lack a narrow network due to CMS's commitment to preserve provider choice for Medicare beneficiaries. He asked Dr.

Zimmerman whether the narrow provider network was essential to Essence Healthcare's outcomes, or if CMS can advance value-based care without limiting provider choice.

- From a primary care perspective, Dr. Zimmerman noted that it is possible to use a broad network of providers if physician organizations are engaged and committed to managing population health. She added that if the primary care network is engaged, then it is also possible to have a broad network of specialists. Dr. Zimmerman emphasized that with an engaged primary care network, specialists are going to see only the most complex patients, so they can be paid more than the market rate. She expressed that policy makers must consider other factors for achieving cost reductions (e.g., referrals, utilization management, alternative payment). Dr. Zimmerman added that all accountable entities do not need to achieve a 26 percent cost reduction; she felt that if all entities mitigate trends, the collective impact could improve health care in the U.S.
- Dr. Kosinski asked Ms. Erickson if ACP has further developed the payment model associated with its recommendations for care coordination agreements and referral best practices.
 - Ms. Erickson confirmed that ACP has not advanced the work on its payment model, other than what is laid out in the *MNM*, because there has not been an opportunity to implement it within CMMI. She expressed interest in additional work on the payment model.
 - As an earlier contributor to the *MNM* development, Dr. Kendrick added that information collected from thousands of referrals demonstrated that the pre-screening of referrals should be reimbursed as FFS to create incentive for physicians to do this. He noted that FFS level two or level three payments were sufficient to attract a specialist's attention and to encourage their participation in the pre-screening activity.
 - Ms. Erickson added that ACP has continued discussions with its subspecialty societies to promote interest in testing the payment model.
- Dr. Sinopoli asked Dr. Zimmerman to clarify what Essence Healthcare has achieved regarding the engagement of specialists with PCPs to drive value, especially for systems where only a small fraction of the patients requiring specialty care are at risk.
 - Dr. Zimmerman described how Essence Healthcare is using data to direct the plan to opportunities for education and training. She noted as an example that Essence Healthcare is focusing utilization management efforts on cardiology, ophthalmology, oncology, orthopedic surgery, and dermatology. Dr. Zimmerman added that specialists are often the best advocates and will educate PCPs on appropriate next steps. Furthermore, Dr. Zimmerman described how Essence Healthcare is using episode-grouping data to identify opportunities for specialists to improve care. She emphasized that this data should go to the specialists, not PCPs, to ensure that the data are credible and prevent a shift in referral patterns based on specialist performance.
- Chair Casale asked Ms. Lin about alternative methods for calculating benchmarks to avoid an overreliance on historical data. Specifically, Chair Casale asked about a method for considering the improvement over time that is likely to occur for value-based care model participants.
 - Ms. Lin described the importance of reconciling past performance with a desirable future state. She recommended using the best performing provider systems in the country or looking at the top performers on specific measures to accurately identify the desirable future state.

Listening Session on Assessing Best Practices in Care Delivery for Population-Based TCOB Models (Part 2)

- David C. Grossman, MD, MPH, Interim Senior Vice President, Social and Community Health, Kaiser Permanente
- Ali Khan, MD, MPP, Chief Medical Officer, Oak Street Health
- Dana Gelb Safran, ScD, President and Chief Executive Officer, National Quality Forum
- Adam Weinstein, MD, Chief Medical Information Officer, DaVita, Inc.

Vice Chair Hardin moderated the second listening session with four SMEs on assessing best practices in care delivery for population-based TCOC models. She noted that full biographies and presentations for presenters can be found on the [ASPE PTAC website](#).

David Grossman presented on the Kaiser Permanente health plan, delivery system, and TCOC model.

- Dr. Grossman introduced himself as the leader of Social and Community Health initiatives at Kaiser Permanente and provided additional background on the organization.
 - He explained that Kaiser Permanente is the largest private, nonprofit, integrated health system in the U.S., with over 12.5 million members, 23,000 physicians, and 200,000 employees. The health plan also includes eight nonproprietary health services research centers.
 - To illustrate the integration of the health plan and care delivery system, Dr. Grossman presented a map of the distribution of Kaiser Permanente's members, noting that most of their members reside in California, and that Kaiser locations are largely concentrated in metropolitan areas and large population centers, with typical penetration of 20 to 40 percent of the insured population in a community.
 - He described how Kaiser Permanente consists of a set of discrete, separately chartered, mostly nonprofit organizations under the Kaiser Permanente umbrella. This includes the Kaiser Foundation Health Plan, which serves the main function of the health plan and distributes global payments; Kaiser Foundation Hospitals and additional contracted hospitals; and shareholder-owned Kaiser medical groups. He noted that in some regions (e.g., Georgia and Washington state), Kaiser relies heavily on contractor facilities as there are not Kaiser Foundation hospitals available. However, the care in these facilities is provided by Kaiser Permanente physicians. The plan also has agreements with eight separate medical groups that cover different regions where there are members, including two regions in California.
 - Dr. Grossman noted that the medical groups are mostly shareholder-owned, but some are moving toward a public benefit model (B-corporations) that serves the community's interest. Each Kaiser Permanente medical group develops medical service agreements with each Kaiser Permanente Health Plan subsidiary to provide mutual exclusivity and grant the medical group control over clinical guidelines, policies, network composition, and the appeals process.
- Dr. Grossman highlighted Kaiser Permanente's unique integration of care, finance, and delivery, noting that the organization also integrates the components of care delivery to provide a full spectrum of care and services, including care coordination, case management, mental health, and social health, while maintaining a primary care centric model. He emphasized that this coordination was facilitated by Kaiser Permanente's linked EHR system, which allows all providers access to all aspects of care coordination and case management. Dr. Grossman explained that mental health and social health are fully integrated into the EHR system.

