PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

PUBLIC MEETING

Virtual Meeting Via Webex

TUESDAY, MARCH 8, 2022

PTAC MEMBERS PRESENT

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

STAFF PRESENT

LISA SHATS, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)
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- Sherry Glied, PhD; Karen E. Holt; Valinda Rutledge, MBA, MSN; and Christina Severin, MPH

Previous Submitter:
- Jon Broyles, MSc; Gary Bacher, JD, MPA; and Torrie Fields, MPH

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- Gail R. Wilensky, PhD; Jennifer L. Kowalski, MS; Judith A. Stein, JD; and Emily Maxson, MD

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* CHAIR CASALE: Good morning, and welcome to day 2 of this Public Meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC. I am Paul Casale, the Chair of PTAC.

* Welcome and Population-Based Total Cost of Care (TCOC) Models Session

Overview

Yesterday, we began with CMS\(^1\) leadership sharing their strategy for CMS and its Innovation Center, which includes the goal for all Medicare beneficiaries with Parts A and B to be in a care relationship with accountability for quality and total cost of care by 2030. That is one reason we chose to explore population-based total cost of care models as our theme-based discussion for a three-meeting series this year.

We had a variety of experts, from academia and payers to one of our own PTAC
members, Dr. Larry Kosinski, provide their insights on how we can move toward population-based total cost of care models. We learned what the research shows on the impact of population-based models and episode-based models on quality and cost, and where further information is needed.

Our guests discussed how population-level efforts can address health equity and what some of the best practices are for improving affordability for patients. We also heard about options for defining total cost of care, state-level innovations, opportunities to align across multiple payers, and how to structure these models so that specialists can participate meaningfully.

Also, the team of PTAC members that worked with staff to prepare the agenda and background materials presented information about relevant key issues and how proposals submitted to PTAC incorporated elements related to total cost of care.
* **PTAC Member Introductions**

Because we might have some new folks who weren't able to join yesterday, I'd like the Committee members to please introduce themselves. Share your name and your organization. If you would like, you can share a brief word about experience you may have with population-based payments or total cost of care models.

Since we are meeting remotely, I will cue each of you. So I'll start. I'm Paul Casale. I'm a cardiologist, Vice President of Population Health at NewYork-Presbyterian, and I lead NewYork Quality Care, which is the Accountable Care Organization for NewYork-Presbyterian, Weill Cornell, and Columbia University.

Next, I'll turn to Lauran.

VICE CHAIR HARDIN: Good morning. I'm Lauran Hardin. I'm a nurse and senior advisor for the National Center for Complex Health and Social Needs and the Illumination Foundation. I spent the last 20 years doing
care management design under many different value-based payment options and currently work on co-designing models for complex, underserved, under-resourced populations.

CHAIR CASALE: Thank you, Lauran.

Jay?

DR. FELDSTEIN: Hi. My name is Jay Feldstein. I'm President and CEO of Philadelphia College of Osteopathic Medicine, and prior to that, I spent 15 years in the health insurance industry, both commercial, Medicaid, and Medicare.

CHAIR CASALE: Great.

Larry?

DR. KOSINSKI: I'm Larry Kosinski. I am a gastroenterologist, having practiced for 35 years. I am the founder and Chief Medical Officer of SonarMD, a value-based transition company in the gastroenterology space.

CHAIR CASALE: Thanks, Larry.

Josh?

DR. LIAO: I'm Josh Liao. I'm a physician and faculty member at the University
of Washington School of Medicine, where part of my work is studying and evaluating the impact of payment models on patient and population outcomes.

In addition, I am the enterprise-level Medical Director for Payment Strategy for UW Medicine, and in that role I'm fortunate to provide leadership to a number of payment models and arrangements, including total cost of care population-based models.

CHAIR CASALE: Great.

Walter?

DR. LIN: Morning. I'm Walter Lin. I'm an internist and founder of Generation Clinical Partners. We are a medical practice focused on caring for the frail elderly in senior living and helping senior living organizations transition into value-based care.

CHAIR CASALE: Thank you.

Lee?

DR. MILLS: Morning. I'm Lee Mills. I'm a family physician, and I'm Senior Vice President and Chief Medical Officer of
CommunityCare of Oklahoma. We operate a fully capitated model across both commercial and Medicare Advantage spaces.

CHAIR CASALE: Thank you.

Chinni?

DR. PULLURU: Hi. I'm a family physician by trade and practicing for about 15 years, currently serving to lead Walmart's health clinic outreach and enterprise. And prior to that, I served to lead the value-based-care business line for a large medical group implementing across the risk spectrum, as well as practicing clinically within that risk spectrum.

CHAIR CASALE: Great. Thanks.

Angelo?

DR. SINOPOLI: Angelo Sinopoli. I'm a pulmonary critical care physician -- until just recently was the Chief Clinical Officer for Prisma Health in South Carolina, where some of my responsibilities were our clinically integrated network of about 5,000 physicians, and also was the founder of the Care
Coordination Institute.

My present role is that of Chief Network Officer for UpStream Healthcare, which is a risk-bearing, value-based organization that partners with primary care docs.

CHAIR CASALE: Thank you.

Bruce?

MR. STEINWALD: Hello. I'm Bruce Steinwald. I'm a health economist in Washington, D.C. I have 50 years of experience in health economics and health policy in academic, government, and private sector settings.

CHAIR CASALE: Thanks, Bruce.

Jennifer?

DR. WILER: Good morning. I'm Dr. Jennifer Wiler. I'm the Chief Quality Officer of UCHealth Denver Metro area. I'm a tenured professor at the University of Colorado School of Medicine, and I'm co-founder of UCHealth's CARE Innovation Center, where we partner with digital health companies to grow and scale their solutions to improve the value of care.
My academic area of interest is payment policy, and I was a co-developer of an APM\textsuperscript{2} that was evaluated by this Committee prior to me being a member.

CHAIR CASALE: Great. Thank you.

So, at this time, we'll take a short break to set up for our first listening session, which the Vice Chair, Lauran Hardin, will moderate. So please join us at 11:15. We have a terrific group of guests scheduled for the day. Thank you.

(Whereupon, the above-entitled matter went off the record at 11:09 a.m. and resumed at 11:17 a.m.)

VICE CHAIR HARDIN: Welcome back, everyone. I'm Lauran Hardin, Vice Chair of PTAC. We have a fantastic group of experts here to present on issues related to population-based total cost of care models.

* Listening Session on Issues Related to Population-Based TCOC Models Day 2

We will have our first two
presenters present, and then our Committee members will have time at the end to ask those two presenters questions in the Q&A session. Then our remaining three presenters will present, and our Committee members will have time at the end to ask each of those presenters questions in a final Q&A session.

You can find all of the presenters' full biographies on the ASPE PTAC website, along with other background information materials for today's meeting.

Presenting first, we have Dr. Sherry Glied, who is the Dean of Robert F. Wagner Graduate School of Public Service at the New York University. Please begin.

DR. GLIED: Thank you very much, and thank you so much for having me here. I'm going to be speaking at the 30,000-foot level, so maybe it's a good way to frame some of the conversation that comes today.

Next slide, please.

So our goal here in general is to reduce the cost of care while improving or
maintaining health care outcomes. And the way that we think about doing that is to do things like reducing duplication, or monitoring and connecting people so that they avoid increases in severity in the future, or increasing prevention efforts to avoid future care.

That is, these are all strategies that focus on the quantity side of the medical cost conundrum. If I were talking about something that was not Medicare, I'd be spending a lot of time talking to you about prices. Since we're talking in a Medicare context, the focus here is around reducing quantities or optimizing quantities.

I think it's really important to keep those two ideas very distinct because a lot of the work around cost containment is around the price side, and your goals here are really very much more on the quantity side. And that, I think, is an important distinction.

Next slide, please.

So we have long thought about this as economists as being about fee-for-service.
The reason that we're not getting where we want
to be on the cost and quality side is because
all of the things that we'd like to do around
preventing unnecessary care or avoiding
duplication, monitoring -- all of those things
are disincentivized under fee-for-service.

The more you do, the more you're
paid, whether the care is necessary, whether it
could have been avoided. And that's why we've
moved to this alternative payment mechanism
story in the first place. So this is all old
history, and you know this.

Go on. Next slide.

But -- okay -- there is a reason we
had fee-for-service, and it's always important
when you're moving away from something to think
about why it existed in the first place. Fee-
for-service has some really big advantages in
terms of paying people.

It's really easy to monitor
performance. It's really easy to know whether
something has happened because a payment is
clearly tied to a specific patient and a
specific process. You can see, if you are an administrator or a bureaucrat, whether that process has happened, whether the patient has been seen.

Second, it allows maximal choice by patients of their provider. So it is the best system if you're just going to let people go to see whoever they want. That is an attribute that is highly valued by patients.

And so fee-for-service continues to exist when you think about out-of-network payments, even in the private sector, if we think of people going out of network in Medicare. We retain fee-for-service in situations where people are going to any provider they like.

Third -- and this is going to turn out to be very important -- it automatically risk-adjusts. If you're dealing with a more severe patient, you get more money. Patients who use more services generate greater payment.

And in normal times -- and we're coming out of non-normal times, but I think
it's important to remember that so far, our track record has been they happen every 100 years -- fee-for-service leaves providers with very little risk. The more they do, the more they get paid. If they do less, they get paid less. They control the amount of risk that they face in their operations.

These are very important, valuable properties.

Next slide, please.

So here's a good question for all of you focused on changing payment systems: how many of these nine countries which we might think of as our peer countries in health care, but who run their health care systems at a much, much lower cost -- right? We know this, and generally have higher-quality outcomes -- how many of them use primarily fee-for-service to pay outpatient providers, outpatient physicians?

Anyone want to guess? Write your own number down on the panel to see whether you're right. Ready? Okay. Let's reveal.
Next slide. Hit the click button.

All of those countries are using, basically, fee-for-service in their health care systems to pay outpatient providers. That is the standard way that they're doing it.

Next slide, please.

Likewise, we talk a lot about global budgets and capitated payment even in the hospital sector. So how many of these countries are using primarily global budgets to pay their hospitals? Again, do your best guess. Go forward, which reveals really just Canada and Sweden. Everyone else is essentially using output-based payments of the kind that we are trying to move away from as a way to pay their hospitals.

So I don't say this to justify fee-for-service. That's not what I aim to do -- just to say that its strengths are pretty big. That's why lots of countries are using it. That's why they've been used in the past in history.

Next slide, please.
So let's think about moving away from fee-for-service to alternative payment mechanisms. Let's move to a capitated, bundled, flat-payment component. That's going to generate a new set of problems.

We have a much higher burden of monitoring. It is better to measure value than volume, but it's a lot harder to measure value than volume. That's the reality. You have to assign patients to providers. And if you're assigning patients to providers, it creates -- can create, doesn't necessarily -- incentives for providers to offload the work they do and the cost of that work to other people.

We've seen that, for example, when we moved to managed behavioral health care, which was -- the first big move into managed care was in behavioral health. Behavioral health carve-outs covered talk therapy, and they didn't cover pharmacotherapy. And so we saw these carve-outs essentially pushing patients towards their primary care providers, who provided them with pharmacotherapy that
wasn't covered under the contract.

Likewise, and in a sort of meta
sense, there's been a big push to bundle
payment from post-acute care. And we have seen
that that works and that there are reductions
in the cost of post-acute care, but it may
shift the burden of care to families and
informal caregiving that we are not measuring.
And, in fact, it probably does because we are
discharging people home with fewer services.
That's not necessarily a bad thing, but we need
to be aware of it.

Next slide, please.