- Dr. Grossman described how Kaiser Permanente's global budget enables flexible care delivery beyond the constraints of the FFS system. He noted that specialty care can often be delivered via telehealth consults with PCPs without any billing processes or requirements for in-person consultation with patients. Dr. Grossman explained that Washington state was able to use telehealth in 75 percent of virtual encounters without concerns of revenue loss. He suggested that Kaiser Permanente was one of the earliest adopters of EHRs, which was a critical investment to its success as a patient-centered, highly-integrated organization.
- Dr. Grossman emphasized the importance of EHR systems in maintaining Kaiser Permanente's high levels of patient engagement and clinical integration across states, citing its early adoption of patient portals and Epic's CareEverywhere program as key products used to reduce redundant care.
- Dr. Grossman noted that a major difference in the experience of Kaiser Permanente medical groups versus other care innovators is that they spend less time having to adapt their practices for different payers. He explained that Kaiser Permanente's coverage policies are fully aligned with the practice guidelines developed by the medical groups. Many referrals for services from different kinds of providers are automatically approved based on those providers' Kaiser Permanente affiliation. Dr. Grossman explained that patients are not caught between providers and health plan disputes over coverage and payments.
- Dr. Grossman detailed the Kaiser Permanente payment structure, describing how Kaiser medical groups are paid a global fee based on a capitation formula, which is then distributed to physicians and other providers on a salary basis. He noted that there is minimal FFS billing, which is done only for external requirements or special purchasers. Kaiser Permanente rewards medical groups and individual providers with incentives based on quality and patient experience targets that are mutually agreed-upon by a health plan and medical group in a memorandum of understanding.
 - Dr. Grossman emphasized that the majority of Kaiser Permanente's revenue comes from premium payments, but also includes a substantial portion funded by patient cost-share revenues. He noted that for self-funded employers, the risk-based model is driven by FFS payments plus a global capitation fee that covers much of the non-billable integrated services, such as case management and care coordination, which are crucial to the success of the model.
- Dr. Grossman discussed Kaiser Permanente's efforts to incorporate social health into mainstream medical care. He noted Kaiser Permanente's legacy of investing in the health of the communities in which their members reside.
 - He noted that Kaiser Permanente provides \$3.6 billion in community benefits through a combination of charity care, grants, and community investments focused on addressing needs uncovered during the Community Health Needs Assessment process.
 - He described how Kaiser's EHRs incorporate social health needs assessments to facilitate discussion at the point of care, care coordination, and care planning.
- Dr. Grossman presented Kaiser's model for identifying and addressing members' social needs. He noted that the model focuses on identifying social health needs using standard tools, connecting members to relevant community resources, and enabling appropriate follow-up for members with social needs, particularly for those with complex clinical and social needs. Dr. Grossman discussed how the follow-up process also informs Kaiser Permanente's ability to monitor the performance of community-based services and make investments in community-based organizations.

- Dr. Grossman noted that the screening process is conducted through a variety of pathways, including screenings at the site of care, digital self-service tools, or through outreach to a call center.
- Dr. Grossman noted that Kaiser Permanente has developed its own “Thrive Local” platform, powered by UniteUs (a software vendor), to provide electronic referrals to community resources. He described how the platform is integrated into the EHR, allowing providers to monitor referrals and monitor whether services were provided.
- Dr. Grossman remarked that Kaiser Permanente’s social health initiative is initially focusing on addressing food resources, housing resources, social isolation, and financial resources. He noted that Kaiser Permanente has also begun using artificial intelligence and algorithmic logic to identify members likely in need of services, even if they had not yet been screened. Dr. Grossman described how the organization recently reached out to 4.2 million members, 80,000 of whom successfully completed the enrollment application for social services.
- Dr. Grossman concluded by emphasizing the importance of integrating social needs into the care delivery system and health plan.

Ali Khan, Chief Medical Officer at Oak Street Health, presented on Oak Street Health’s experiences in developing a value-based care program and addressing health equity.

- Dr. Khan presented some of the existing challenges with the U.S. health care system, noting that the system’s spending does not achieve desired value and quality outcomes. He highlighted how many high costs, negative experiences, and chronic disease burden are concentrated in seniors and older adults, many of whom are forced to choose between paying for health care and paying for everyday expenses. He highlighted how chronic disease is a major issue for these communities, accounting for 96 percent of total Medicare spending.
 - Dr. Khan emphasized that some issues affect some communities more than others, highlighting the relationship between social vulnerability, health risk factors, and race that can worse health outcomes.
 - He highlighted data from the RAND Corporation and CMS suggesting notable discrepancies in health care screening, treatment, and disease prevention across racial and ethnic categories.
 - Dr. Khan underscored the importance of improving quality and consistency of care for underserved populations and increasing equity among all populations, noting that addressing issues of quality and equity in health care are key concerns at Oak Street Health.
- Dr. Khan provided additional background on Oak Street Health.
 - Oak Street Health is a national network of primary care centers for Medicare eligible patients, operating over 140 centers in over 20 states and providing care for about 115,000 members in full-risk MA, Medicare/Medicaid dual-eligible programs, and direct contracting programs with a total of approximately 150,000 members, including traditional Medicare FFS beneficiaries.
 - Oak Street Health focuses on serving urban, working class, suburban, and immigrant communities across much of the Midwest, Northeast, Southeast, and Southwest.
 - Oak Street does not selectively enroll patients, noting that 42 percent of Oak Street patients are dually eligible for Medicare and Medicaid; 86 percent have at least one chronic condition; the majority identify as Black, Latinx, or Indigenous; and 50 percent have at least one social risk factor. Dr. Khan explained that many patients take numerous medications

prescribed by different providers for varying conditions and require help filling and taking these medications. He shared stories of patients who face real challenges staying on top of medications prescribed by different providers. He also highlighted that the social needs of Medicare beneficiaries are not unique to Oak Street Health, citing data from Humana showing that most Medicare beneficiaries enrolled in their MA plans have two or more social risk factors, which often include financial strain.

- Dr. Khan highlighted the importance of moving from reactive to proactive primary care. He noted that Oak Street Health, along with other organizations like Aledade, CityBlock, and ChenMed, use capitation in a full-risk setting to invest in more time, resources, and follow-through, as compared to typical primary care.
 - He noted that Oak Street Health invests in time by taking care of smaller patient panels, having longer visit lengths and increased numbers of visits, and proactively reaching out to patients in a high-intensity model.
 - He described how Oak Street Health relies on large, interdisciplinary teams comprised of physicians, nurse practitioners, physician assistants, nurses, community health workers, pharmacists, social workers, behavioral health practitioners, and chaplains. These multi-disciplinary care teams follow through with patients, connect them to resources (i.e., pharmacies, social workers, financial resources, behavioral health care), and quickly and efficiently answer care-related questions. He emphasized that this focus on proactivity and the team structure at Oak Street Health ensure that providers address all patient issues before they worsen.
- Dr. Khan noted that Oak Street Health relies on integrated public and proprietary data sources to get a holistic understanding of patients, including looking at a measure of “level of worry” and the frequency and intensity of engagement needed in primary care. He highlighted Oak Street’s use of population health management tools to support consistent, proactive care through electronic specialty care consultations, home-based primary care, and medication management, among others. Dr. Khan emphasized the importance of care navigation to ensure that patients are adequately served and build trust.
- Dr. Khan discussed the importance of trust between Oak Street Health and the populations it serves, emphasizing that the organization has consistently taken higher-risk populations and faces more structural barriers than other providers in achieving five-star Healthcare Effectiveness Data and Information Set (HEDIS)-level performance on national standards.
 - Dr. Khan noted Oak Street Health’s success with integrated behavioral health, highlighting that the combination of rigorous screening, consistent hand-offs, and the integration of behavioral health into primary care has led to substantial reductions in depressive symptom management.
 - Dr. Khan noted that Oak Street’s success was similar to other value-based care organizations, citing data from Aledade showing that more substantial, more engaged primary care relationships reduce ED utilization, inpatient utilization, and TCOC.
- Dr. Khan emphasized that value-based care arrangements, with increased focus on primary care, consistently yield reductions in hospital admissions and ED visits, better patient outcomes, and higher levels of satisfaction.
- Dr. Khan discussed Oak Street Health’s experience as a Medicare Shared Savings Program (MSSP) ACO, noting that even without the risk adjustment and other benefits associated with MA, Oak

Street Health was able to achieve the fourth-highest savings rate of all 513 ACOs in the cohort. He highlighted that value-based models can continue to produce consistent results.

- Dr. Khan noted that important questions on incentive design, particularly rewarding quality and equity, scalability, and evaluating clinical excellence, remain unanswered and need to be considered moving forward.

Dana Safran, President and Chief Executive Officer at the National Quality Forum (NQF), presented on her time on the executive team at BlueCross BlueShield Massachusetts working on the Alternative Quality Contract (AQC) model, high-priority issues for the success of value-based payment models, and the issues surrounding health equity and adjustment for social risk in models.

- Dr. Safran described the AQC model as a catalyst for the ACO movement and distinct from traditional FFS payment due to its payment based on a global population-based budget, symmetrical two-sided risk, significant upside potential based on quality and outcome measures, and five-year contracts with a fixed cadence of inflation predefined prior to the contract's beginning.
 - She provided a summary of the quality measure set for performance incentives, noting that the measures were created to provide protection against potential care stinting. The measure set contained a range of process, outcome, and patient experience measures across both ambulatory and hospital settings, noting that today's measure sets look relatively similar to the measures developed in 2007 for the model.
- Dr. Safran highlighted the importance of two key methodological innovations in the AQC's incentive models for contributing to the success of the AQC in driving improved quality and outcomes. These innovations included offering a range of performance targets, rather than single set targets, for each performance measure, and basing those targets on absolute improvements in performance, rather than improvements in relative performance. The innovations allowed for increased motivation and cooperation between providers.
- Dr. Safran noted that evaluations of the AQC during the model's implementation showed that the model substantially improved quality and health outcomes and resulted in 12 percent cost savings over traditional FFS contract models.
- Dr. Safran indicated that four broad areas of innovation in delivery systems made during the AQC implementation period include improving staffing models, approaches to patient engagement, referral relationships and integration across settings, and data systems and health information technology (HIT).
- Dr. Safran emphasized the importance of moving toward outcomes-oriented measure sets on the path toward value-based payment. She noted that current measures, which are similar to those developed in 2007 for the AQC model, are smaller process measures and are the product of an FFS mindset. She noted that future value-based measures need to focus on outcome measures and can be narrower and more parsimonious to be consistent with the goals of value-based payment.
- Dr. Safran highlighted that five clinical domains (cardiovascular, orthopedics, mental health, obstetrics, and oncology) account for more than 50 percent of medical spending in both public and private payment. However, very few, if any, outcome measures related to these five domains are covered in NQF's endorsed portfolio of measures. Dr. Safran noted this lack of relevant measures was a key priority for NQF moving forward.
- Dr. Safran noted that improvement in health equity could come from investments that adjust payment, rather than by adjusting performance outcomes, to account for social risk. She suggested

that providers caring for patients with higher social risk should receive preferred base payment rates or be subject to lower benchmarks, as the ACO Realizing Equity, Access, and Community Health (REACH) program does. She advocated for the creation of a multiplier based on performance level to help providers with higher social risk patients earn more for the same level of performance. Dr. Safran highlighted the important opportunity to use measures to adjust for social risk in financing payments and invest in health equity, rather than masking disparities by adjusting performance outcomes based on social risk.

Adam Weinstein, Chief Medical Information Officer of DaVita Incorporated and advisor to the Renal Physicians Association, presented his listening session on the role of specialists in TCOC models.

- Dr. Weinstein provided a brief summary of relevant vocabulary prior to beginning his presentation, including chronic kidney disease (CKD), ESRD, and end-stage kidney disease (ESKD).
- Dr. Weinstein discussed the physiology and logistics of kidney care delivery. He noted that nephrologists deliver care in a wide variety of practice organizations, with most practices consisting of between four and seven nephrologists, while others are part of large health systems with practices as large as 30 to 70 nephrologists. He discussed that kidney disease is an ongoing condition requiring continuous monitoring, noting that intervention during early Stage III to mid-Stage IV kidney disease can result in the most cost reduction and risk mitigation. He noted that patients with late Stage IV, Stage V, and ESRD can have the highest medical complexity and associated costs if earlier interventions and risk mitigations are not taken. Dr. Weinstein noted how nephrology incorporates collaboration with many other specialties but emphasized that nephrologists should serve as the “quarterbacks” of care, especially for Stage III and beyond patients because of their unique ability to slow disease and prepare patients for future treatment. He highlighted the necessity of maintaining nephrologists at the center of future models incorporating nephrology patients.
- Dr. Weinstein noted that kidney disease is an appropriate condition to be addressed in a TCOC model for the following reasons:
 - There are numerous opportunities for cost savings and quality of life improvements through optimal care delivery for kidney patients.
 - Kidney disease is highly prevalent, with long lead times before patients enter the period of highest cost and highest complexity.
 - Kidney disease patients can be easily identified through their lab data.
 - Existing measurable and cost-effective solutions for slowing the progression of kidney disease can be tracked using administrative data, claims data, CPT (Current Procedural Terminology) codes, and ICD (International Classification of Disease)-10 codes.
 - Kidney disease patients can be easily attributed to providers through claims data.
- Dr. Weinstein described the stakeholders in a kidney disease payment model and noted their ideal goals and characteristics:
 - CMS and other payers have a strong interest in ensuring patients receive high-quality, optimally-priced care.
 - Patients and caregivers can benefit from incentives to engage and participate in models, particularly considering the more complex way patients receive their medications.
 - Nephrologists and nephrology practices participating in payment models are business entities and need time to adapt from their typical FFS-oriented practices. Dr. Weinstein

suggested that nephrologists and nephrology practices participating in APMs are incentivized to deliver care differently to small subsets of their patients.