We need a way to risk-adjust because
if we don't risk-adjust, providers are
incentivized to avoid the sickest patients.
Risk adjustment -- I first worked on risk
adjustment in 1992. This is a miserable,
difficult problem.

Every risk adjustment system creates
other perverse incentives. Right now, the ones
we have create enormous incentives to over-
diagnose people, and these incentives are
pervasive across the system. And even after you risk-adjust, you have to think about the risk that providers take on when they participate in these systems.

And that leads us to move to voluntary participation because it's really hard to force providers to take on risk if they don't want to, and it leads to this multiplicity of models. If you have a lot of different Alternative Payment Models, you are necessarily going to spend more money.

Why is that? Because there's a lot of variability in structure and cost to provider organizations. So each organization can select the model that works the best for it, which means it gets the most revenue relative to cost. And that is going to mean that it's going to capture savings that would otherwise accrue to the Medicare program.

So each organization has some payment model that would most perfectly fit what it's already doing. And if you move to that payment model, Medicare is going to lose
money. It's also really hard to accurately assess the performance of many Alternative Payment Models because of selection problems at the patient and program levels.

Next slide, please.

So the underlying problem is really tough. A lot of recent economic research looks at the level of inefficiency in the health care system and says, you know, it's actually not that bad. There isn't that much inefficiency. We aren't as much of a mess as we think. We're just as inefficient as the rest of the economy.

That means there is lots of reasons to improve processes, just as there are lots of reasons to improve processes in cement manufacturing, which are the ones that people look at, and coffee shops. But these problems are not more pervasive in health care.

And that means it's not so easy to fix them, and it's easier to generate positive financial returns by manipulating incentives than by doing really hard work that might improve care, because it's not like it's low-
hanging fruit. Improving care is going to be really hard. Manipulating financial incentives is often pretty easy.

Next slide.

So now we come to this idea of total cost of care, and I have to say I'm on the Board of the Milbank Fund, which has been thinking a lot about total cost of care. And one of the things I've learned about it is that everybody uses that term to mean something different.

So I don't know exactly what total cost of care is, but I think the general idea of it is that the unit of analysis is very broad. The best established example of it is Maryland, where you basically take the entire Medicare system, the entire health care system, and you look at the cost of the total cost of care. There are other models at the employer level.

I think key features of what this ought to mean is that the population is not discretionary. It is assigned. It is the full
population of some unit that is independent of
the choice of plan or -- there are no decisions
that are made around health care that are
around the population that is being considered
for total cost of care.

So an employer might think about all
employees in the firm, or a state might think
of all the residents in the state. If you do
that, you don't need very sophisticated risk
adjustment. You probably can just use age and
sex because you're actually looking at the
total cost of this entire population.

And, ideally, you measure all
aspects of the cost of care. So you want to
think about the services that are paid for by
Medicare. You want to think about all
beneficiary out-of-pocket payments. You also
probably want to think about things like
informal care because if what we're doing is
shifting burden to informal care, at least we
ought to know that that's what we're doing,
whether it's the right thing or not.

So some examples going forward --
next slide -- Maryland is doing it looking at Medicare beneficiaries, and several states have done it to develop cost-growth benchmarks as a step towards further regulating their health care systems.

So Massachusetts has a total cost of care measure. Connecticut has one. Oregon has one. Nevada, New Jersey, and Washington are building these.

Yes. Next slide, please.

So it's a management tool. It's about selecting -- not avoiding selection, risk adjustment assignment, but it is not an incentive program. It is a monitoring and management tool that the incentives fit within.

Do I have any more slides? That's it. Thank you.

VICE CHAIR HARDIN: Thank you so much, Dr. Glied. That was very interesting.

Next up, we have Karen Holt, who is Vice President of Collaborative Health Systems.

Please go ahead.

MS. AMERSON: The slides will be up
in just one moment. Thanks. It takes a moment to transition.

MS. HOLT: (Audio interference) My personal passion has been the opportunity to work with providers in order to help them become successful in managing the care of patients -- good providers who want to do the right thing but don't always have the right tools and technology developed to get them there.

Today, the goal of my presentation is really to talk to you about specific opportunities to improve PCPs' ability to successfully manage care coordination in patients.

Next slide.

So Collaborative Health Systems has been in operation since 2011. We have supported $475 million in savings to the Medicare Trust Fund, to quality and clinical programs for physicians. We have 15 different programs currently today in 22 different

3 Primary care providers
states. We're in MSSP\textsuperscript{4}, Direct Contracting\textsuperscript{5}. We have three IPAs\textsuperscript{6} and a Maryland CTO\textsuperscript{7} program. We are supporting over 2,000 providers, independent providers, and 160,000 Medicare patients. Again, the goal of this is really, what are we doing to make sure we're supporting those providers who are independent and being successful in the opportunities of growing and changing medicine?

Next slide.

As many of you know, administrative and clinical activities of moving value-based care are overwhelming to providers. Increasing financial pressures for the cash-flow challenges -- right -- the cost, technology requirements, are burdens that push many providers into becoming employed.

When we see providers become employed, we actually see a change in their -- they lose their autonomy for how they practice for -- practice and care for patients, as well

\textsuperscript{4} Medicare Shared Savings Program
\textsuperscript{5} Global and Professional Direct Contracting
\textsuperscript{6} Independent Physician Associations
\textsuperscript{7} Care Transformation Organization
as we know that this change is actually changing the passion for those younger generations to actually move into medicine. So, again, who are we replacing our providers with, or independent providers?

Collaborative Health Systems -- you know, it partners with a value-based values coalition that utilizes the Medicare programs to support providers really to be able to move through that risk continuum -- right -- with providing tools, technology, hands-on training, and clinical program implementation to support patients when and where they receive care outside of the practice of the four walls of providers to really be able to drive that value-based care.

Next slide.

Population health management is the management of patients in all care settings. And the coordination of care requires that we know where patients are and at all care levels. In addition, the successful management of patients with chronic conditions requires that
the care is well coordinated between providers,
patients, and the care team.

This has been a challenge for many,
many years. It is not unknown to this
organization or to others. But what we do know
is that the lack of care coordination costs
Medicare billions of dollars of wasteful
spending or avoidable complications and
hospital readmissions.

As well, we all know that care
coordination is known -- I apologize. My
computer is dinging. Many hospitals, the new
requirement for CMS to actually be able to
fulfill their ADT\(^8\) roles is requiring those
hospitals to be sharing ADT feeds.

The challenge with that is that we
have providers and groups who are sharing data,
but it's not really actionable for these
providers. And so we know that they're sharing
where a provider can log in to a tool; they can
download patients who have admitted into their
hospital. And so, gosh, we hope that that

\(^8\) Admission, discharge, and transfer
patient does remember who their PCP is at that
time of admission to really be able to add a
username.

And again -- so where we see that
opportunity is an additional burden, and it
requires providers to log in to a tool and be
able to know where their patients are instead
of being able to have the opportunity to use
the technology with algorithms and being able
to lift this burden off of providers.

As Medicare looks to move more
providers into value-based payments, utilizing
ACOs⁹ as that glide path, we're looking for CMS
to support the opportunity to recognize ACOs
and IPAs into the payer definition instead of
just saying it's a provider who's failed to
know when their patients are there -- utilizing
these organizations just like they are with
health plans, recognizing ACOs and IPAs as
being organizations that health care providers'
hospitals will actually share that data with
directly so that we can support them.

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⁹ Accountable Care Organizations
Additionally, we're looking for -- it's just not really the hospitals, but really, how do we grow this opportunity for ADT feeds to grow into home health and SNFs? We know that there are organizations like Experian, and patient teams are moving into this opportunity.

They're using algorithms, allowing us to use messaging to be able to devise programs so that we're not just communicating with one source, but using real-time data messaging so that we can send messages to multiple places. We'll send it to the hospital, the hospitalist. We'll send it to the home health care company, our care team, the PCP, and outpatient specialist that we know are looking at the claims data that allow for the true care coordination so that all parties know when that patient has admitted into a facility.

An additional enhancement would be to really support those -- again, and not just the hospitals, but really using a tool that

10 Skilled nursing facilities
allows these algorithms. It is one thing to say that messaging is that we're just sending an ADT feed, but again, that opportunity for real-time data is really the care coordination that allows for us to truly care for these patients.

So not just requiring for hospitals to participate with these organizations but allowing the ACOs and IPAs to be a part of that, just like they are with the health plans, right? Touching the right patients at the right time and really giving that care coordination.

Next slide.

So this is the CHS\textsuperscript{11} core model as designed, and this design is really to support providers for what's happening outside its four walls. Again, the point behind this is that really, that our teams, as for those Medicare opportunities through our MSSP, our Direct Contracting, or other type of state programs -- opportunities that we're really trying to

\textsuperscript{11} Collaborative Health Systems
support these providers what's happening outside of the four walls of their practice and, again, making sure that we're getting that data back to those providers, so really that--enhancing the practices and their care coordination opportunities.

Tools are important, but really, it takes people touching people. And so where we're providing the opportunities for a practice, an independent provider may not be able to afford someone to go to a patient's home. That opportunity that we're allowing for them, really, we need the right level of data.

So we know that the significant challenge for us touching the right patients at the right time is the patients who have the highest chronic conditions. They're not -- they're moving a lot. They don't have the same phone numbers. There's a lot of changes that are happening there.

And so that data that may be in a practice is not always accurate for us to be able to outreach to them. And so really
looking for some opportunities for enhancement that, again, that ADT feed for hospitals, when a patient is admitting into those facilities, that they're sharing that level of data with the hospital.

How do we make sure that those providers are getting that communication back? Or the patient who has 11 different chronic conditions may not have shared with or been back to see their PCP in the last six months, but they have shared their current address and phone numbers with the hospital system.

How do we make sure that that data is actually shared with those organizations, right? Making sure that we're touching the sickest patients and the opportunity to be able to manage their care.

Next slide.

Great. So thank you, you guys, for your time today and opportunity to share with you the opportunities to grow this program, and the opportunity to increase the care coordination in our ACOs and our IPAs. Thank
VICE CHAIR HARDIN: Thank you so much, Karen. Very interesting presentation.

Now we have about 10 minutes to ask questions. I want to open this up to our Committee members. We have an opportunity to ask questions of Dr. Glied and Karen Holt. Please go ahead, and please remember to unmute yourself as you come forward with a question.

MR. STEINWALD: Dr. Glied, it's always a dash of cold water when we look at these international comparisons and realize that what we're attempting to do here is rather contrary to what's done elsewhere.

I wonder, though, if it's worth making a distinction -- especially when we look at fee-for-service and how sticky it is, how hard it is to get providers to be willing to unstick themselves -- to make a distinction between how a plan is paid and how the doctors are paid. And can we accomplish much of what we want to do by focusing on the plan as opposed to the individual provider?
DR. GLIED: So, certainly, I think that is -- well, first of all, plans are almost always paid by some form of capitation. Right? We pay them a premium. And that's the way we've always paid them. Nobody pays health plans, I think, fee-for-service, although if we make our risk adjustment sufficiently granular, we may almost wind up doing that. But hopefully that's not what we're doing.

And I think in those countries that have competing health plans in other countries, they also pay on some form of risk adjustment capitation. I do worry a little bit that our risk adjustment methods generate some really perverse incentives for the plans, and that's something to worry about.

But I am with you. I agree. I think that focusing a lot on plans and thinking about letting the plans figure out how to manage within themselves has a lot of positive value. One of the things that I think we have learned is that these micropayment incentives at the level of the provider may be a lot more
trouble than they're often worth and that management, in the more conventional sense, may be a better way to address some of the concerns that we have, management including things like buying better data systems and implementing electronic medical records to avoid duplication of care.