- Kidney care companies are new entrants in the kidney care space. Some, such as DaVita, are dialysis organizations, while others are independent organizations helping nephrologists and nephrology practices manage the logistical challenges associated with patient care, population health improvement, financial risk, and payment models.
- Other specialties and health systems play an important role in managing care of kidney care patients, and they also need to be incentivized to achieve success under kidney disease models.
- Dr. Weinstein described successful roles for nephrologists and nephrology practices, kidney care organizations, health systems, payers, patients, and caregivers in developing and managing successful value-based care models for kidney disease.
 - Nephrologists and nephrology practices should serve as the “quarterbacks” of patient care, providing direct patient care decisions and making population health decisions. To accomplish this, nephrology practices will need high-quality data, clinical data systems such as EHRs that are interoperable with the systems of other providers and organizations, and useful analytic tools. Dr. Weinstein emphasized that nephrology practices need meaningful rewards for improvements in quality of care and TCOC, noting that most practices are willing to take on moderate risk, but cannot provide up-front investments and require simplified reporting and accountability burdens to be successful.
 - Kidney care organizations can begin to fill in some of these gaps by taking on risk, offering up-front investments, and providing IT and data analytic tools that smaller and moderate-sized practices cannot afford on their own.
 - Health systems and payers are not fully engaged in the nephrology care space with capitated and at-risk payments, but they provide important data, such as ADT notifications, and partnerships with additional subspecialties.
- Dr. Weinstein emphasized the importance of considering longer model periods, five to 10 years, to allow nephrology providers to build systems that incorporate all entities that provide care to their patients and allow nephrology practices time to adjust their workflows, engage patients, and change their behavior.

Vice Chair Hardin invited the Committee members to ask the listening session presenters any follow-up questions.

- Dr. Sinopoli asked Dr. Grossman how Kaiser Permanente partners with community-based organizations to hold them accountable for delivering services and outcomes.
 - Dr. Grossman noted that Kaiser Permanente is still working on how to develop effective accountability programs. He indicated that the organization focuses on developing incentives and resources for community-based organizations to participate in the network. Dr. Grossman emphasized the importance of collaborating with the community and recruiting other delivery systems to participate in the network, which would achieve a broader community level of accountability. He noted that the coverage of community resources would likely impact the evolution of the accountability process, suggesting that the process will likely involve process outcomes to ensure that services are actually being delivered, such as feedback based on how often members receive services through referrals and how often receipt of those services is captured back in the EHR systems of the

providers making referrals. He noted that measuring the quality and outcomes from those services delivered by community partners will be more challenging and is a gap that should be addressed moving forward.

- Chair Casale asked Dr. Khan to provide additional information on how Oak Street Health engages specialty providers in its care delivery model, both virtually and in person.
 - Dr. Khan noted that one important consideration for Oak Street Health's engagement with specialists is understanding specialists' heterogeneous levels of motivation to partner with Oak Street Health and Oak Street Health's main goal of providing robust primary care. He explained that while some specialists are interested in providing high-quality consults to PCPs, others are more comfortable in the FFS system and traditional methods of communication.
 - He discussed how addressing differing levels of willingness and engagement among specialists led Oak Street Health to use electronic consultation through a service called RubiconMD, which uses publicly available data to identify potential high-value specialist partners. Oak Street then builds targeted relationships with those specialists.
 - Dr. Khan emphasized the importance of frequent communication and engagement from both PCPs and specialists. Oak Street Health also approaches providers for inclusion on its e-consult platform to facilitate increased patient volume from Oak Street Health to specialists, with the goal of establishing effective, bi-directional communication between primary care and specialists. He noted that engaging specialists relies on a combination of both digital tools and in-person interactions to build relationships, particularly as Oak Street Health increases the size of its patient population in certain markets.
- Dr. Liao asked Dr. Khan to identify what Oak Street Health has done that can be replicated across MA and FFS, including what components of Oak Street Health's approach can be implemented in both MA and FFS-based settings, and what components cannot be implemented in an ACO setting but could be done under MA or other programs.
 - Dr. Khan noted the distinction between elements that are easily executable and those that are financial sustainable. He responded that recruiting patients, conducting risk stratification, identifying primary care needs, building longitudinal care plans, and integrating clinical care teams have consistently achieved high performance across both settings. Dr. Khan offered that Oak Street Health encountered challenges when attempting to offer additional services that cannot be covered in a non-MA or non-capitated environment, explaining that Oak Street Health had had difficulties in sustainably integrating ancillary services (i.e., behavioral health, podiatry, and transportation) in an FFS environment. He highlighted that Oak Street Health's basic model of providing higher-touch, higher-intensity, proactive primary care using a large team can offer significant benefits even in an FFS structure, but noted that there are challenges when navigating additional services like transportation, medication, delivery, and financial supports under FFS payment rules. He provided an example of a patient in MA under full risk, noting that he had the flexibility to provide her with new medications on the same day of the appointment, which he would not have been able to do in Medicare FFS.
- Dr. Kosinski asked Dr. Grossman how Kaiser Permanente recruits and maintains specialists.
 - Dr. Grossman noted Kaiser Permanente is very competitive in recruiting and maintaining specialists. He discussed how many specialists are motivated to join Kaiser Permanente because it frees them from the constraints of the FFS system, highlighting how specialists

enjoy enhanced relationships with PCPs and are not pressured to maintain high patient volumes if they are paid on a salary basis. Dr. Grossman further noted that specialists can play mentorship roles within a region, providing them additional practice opportunities and the ability to practice at the top of their licensure.