So I think there are ways to do this. Plans also have more leeway to pick and choose which providers are in them and to look at practice patterns. So yeah. I guess the answer is yes. We economists.

CHAIR CASALE: Dr. Glied, thank you for a great presentation. A question -- CMMI\textsuperscript{12} has spent a lot of time thinking about how to engage specialists and total cost of care larger population-based models.

I'm just curious, in your thinking, whether the approach would be -- create this population-based model, and then under that, the providers and others will sort out how to engage the specialists within that, or having

\textsuperscript{12} Center for Medicare and Medicaid Innovation
more prescriptive models for particular specialties will be a different path for engaging specialists.

I'm just curious if you have thoughts as to which approach might be more effective.

DR. GLIED: So let me just divide specialists into a couple of categories. I think there are a lot of specialists whose interactions with patients are very episodic and time limited, and they're going to see a lot of patients, and they're not going to establish relationships with them. And their referral patterns are going to be from all over the place.

So I think in those circumstances, trying to establish complex payment mechanisms for them may just be very costly in terms of the selection consequences.

I think it's actually really hard. I think there are other patients who have ongoing relationships with -- sorry. Other providers, other specialties, have ongoing
relationships with patients that last for a while where you might think that a single payment covering a scope of service -- think about OB/GYN.

There you've got a very clear path. You're covering this person for -- let's say for a year. And we expect certain things to happen. We have a good sense of what we're looking for. Monitoring is relatively easy. There's a place where I think you have a specialist -- a specialty care scenario that you could think about, on its own, sort of sitting separately, having an alternative payment mechanism for.

And I think there's a lot of things that fall between those. And as you are on that continuum, I guess a couple of things I would say is think about how much you are concerned about the downstream communication and interaction.

So to what extent is this thing wholly within the province of the specialist, and to what extent is this an interaction
across the system? And what incentives and challenges are injected by having those interactions? So do you want them to happen more or less? Do you want your cardiologist to be referring people back into primary care more, or do you want them to be taking on care more?

And those sort of subtleties are going to color how you think about the alternative payment mechanism there and whether you want to do it entirely from, well, let's just give the primary care doctor the capitation and let them figure it out with the specialist or let the health plan deal with both of them, or is it actually worth coming up with a separate alternative payment mechanism for, say, a cardiologist who's in regular contact with a patient? And it's very granular in that way.

VICE CHAIR HARDIN: Very helpful.

Karen, I'm very curious, as a follow-on question to that, what have you learned about in practice about bridging those
relationships that is really key and really makes it a very effective system?

MS. HOLT: We do have a few of our ADT providers that are providing us notification through -- for SNF, home health, as well as in the hospitals. And what we've found is when we're comparing the patients who are admitting into facilities where we have those notifications, that that continuum for us in being able to manage that patient all the way through -- we see a higher success rate in making sure that we're managing the readmission when we know that they were in the hospital. We know where they went to SNF.

We can make sure that we're supporting that they get the right care at home to make sure that they're not readmitting and that that success rate is twofold in being able to make sure that we're managing the cost of that patient.

So really looking at that opportunity to be able to grow that initiative for the CMS ADT piece, as it's not just the
hospitals. But let's also make sure that that
algorithm and being able to have the tools and
technology to really be able to score is not
just, let's go look for the patient. Let's
make sure that there's automation. We're in a
world with technology with artificial
intelligence.

Let's make sure that everybody knows
at the same time by being able to write the
right type of messages. So we know that it has
been successful in really managing that care
and keeping readmissions from happening, and
truly unnecessary readmissions.

DR. KOSINSKI: I'd like to ask a
question of Karen. I enjoyed your
presentation. How do you maintain patient
engagement in your care coordination, and how
successful have you been?

MS. HOLT: So how -- it's truly --
in our matter, there is the reality that we can
only touch a certain level of patients, and how
we're keeping them engaged in sort of an
educational opportunity -- it's what we're
doing with our providers and a masked opportunity to be able to send out education for disease management outside of what's happening in a practice, but really looking at how can we touch those type of chronic conditions?

And so there's only an opportunity to manage a certain level of patient at these areas. And so it is using our care coordinators, outreaching to them proactively before they're admitting, using our tools to be able to -- what we call percolate who has the highest opportunity of readmission by looking at their data and making sure that we're proactively getting them into educational opportunities, hoping that we're going to teach them about how to manage their diabetes, manage their ESRD\(^\text{13}\).

Are they on that continuum moving into ESRD -- to outreach to them to get them to the right level of care.

DR. KOSINSKI: Thank you.

\(^{13}\) End-stage renal disease
VICE CHAIR HARDIN: We have time for one more question.

(Pause.)

VICE CHAIR HARDIN: Dr. Glied, I'm very curious how you think about managing carve-outs of value-based payment.

(Simultaneous speaking.)

DR. GLIED: Managing carve-outs?

VICE CHAIR HARDIN: Mm-hmm.

DR. GLIED: Is that -- the audio was funny. So I think the total cost of care vision is actually really important there because carve-outs do have these incentives to shift care back into the main contract, and we definitely observe that. And incentive is strong.

And wherever it's possible to do it, you can expect the carve-out to be going there. So, I mean, some of this is about who is managing the full contract, and how are they monitoring those places where you might see something happening under the carve-out?

A lot of this is just keeping your
eye on the ball and being really thoughtful about monitoring a full population and not just that aspect of the contract. So if I think about this total cost of care idea really as being sort of an overarching monitoring tool, why are my costs not going down when the carve-out seems to be spending less money?

If the carve-out says that they're spending less money but my costs are not going down in total -- so what's happening here?

VICE CHAIR HARDIN: So helpful. And I thank both of you for this rich conversation and information. We really appreciate you joining us today.

Our next presenter -- we're going to move to the next section. Our next presenter is Valinda Rutledge, the Chief Corporate Affairs Officer at UpStream.

Please remember to unmute yourself, and please go ahead.

MS. RUTLEDGE: Great. Thank you.

Well, first of all, I'd like to thank PTAC for inviting me to present at this
session. I feel very honored to have the opportunity to share my thoughts and experience with this group.

Just for background, I'm a nurse -- nurse practitioner -- and was a health system CEO for 15 years before Rick Gilfillan and Don Berwick persuaded me to come into CMMI as a founding leader with CMMI. I was one of the leaders that helped write the Bundled Payment for Care Initiative, so I never know whether I should apologize for that or not.

I was most recently the EVP of Federal Affairs for America’s Physician Groups, where they have over 300 practices with 200,000 physicians that are committed to value-based health care. I interacted with many of those practices and began to understand firsthand their challenges in trying to implement total cost of care risk-based models.

Just a month ago, I joined UpStream, which is a global value-based risk organization that is focused on supporting primary care through this transition. My presentation will
focus on the barriers that are found in the adoption of total cost of care model focused on the primary care practice.

So, with that, if you could move to the first slide.

So the first slide sort of talks about UpStream, three components of it. And this is from my experiences working with APG over the last four and a half years.

We have embedded pharmacists and care coordinator nurses physically in the office, and we also have extended services such as integrated pharmacy that can dispense it with home delivery. Many of these patients with chronic disease, as you know, medication and medication adherence is really a problem.

The physicians - get guaranteed advance payments for quality. These payments start where they're at from a quality perspective. So if they're at a four-star now, we pay them a certain amount, and as they move up, we expect them to be a five-star or 4.5,
probably within six to seven months.

We take all the contract risk through substantial capital investment. We feel comfortable with that because we have a model that we think is very successful and has been shown to be successful in the areas in which we have implemented.

We have a technology that, of course, goes ahead with it, and we have seen significant improvements in patient outcomes and satisfaction with this model we're implementing.

So next slide.

So the next -- I'm going to talk in terms of the barriers that I have seen in talking to hundreds of practices over the last four years in terms of adoption and total cost of care, as we recognize 70 percent of Medicare beneficiaries have at least one chronic disease. And they account for 95 percent of the Medicare spend.

However, most of us in the industry, including myself as a health system CEO, really
focused on the specialist and really focused on the inpatient. Thus primary care is the engine behind care transformation. But we have not in this country put dollars and resources into primary care.

The adoption in value-based models has been very slow with primary care. And in fact, anything, it has been the specialists that sort of have been knocking on CMMI's door in terms of getting episodic payments.

The primary care physicians have been somewhat reluctant to enter a value-based model. Now, over the last few years, we've seen that change because there have been aggregators that have come forward in terms of helping them support the risk involved.

So the barriers can be put into four categories, in my estimation. The first one is financial. The second one is our current payment models. The third is the lack of integrated team approach. And the fourth is the adoption of technology.

So the first one, both -- Sherry
shared with this -- is the losses of taking on total cost of care and having downside risk go straight to the personal income. So, if any of us really believed in something and we wanted to do it for our patients, but we had a worry that it would actually impact our personal income and our family's income and our ability to provide resources for our family, we would probably be reluctant with that. And that's what we're seeing.

Second is, when you look at their percent of business, the traditional Medicare percent of business for most of primary care practices, this is only 15 to 20 percent. So you're talking about taking a personal risk on your income on a small piece of your business. Even if you may philosophically believe in it and not believe that fee-for-service is the way to go -- but to take on that risk for small amount of your business is very, very disturbing.

Also, we don't have a proven care model. It's not like clinical practice, in
which there are best practice standards and they follow them. In their estimation, everything seems to be experimental. We know some things work in terms of decreasing post-acute care.

But in terms of really knowing that if I follow A to Z, it's going to make a difference in terms of the overall utilization in that patient, makes them -- they're not sure that that is out there. And so that makes them feel uncomfortable.

And there's the cost of the initial infrastructure. For them to enter into it, they need the cost of the initial infrastructure. Now, CMS has tried to overcome that by putting some PMPM\textsuperscript{15}s in it on the front end. But again, it's not like someone hands you a million dollars or 500,000 on the front end to set up care coordination teams. They're going to give it to you on a PMPM, but for you to be effective, you've had to develop a team approach.

\footnotesize \textsuperscript{15} Per-member per-month
The next is the fee-for-service. And Sherry was talking about this. The fee-
for-service is the underline of everything. And for the exception of a few codes, which I
will be talking about, it represents billable
time from work done by a single provider.

And so it is not set up for team
codes other than care coordination, management
codes, TCM -- Transitional Care Management,
advanced care planning. Those kind of codes
are set up as team codes. For the most part,
our fee-for-service codes are the work done by
a single provider.

And even the advanced ACO models
like ACO REACH\textsuperscript{16} -- how they set up the
capitation is they take your fee-for-service
codes that you have embedded -- that you send
no claims code into the MAC\textsuperscript{17} to determine what
your capitation amount will be for the next
year. So we're saying we want to get away from
fee-for-service, but fee-for-service becomes
the infrastructure of how we build the new

\textsuperscript{16} Realizing Equity, Access, and Community Health
\textsuperscript{17} Medicare Administrative Contractor
model with capitation.

This year, I can give you a good example of how, suddenly, we're doing both things at the same time. We're saying -- CMS is saying I really, really support value-based. We need to move away from fee-for-service.

However, there is a code called a split visit code, which is if a physician is seeing patients in a facility and they're working with a non-provider practitioner like a PA\textsuperscript{18} or an NP\textsuperscript{19}, nowadays what they've -- they modified the code. And so the code is now put in at who spends most time with the patient.

So, if the non-physician provider, the NP and PA, spent more time with the patient, then they put in the code at 85 percent of what the code would be, the E&M\textsuperscript{20} code. If the physician spends the majority of time with the patient, then it's put in at 100 percent. But they're working as a team. They're working as a team.