- Dr. Kosinski inquired how Oak Street Health engages specialists in its care delivery model, asking Dr. Khan what percentage of specialists' business is derived from Oak Street Health.
 - Dr. Khan clarified that Oak Street Health has not developed specialist relationships where its patients represent a substantial share of the specialists' overall business. He noted that Oak Street Health's wide geographic dispersion and relatively small saturation in some markets limit the patient volume Oak Street Health can offer to specialists. Dr. Khan contrasted Oak Street Health to organizations with larger market shares, such as Kaiser Permanente, CareMore Health, and Agelon, noting that Oak Street Health does not have the luxury of convincing specialty providers to participate based on the volume of their business, but rather must emphasize the specific ways in which it achieves programmatic excellence to make the case that they should partner with Oak Street Health.
 - Dr. Grossman noted that because Kaiser Permanente is a nonprofit organization, it is somewhat constrained in terms of what financial incentives it can offer to providers. However, he emphasized that its salary structure is competitive within the market. He highlighted that physicians come to work for Kaiser Permanente not because it is the best-paying offer available, but because they decide to trade some compensation for the practice philosophy and lifestyle offered by Kaiser Permanente. He noted that the seamless integration between the health plan and the practice can be very important for providers, as it eliminates the need to appeal payment determinations and negotiate with insurance companies.
- Dr. Liao asked Dr. Safran what partners in the AQC achieved with the additional funds provided by PMPM quality dollars and how PMPM payments might be incorporated in future population-based TCOC models.
 - Dr. Safran discussed how PMPM payments offered providers opportunity to invest in new types of staff, new ways of engaging patients, IT and data systems, and new ways of relating to others in the network. She noted that providers brought behavioral health specialists into primary care settings, hired on-site pharmacists, and incorporated social workers and other allied behavioral health specialists on staff.
 - Dr. Safran highlighted some AQC providers' patient engagement strategies, noting that they leveraged new kinds of staff to conduct direct patient outreach in between visits and after hospital discharge to extend care outside the clinical setting. She discussed how the AQC model was potentially constrained by delayed disbursement of PMPM payments, noting that BlueCross BlueShield attempted to provide for initial investments with infrastructure payments designed to help organizations invest in EHRs and other needed tools. She suggested that some of the attraction of capitated payment models is their ability to address cash flow concerns and enable organizations to invest in infrastructure without waiting for delayed performance-based payments.
- Chair Casale invited Dr. Safran to provide her thoughts on the concept of cascading accountability and what outcome measures should be used to establish accountability across providers.
 - Dr. Safran indicated that the AQC model focused on accountability within a system, noting that systems could include anything from a large primary care practice to a multi-hospital

system. She suggested that accountability with respect to ambulatory and hospital outcomes within the AQC model was appropriate and fair at that level (large practice or hospital system) but would not be appropriate for individual clinicians or care teams involved in individual episodes of care.

- She noted that effective use of accountability measures requires appropriate sample sizes, which are not possible on smaller scales. Dr. Safran highlighted that measurement on the smaller scale does not create the desired incentives to drive value-based care because no single physician or care team can drive transformation forward individually. She emphasized the importance of creating incentives that are aligned at the system level and the individual provider level, noting that the differential incentive structures for systems and individual providers may stymie efforts to achieve value-based care transformation. Dr. Safran noted that organizations should cascade incentives down to providers, but highlighted the necessity of choosing the correct incentives, arguing against creating accountability for measures related to individual providers.
- Dr. Lin inquired about the flow of funds in Oak Street Health's model, asking Dr. Khan to clarify if Oak Street Health has its own health plan or if it takes delegated risk from incumbent MA plans.
 - Dr. Khan noted that Oak Street Health does not have its own health plan. He clarified that for the members that Oak Street Health assumes full risk for, they are in full percentage of premium arrangements with over 40 health plans. He explained that for a smaller subset of plans, Oak Street Health is delegated a partial set of functions, typically care management or utilization management. Dr. Khan clarified that Oak Street Health rarely takes on network claims and grievance appeals, which distinguishes Oak Street Health from other organizations directly incorporated with a health plan and gives Oak Street more control over its approach to care. He discussed how Oak Street Health receives some up-front primary care capitation payments from a smaller number of plans, but typically works toward developing full-risk arrangements moving forward.
- Dr. Lin asked how Oak Street Health incentivizes PCPs to reduce ED utilization, patient hospitalization, and TCOC. He asked Dr. Khan to describe Oak Street Health's general compensation arrangements and to clarify whether compensation has changed PCP behavior.
 - Dr. Khan articulated that similar to Kaiser Permanente, Oak Street Health offers competitive salaries above the 50th percentile for primary care. He noted that Oak Street Health maintains a significant portion of total compensation in bonus eligibility for all team members, from physicians to social workers, specifying that bonus measures are driven almost entirely by engagement and quality measures with the goal of optimizing patient experience and providing consistent follow-through. Dr. Khan noted that this patient-oriented compensation structure facilitates high levels of creativity in providing patient-centered care, allowing providers to care for patients in their homes and communities, which boosts patient engagement. He noted that in some cases, Oak Street providers take unconventional approaches to reaching patients and addressing their health and social needs to reduce their use of EDs or inpatient care.

PTAC Member Listening Session on Assessing Best Practices in Care Delivery for Population-Based TCOC Models

Dr. Sinopoli presented slides focused on his previous experiences working with large, integrated delivery systems and large network enablement companies, as well as his current experience as Chief Network

Officer for UpStream, which underwrites and supports the delivery of value-based care for older patients and people living with chronic condition.

Dr. Sinopoli summarized the building blocks necessary for maintaining and building high-functioning, integrated networks. He highlighted that in his experience, most clinically integrated networks do not use all the building blocks he summarized, but he emphasized that ideal networks, and the most successful integrated delivery systems like Kaiser Permanente, would have active participation in each of these building blocks. Dr. Sinopoli discussed some of the most important building blocks and their impacts:

- Physician leadership is the most important building block because engaged physicians, especially PCPs, understand attribution, referrals, and network volume, but they also manage patients, ultimately impacting cost containment and accounting for quality improvements.
- Data and analytics are critical to developing appropriate care models. Many providers who are new to value-based care arrangements rely on easily accessible data such as payer reports and data from hospital systems, but more advanced data, sophisticated analytic methods, and investments in platforms and staff are necessary to develop financially sustainable and successful models.
- Dr. Sinopoli finally highlighted UpStream's unique efforts to work with all practices that see Medicare patients, evaluate practices' cost and quality metrics individually, and incentivize successful practices immediately. He emphasized that without enough upside potential, practices cannot generate enough revenue to be financially sustainable. He acknowledged that while hiring individuals with data expertise and experience is expensive, necessary funding is available from CMS.

Dr. Sinopoli discussed the value of addressing all aspects of the continuum of care to establish successful APMs. He highlighted the fragmentation within the care continuum even for integrated delivery systems. He noted that from ambulatory care to acute care to post-acute care, there are multiple entities within each category of care, which can make it difficult to establish seamless care across an entire organization. Dr. Sinopoli emphasized the importance of primary care, particularly primary care teams, in providing direct care and developing patient relationships to create linear integrity across the continuum of care. He described how primary care practices, with the right teams and support systems, can become a "mini care management company" for their patients and drive coordination across the continuum of care.

Dr. Sinopoli emphasized that it is necessary to rethink primary care and take advantage of opportunities to use primary care for patient contact, risk stratification, and intervention. He suggested that the goal should move from the traditional PCMH model to a true primary care transformation model, which requires embedded care teams with adequate resources. He discussed that the funding to transform primary care practices can come from several preexisting services eligible for FFS payment that are currently underutilized, including Chronic Care Management (CCM) fees, transitional care management (TCM) fees, remote patient monitoring, and annual wellness visits. He emphasized that forgoing these potential payments is a missed financial opportunity for PCPs and that payments for delivering these services could be put toward transforming a primary care practice into a care management hub that can identify risk, target patients, and improve outcomes. Dr. Sinopoli shared that [PTAC's research on CCM and TCM](#) revealed that CCM codes are used in only 14 percent of practices (with 25 or more providers) that have beneficiaries eligible to receive billable services under these codes.

Dr. Sinopoli stressed the importance of finding and hiring innovative care management teams, noting that when assisted by the right care teams, physicians do not have to prioritize physical care over addressing HRSNs, as care teams will have already worked to address these needs before the appointment. Dr. Sinopoli provided an example from a recent conversation with a primary care doctor at the America's Physician Groups (APG) conference, noting that the doctor asked how to strategically manage a patient with five chronic medical problems, 12 medications and side effects, transportation issues, and significant HRSNs in a 15-minute visit, emphasizing that doctors should not have to prioritize among these issues. With supportive teams working to address patient needs, many patient needs are already addressed prior to the visit, and doctors are kept informed of what care teams have worked on.

Dr. Sinopoli described how care management teams include many highly-trained professionals, including nurse care managers and pharmacists, to track down medical records and specialist reports, and work one-on-one with patients to understand their needs and expectations. For example, Prisma Health's (a nonprofit health care system in South Carolina) care management teams are available to patients 24 hours a day, seven days a week, and are embedded within every primary care practice.

Dr. Sinopoli noted that care management teams can become integral parts of the patient care experience, engaging patients one-on-one, managing calls from pharmacies and insurance companies, closing gaps within practices, scheduling follow-up appointments and labs, and supporting doctors to provide better care. UpStream achieves almost 100 percent retention for patients participating in the care team model.

Dr. Sinopoli explained that UpStream relies on building and training effective care teams and capitalizes on varying levels of expertise. For example, UpStream does not simply recruit pharmacists to join care teams, but places potential candidates through a program called UpStream University to train individuals on motivational interviewing, listening, and documenting issues to address SDOH. He emphasized that UpStream's embedded care teams also work in a way that complements care delivered by practice physicians (including being embedded in the office setting) to meet patients where they are.

Dr. Sinopoli described UpStream's unique focus on paying physicians up front for quality improvement, rather than waiting for and distributing payments from shared savings. He noted that the delay in receiving retrospective shared savings payments can be demotivating for providers. He noted that UpStream is confident enough in its model's ability to generate shared savings that it can focus on rewarding quality improvement up front in its physician compensation, rather than holding physicians accountable for shared savings or utilization after care is delivered. UpStream uses a star rating system for tracking quality metrics at the physician level, and as physicians' quality ratings improve, their PBPM payments increase, which motivates them to improve quality. The care team addresses utilization by managing referrals, hospitalizations, and post-acute care, which encourages physicians to work with the care team. UpStream takes on all the downside risk, as clinically embedded teams work to manage utilization by overseeing referrals, hospitalizations, and post-acute care, and physicians see immediate benefits of upside risk, as their payments increase as soon as their quality ratings increase. Dr. Sinopoli emphasized that the embedded care teams, with physicians focusing on quality and care teams focusing on outcomes, has led to dramatic improvements in both quality and shared savings, compared to a model where care management services (e.g., support for pharmaceutical management) are provided through the telephone or outside of the office setting.

Dr. Sinopoli emphasized the importance of data and analytics and noted that the goal is for practices to have access to a sophisticated data system with high levels of data integrity and analytic capabilities. He noted that while building data systems can be very difficult and expensive, organizations should not rely on hospital data that are aggregated outside their practice or health system. Instead, organizations should either build their own data systems, reach out to partners, or work with data companies, which could enable more primary care practices to participate in value-based care arrangements.

Dr. Sinopoli presented some of the barriers to developing successful networks. He noted that many primary care practices do not have access to up-front investments to participate in downside risk arrangements. He discussed how a reliance on hospitals to help drive the transition to value-based care does not support the transition, because this transition is typically not financially sustainable for hospitals or necessary for hospitals to achieve beneficial financial outcomes. Dr. Sinopoli also highlighted the absence of real-time incentives, the inability to take on downside risk, and inadequate patient volume as additional barriers.

Dr. Sinopoli provided suggestions on how provider organizations can develop value-based care resources, including:

- Develop resources that support value-based care into a separate company or partner with companies, particularly in the data and analytics space;
- Make up-front investments in educating practitioners to use billing opportunities like CCM, TCM, and annual wellness visits;
- Offer physicians real-time incentives and payment up front; and
- Embrace downside risk with enough upside potential by building networks with large enough scale to even out the risks.

Vice Chair Hardin invited Committee members to share additional thoughts and ask Dr. Sinopoli questions on his presentation.

- Bruce Steinwald asked what the minimum patient volume is needed to develop a value-based care program in a particular market.
 - Dr. Sinopoli responded that UpStream looks at the scale both within practices and within micro-geographies, requiring at least 200 patients within a practice and at least 4,000 patients in a micro-geography to implement the care management team model. Dr. Sinopoli clarified that UpStream will go down to practices with about 200 patients when there are a few smaller rural practices within a much larger network, because the larger network can overcome the additional costs of partnering with a small number of smaller practices.
- Mr. Steinwald inquired about how UpStream's model compares to Oak Street Health's model, where market penetration is relatively low, asking whether UpStream would pursue a similar strategy.
 - Dr. Sinopoli noted that UpStream takes an opposite strategy to Oak Street Health. Instead of trying to create individual practices and sites of care, UpStream pursues a broader footprint model and embeds resources within existing practices to drive utilization down and create savings, allowing patients to continue seeing their preferred providers and maintaining their long-standing relationships.