\textsuperscript{18} Physician assistant  
\textsuperscript{19} Nurse practitioner  
\textsuperscript{20} Evaluation and management
The split visit code decides whoever spends most time with that patient and does not recognize the team approach. So we continue to say we want to get away from fee-for-service, but everything we have is built on individual clinical encounters for an individual provider.

Second, we have an inability to connect the dots between coordination of care codes, CCM\textsuperscript{21}, TCM, remote patient monitoring, advanced care planning -- these are rarely used by the primary care practice, really rarely used.

In fact, I asked one of my friends -- has one of the largest primary care practices in an area, very complex patients. He's very experienced, and he really believes in value-based. And I asked him, how many times does he bill under CCM? He says, not a single time.

He does not bill at all under CCM, and I asked why. And he says, because it seems so complex; there's so many requirements to bill under that. So, in fact, CMS increased

\textsuperscript{21} Chronic Care Management
the rates for CCM to improve adoption. And so the workforce shortage has continued to limit the use of that.

The next is the adoption of technology. We're having difficulty in independently applying technology. The practices modified their face-to-face interaction into virtual during the pandemic, but they continue to lag in the adoption of new technology.

So next slide. I'm going to go through quickly in terms of the solutions.

The first solution is to increase incentives. We need the development of more independent primary care groups. We need to look at tax or financial provisions to help them set up their practices.

We need to engage patients as partners, to develop compacts and contracts with those patients, in which patients sign saying, I agree to this care plan, and this as a position is what I am supporting.

We need to reduce regulatory
requirements. We get waivers through total cost of care models, but they're burdensome in terms of documenting. We need blanket waivers with minimum burdensome documentation. We need the funds to address social determinants of health, and we've talked about different ways to do that.

We need to minimize the risk by having the benchmark modified for the high performers. They did that in Pathways to Success. They have a greater weight on geographic with the high performers. However, the most you can get is a 50/50 weight.

We need education and technical assistance programs, including a central repository for independent docs to go in and identify best practices. And we need financial support for them to develop or buy analytic tools as independent physicians.

And then, last, we have to overcome the inertia. I wouldn't say lower the fee-for-service schedule. I would say adjust it so we accelerate the movement to value. Maybe go back and relook at that split visit code and
say, if you're in a risk-based contract, we're going to look at it in total when you get 100 percent if you're working together.

And then strengthen the architect of the MIPS\textsuperscript{22} program. The MIPS program, as this PTAC is aware, has become very, very minimal in the impact to move people to value. And most of it is because there's very little penalties, and everyone uses the uncontrollable circumstances.

And the 5 percent advanced APM bonus goes away December 31st, 2022. Congress is aware of it. They would like to make a change and continue it, but we must maintain that.

So, with that, thank you.

VICE CHAIR HARDIN: Thank you so much, Valinda. That was very interesting.

Next up is Christina Severin, who is President and CEO of Community Care Cooperative.

So, Christina, please unmute and --

MS. SEVERIN: Can you hear me okay?

\textsuperscript{22} Merit-based Incentive Payment System
CHAIR CASALE: Yes, we can hear you.

MS. SEVERIN: Thank you. Thank you for having me here today. Happy to bat cleanup.

As introduced, my name is Christina Severin. I'm the President and CEO of Community Care Cooperative, or C3, as we call ourselves. We are an FQHC\textsuperscript{23}-based nonprofit organization, and we are headquartered out of Massachusetts, doing business in Massachusetts, mostly in a Medicaid ACO but also some Medicare ACO and some commercial, and now have diversified our product offerings to also offer Federally Qualified Health Centers, the Epic EHR\textsuperscript{24}, in addition to other shared services.

Next slide, please. Next slide.

So a little bit of background on health centers and on us. We were formed in 2016 in response to the Massachusetts Medicaid program, which is known as MassHealth, moving from our traditional MCO\textsuperscript{25} model to an Accountable Care Organization model.

\textsuperscript{23} Federally Qualified Health Center
\textsuperscript{24} Electronic health record
\textsuperscript{25} Managed Care Organization
In 2018, we launched the full program with 15 FQHCs and 110,000 members. And in '19, we grew to 17 health centers and 125,000. And today, we have -- can't quite keep the PowerPoint current; 18 is now 20 FQs. We have about 200,000 members and three risk contracts. And, as mentioned, we're also now -- we have licensed the Epic EHR, which -- all of you, I'm sure, are familiar enough with the market to understand that the Epic product, has been a hard product for FQHCs to be able to obtain.

So we used our -- the same C3 playbook of if we bring independent FQHCs together, we can leverage our scale to make things possible that have not been possible in the past. This has been true with risk-taking on total cost of care in the core ACO business, but also, now, the other accoutrements that are coming along with this business, such as being able to license down Epic.

Next slide.

This is our vision, mission, strategy, and core values. I'm just going to
read the strategy. So this is a trifecta strategy for C3. It's focused on uniting FQHCs at scale in order to transform primary care, improve the financial position of health centers, and advance racial justice at health centers, at C3, and in society.

Next slide.

As a reminder, there is very strong evidence to support that health centers outperform other primary care settings on quality and on total cost of care. This slide is about quality, and it is a reminder that the publicly available data concludes that health centers outperform the rest of the national market on two quality measures here.

One is patients with hypertension whose hypertension is well controlled, and people with diabetes whose hemoglobin A1C is being successfully controlled.

And then on the last section of the slide is the third quality metric on this slide, which is about patient satisfaction, where health centers also outperform the market. You can see the first line is users
satisfied with hours, 96 against 37, FQ to nation. And the second one is overall satisfaction with care, 98 against 87, FQ against national respectively.

Next slide.

This slide is complex. No worries. I'm going to talk you through the punch line. I said health centers outperform the national market on quality and cost. Prior slide was quality. This one is cost.