- Vice Chair Hardin asked Dr. Sinopoli what UpStream had found to be the most impactful investment to address HRSNs and what partnerships or revenue shifting were needed to meet the demands of addressing the SDOH of UpStream's populations.
 - Dr. Sinopoli discussed how one of UpStream's first steps was to invest in patient education, including working with patients and pharmacies to synchronize patients' prescriptions. Additionally, UpStream has partnered with cab services and emergency medical services (EMS) to help transport patients to the pharmacy, appointments, and community-based organizations (CBOs) where they can have their health-related needs addressed.
- Dr. Mills commented that he had similar experiences and lessons learned. He noted that in his experiences with a private practice in Kansas, the practice greatly improved after modest investment in a nurse care manager, extra medical assistants, a licensed private counselor, and a clinical pharmacist. Dr. Mills noted that one of his challenges was getting physicians to work with and trust care management teams. He asked Dr. Sinopoli to share what steps UpStream took to get physicians to engage with and trust their teams. Dr. Mills also noted that he experienced more resistance at the management level than from physicians, even having to conduct additional training at the management and leadership level to emphasize the importance of team-based care management, and asked Dr. Sinopoli to comment on his experiences.
 - Dr. Sinopoli explained that UpStream trains staff to focus on the patient as the primary responsibility and the physician as the secondary responsibility. He clarified that UpStream trains staff members not to disrupt a physician's existing workflows, but to partner with physicians to make their workflows more efficient. He noted that physicians typically take about four months to trust the new UpStream staff, and there can be periods of tension and resistance during the adjustment period. Ultimately, after the adjustment period, both physicians and office staff support the incorporation of care teams, because they take a significant amount of administrative burden off staff and allow them to spend more time with patients.
- Dr. Feldstein asked if UpStream hires the team for physician offices and if physicians have input into hiring decisions.
 - Dr. Sinopoli confirmed that UpStream hires and trains care teams with the goal of finding appropriate staff for each office but emphasized that individual physicians and practices can hire and fire staff on these teams. He confirmed that UpStream is responsible for paying the care teams and includes the costs of care teams and monthly PMPM payments to providers as part of the UpStream package of services.
 - Dr. Feldstein asked how UpStream's care teams are embedded in practices and inquired whether interactions with the care team could be telephonic or whether they were required to be in person.
 - Dr. Sinopoli answered that UpStream has both in-person and telephonic care teams, but he clarified that both clinical pharmacists and nurse care managers have a physician presence in practices where they can meet with patients and interact with physicians in person. Dr. Sinopoli noted that while UpStream does use telephonic care management services, it prefers to use telephone interactions only for simple follow-ups. It maintains in-person care managers and pharmacists as the primary resources for care management. Dr. Sinopoli also emphasized that UpStream has another

team to follow up with the 70 percent of patients who are not being regularly seen by providers, with the goal of reducing gaps in care and encouraging preventive care that is important even for patients that are not high-utilizers of care or that do not have significant care needs.

- Dr. Wiler commented on how it is typically understood that balancing costs in FFS requires utilization management and restricting access to care, but that several speakers discussed using the number of patient “touches” as a process measure to validate interactions and improve outcomes. She recalled Dr. Zimmerman’s goal of having 95 percent of patients being seen once per year and noted how UpStream similarly operationalizes high-touch, 24/7 access. Dr. Wiler asked if, given the current concerns around workforce issues and placing undue stress on health care workers, whether Dr. Sinopoli found it difficult to find staff that are willing to accept patients 24/7. She also asked about what metrics UpStream was using to validate high-touch care.
 - Dr. Sinopoli responded that UpStream has not found it difficult to recruit staff. He discussed how many pharmacists are interested in working with UpStream, and there are an abundance of pharmacists currently on the labor market. He noted that nurses were slightly more difficult than pharmacists to find. However, due to the different nature of the positions offered by UpStream, they have not had difficulty recruiting. He also emphasized that while staff is available 24/7, they typically do not receive many after-hours calls. Dr. Sinopoli described how UpStream measures patient touches using the average amount of time staff members spend with patients, noting that staff members average around 7.5 hours per year providing direct patient care. In addition to measuring touches, UpStream also measures patient experience and seeks feedback from patients.
- Dr. Kosinski highlighted the importance of patient contact, emphasizing that proactive engagement with patients is critical for both PCPs and specialty care providers. He discussed how his practice has begun to automate patient outreach as a part of its technology platform, enabling additional ways to engage with patients on their terms. Dr. Kosinski discussed the importance of using care managers to develop efficiencies, noting that care managers can handle many more than 200 patients and can become more efficient with increased numbers of patients. He explained that use of CCM and Primary Care Management (PCM) codes may be limited because of patient hesitancy to cost share. He suggested that changing PCM and CCM codes to first dollar codes to reduce cost-sharing with beneficiaries could accelerate their use.
 - Dr. Sinopoli noted that UpStream warns patients about the potential impacts to their copays. This means only about 70 percent of eligible beneficiaries use these services because individuals are concerned about their copays. He highlighted that the ACO REACH Model offers a copay waiver for CCM fees if they are offered to all patients.

Vice Chair Hardin thanked Dr. Sinopoli for his presentation and introduced Victoria Aysola, Public Health Analyst at ASPE, to present a summary of [stakeholder responses](#) to the [population-based TCOC RFI](#).

Stakeholder Responses to Population-Based TCOC RFI

Victoria Aysola started by noting that she is not speaking on behalf of PTAC and is not endorsing specific comments or policy positions. She informed the public that PTAC’s RFI on population-based TCOC would be open until July 20 for stakeholders to submit comments and insights for the Committee’s consideration during the September public meeting. She indicated that PTAC has received at least 10 stakeholder-

proposed PFPMs that discussed the use of TCOC or related elements, which led the Committee to explore TCOC during a series of theme-based discussions. Ms. Aysola explained that the purpose of the RFI is to gain stakeholder insights that can inform the Committee's review of proposals and recommendations to the Secretary.

Ms. Aysola provided a summary of the seven stakeholder responses to the RFI that have been submitted thus far. She summarized some of the key insights from stakeholder responses and emphasized that the presentation was not a comprehensive review of the responses. Some of the key insights included:

- Stakeholders offered a variety of suggestions for which services, providers, and entities should be included in TCOC calculations.
- Several respondents highlighted the importance of clinical workflows and data analytics to facilitate innovative care delivery.
- Stakeholders tended to favor setting accountability for TCOC at the entity level rather than at the individual provider level.
- Stakeholders emphasized that many factors impact the ability to manage TCOC, including data availability, providers' history of prior participation with value-based arrangements, and patients' health status, among other factors.
- Respondents noted that improved coordination between primary and specialty care can be facilitated by accessing timely and accurate data, expanding payment opportunities to all necessary services in real-time, and expanding regulatory flexibility.
- Respondents emphasized the importance of clearly defining episodes and providing transparent accountability rules when embedding episode-based payment models into population-based TCOC models.

Committee Discussion

Chair Casale invited the Committee members to discuss what they have learned from today's presentations. He noted that PTAC will submit a report to the Secretary of HHS after the series of theme-based discussions on PB-TCOC models concludes in September. Chair Casale referred the Committee members to the *Potential Topics for Committee Deliberation* document to help facilitate their conversation.

- Dr. Kosinski noted that the SMEs highlighted a best practice of high-touch, proactive engagement between the patient and the physician, whether that is a PCP or a specialty care provider.
- Dr. Mills noted that the health care system must rethink primary care; however, changes in relative access to resources for PCPs may be modest. He commented that the health care system should focus on and enact compensation changes that focus on achieving value-based care. Dr. Mills recalled the lessons that Dr. Kendrick presented, including the centrality of using data from multiple sources, instead of focusing on a single practice, physician, system, or model. Dr. Mills also agreed with Dr. Kosinski's points on the importance of high-touch care between the physician and the patient.
 - Chair Casale recalled the map Dr. Kendrick presented showing how patients from Oklahoma receive care from around the country. He noted that this highlights the challenge and importance of addressing data issues. Chair Casale agreed with Dr. Kosinski and Dr. Mills on the importance of high-touch care and emphasized the need for a culture change with a focus on team-based care and active coordination between PCPs and specialists.

- Vice Chair Hardin discussed the concept of “case finding” or using data to proactively form longitudinal relationships with patients at risk for having substantial medical needs in the future. She spoke to the need to establish longitudinal relationships between physicians and their patients across care settings, and making sure that relationship includes an understanding the patient’s story. She emphasized that proactive engagement and new trainings are necessary for furthering TCOC. Vice Chair Hardin also noted that she looked forward to hearing from presenters on opportunities and investments to address SDOH, including with the populations that do not interact with primary care. She appreciated the dialogue from the day’s discussion on reaching out to patients where they are and the importance of transportation and SDOH.
- Dr. Sinopoli recommended that the health care system address the regulatory barriers that make it difficult to mitigate risk through partnerships that increase patient volume and reduce overall risk.
- Dr. Wiler stated that reforming care delivery at the patient level may be easier than determining the incentives and payment programs associated with that reform. She mentioned that a disproportionate amount of innovation is happening at practices where physicians are salaried employees, which may not be replicable.
- Dr. Wiler appreciated the focus on linking data across sources and recalled that there may be 25 nodes of data that could be linked. She also noted that there is an opportunity for CMMI to incentivize effective use of data by providers participating in value-based models.
- Dr. Wiler added that there are multiple examples for how to entice care teams to participate in TCOC contracts. She noted that use of private-public partnerships to address health needs appears to be an important component of successful models.
- Dr. Lin commented on the need to incentivize innovative primary care and substitute low-cost, high-value care for high-cost care downstream care, citing real-world examples from Kaiser co-founder Sidney Garfield and listening to how session presenter Dr. Khan described working to prevent foot infections.
- Mr. Steinwald raised the question of how to establish that providing more care in some ways can result in less overall spending. He noted that there is not actuarial evidence to address this question. Therefore, he appreciated hearing real-world examples from Dr. Kendrick and Dr. Zimmerman on how their up-front patient engagement approaches yielded less spending.
- Dr. Liao commented on flexibility available to MA plans that can implement specific care delivery strategies related to value-based care, and asked how other models can provide this flexibility, even if there are trade-offs to allowing this. One opportunity to remove barriers to the use of innovative services may be reducing patient copays associated with these services through waivers. He added that the health system overall should maximize opportunities to reframe the “downsides” of PB-TCOC models and emphasize the upsides.
 - To reach a team-based approach, Dr. Liao suggested specifying which types of professionals should provide different kinds of services and facilitating access to those professionals. For example, the ACO REACH Model proposes extended access to nurse practitioners. Dr. Liao suggested that there are practical ways to assign different activities to different professionals incrementally.
 - Dr. Liao referenced Dr. Safran’s and Dr. Sinopoli’s comments on quality and how quality motivates clinicians. He added that Dr. Safran commented on how they pay clinicians based on their performance related to quality of care, instead of whether they achieve cost

targets. Dr. Liao noted that the FFS models he is aware of tend to acknowledge quality, but they do not reward for quality.

- Dr. Liao noted that they have heard from clinicians around the importance of a “glide path,” but he does not know that the population-based TCOC models have a clear glide path. He referenced Ms. Erickson’s presentation on high-value referral services and how rules regarding coding and securing reimbursement for these services can be frustrating, but these rules also help ensure quality, coordinated care.
- Dr. Liao referenced the value of the presentation on kidney models and the non-primary care spaces in which PB-TCOC strategies can be applied. He also acknowledged that accountability and culture change need to be addressed, but those may require building in more flexibility for clinical innovation.
- Chair Casale commented on the importance of addressing unintended consequences around TCOC. He stressed having physicians focused on utilization can sometimes exacerbate unintended consequences that affect quality care. When physicians focus on quality measures and outcomes, the physician-patient relationship is enhanced because they are focused on providing quality patient care.
- Dr. Liao suggested that financial incentives are not the only motivating factor for clinicians. He noted the idea that PCPs will complete their EHRs because it is the right thing to do, not to earn a bonus.
- Chair Casale explained that the current process of risk adjustment focuses on costs instead of patient needs. He acknowledged that this is an issue in the current risk adjust methodology and asked how risk adjustment can be more patient-focused.
- Dr. Wiler recommended that the health system consider payment adjustments for caring for complex patients, instead of trying to create a homogenous benchmark. She noted that could be a way to incentivize models that include components focusing on specific patient populations. Dr. Wiler added that many of the population-based TCOC models for innovative care delivery programs disproportionately focus on high-cost utilizers. She explained that even the renal care model does not incentivize value and questioned whether that model is sustainable. Dr. Wiler referenced a common theme: Only focusing on high-cost potential patients, such as kidney care patients, rather than the full population, is not always associated with good outcomes over time.
 - Dr. Kosinski added that it is a flawed assumption to assume that the high-cost patient of last year will be the same in future years.

Closing Remarks

Chair Casale thanked the Committee members, presenters, and the public for their contributions to the meeting. He noted that they will continue discussions on care delivery for population-based TCOC models tomorrow, and Liz Fowler, the CMS Deputy Administrator and Director of CMMI, will deliver opening remarks at 9:30 a.m. EDT.

The public meeting adjourned at 3:53 p.m. EDT.

Approved and certified by:

//Lisa Shats//

9/2/2022

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

Date

//Paul Casale//

9/2/2022

Paul N. Casale, MD, MPH, Chair
Physician-Focused Payment Model Technical
Advisory Committee

Date