This was a study published in the American Journal of Public Health, November 2016. The study examined two cohorts prospectively over time. The study was looking at total cost of care. The study found that the cohort who got their primary care in an FQHC had total cost of care that was about 24 percent less expensive than the total cost of care in any other primary care setting.

This article was actually published right when we were in the middle of starting up the company. So, as you can imagine, this was a thesis that we were working off of, and this was very reassuring as we were getting ready to
embark on a total cost of care journey.

Next slide.

So how we got started. Next slide.

So this was a group of health centers at the beginning. This was a start-up nonprofit. We had zero dollars in our bank account, and so we needed to develop a plan. And so part of the plan -- we were looking at bidding on a five-year contract that had a total cost of care with corridors that expanded over time.

For example, this year, we're in the last year of this five-year contrast. We will renew it. This year, our total cost of care exposure is 100 percent up/down, two-sided.

We knew going into this -- my background is I ran a different ACO for a Harvard teaching hospital system. I ran a Medicaid health plan. I worked in public hospitals, and I worked in FQHCs. So I knew that we needed to have a way to harness lots of different data assets. Some of those data assets have been discussed by other panelists today.
Our data assets include we harvest all clinical data from EHRs at night. We get these so-called ADT transactions in real time. Refresh three milliseconds throughout the day. We have paid claims files from all of the carriers that we do business with, including Massachusetts Medicaid.

We have member self-reported data. We have SDOH²⁶ data. We normalize and harmonize all of that data in an enterprise data warehouse, and that is the big data set that allows us to do lots of things like a rules-based approach to workflow automation, stratification, performance analytics, research, et al.

Next slide.

This is just a pictorial of that. The circle is around the enterprise data warehouse, and you can see these are the data assets that are coming in to the enterprise data warehouse, FQHC clinical data, hospital ADT data. We have national feeds from Quest

²⁶ Social determinants of health
and Labcorp. We have the paid claims data. And as stated, we have member self-reported data.

Interestingly, we also do business with a BH\textsuperscript{27} carve-out. I wasn't planning on mentioning it, but since it was raised by other panelists, I will mention it. That was a blind spot. We were not getting ADT transactions there.

We were able to work with that behavioral health carve-out who issues prior authorizations for inpatient stays -- inpatient behavioral health stays. We're able to work with that BH carve-out to translate that prior authorization transaction essentially into a hospital admit ADT ping. So we're able to have a real-time BH inpatient census based on that unique transaction.

Next slide.

As mentioned, when we were a start-up, we had zero dollars in the bank. And this shows you coming into year one. We had to come

\textsuperscript{27} Behavioral health
up with a little bit over 14 million in order to prove to our regulators -- and in Massachusetts, there are many financial regulators -- that if we had a bad outcome on this total cost of care contract in terms of incurring deficits, that we had the financial wherewithal to repay those liabilities.

And so we used a multifaceted approach to be able to sort of have a portfolio strategy to skin the cat on coming up with that 14 million, as displayed here in this waterfall. So we bought excess loss insurance that covered about five million of that.

We have a system of responsibly sharing risk with our provider organizations, our FQs. We're going to talk about the details of that in a moment. That moved five and a half million off of our balance sheet. We had a partner who was offering us a service, a vendor who was willing to take a little bit of risk, that underwrote about a million.

That left us with 2.7. The contract with Mass Medicaid did come with some financial support, and we were able to meet that 2.7
through the contract. This was good enough for our actuaries to sign off on our repayment mechanisms and to pass muster with the many regulators, including Mass Medicaid in Massachusetts.

Next slide.

Similar to other panelists today, we also have a model of care. Four core components. A lot of detail. Of course, within the four of these, not planning on talking about them today. Of course, happy to take any questions on our areas of practice transformation, pop health care management, and the miscellaneous things we do.

I would say of all of the things that we do, focusing on closed-loop referral for social determinants of health and practice transformation are probably the most existentially powerful in terms of trying to make real change in this local health care ecosystem.

Next slide.

So going to move to wrap up now on how it's going. Next slide.
As you can see here, things have been good for us financially, and we've outperformed the market.

Next slide.

The growth in our balance sheet -- you know where it started, at 55. I think, actually, right now, it's at 58. So things are good.

Next slide.

Growth in membership has also been excellent.

Next slide.

As mentioned, we have these other business lines, Epic and pharmacy services.

Next slide. Next slide.

In closing, I would say -- we'll make this the last slide -- that we agree that getting off of the fee-for-service chassis is existentially important. Is primary care capitation perfect? No, it is not. But all of our health centers very much agree that it is a more progressive way to embed prospective payment, even if it's not a prospective payment on the entirety of total cost of care.
So we are moving to primary care capitation. We hope to have 80 percent of our visits in primary care capitation by the end of next year.

Thank you very much.

VICE CHAIR HARDIN: Thank you so much, Christina. As our last presentation, we now have some representatives of a previously-submitted proposal, to the PTAC. We have Jon Broyles, CEO of the Coalition to Transform Advanced Care; Gary Bacher, Chief of Strategy, Policy, and Legal Affairs, Capital Caring Health; and Torrie Fields, Chief Executive Officer of Votive Health. C-TAC submitted the advanced care model, ACM, service delivery and Advanced Alternative Payment Model in 2017. Please go ahead and remember to unmute yourself as you present.

MR. BROYLES: Thank you. I'm going to do some framing at the outset and then turn it to my colleague, Gary Bacher, who was part of the team from 2017 that submitted and spoke before the PTAC. C-TAC is a large alliance of nearly 200 organizations. You may not know C-
TAC but you likely know our members, AARP, American Heart Association, American Hospital, large systems and health plans. And our focus is on transforming the experience of the patient and family from the point of diagnosis through to the end of life. So we're here speaking on behalf of the patient and family. Next slide, please.

So our story today begins, you know, from 2017 where we were last before the PTAC, and two things happened after that. One is you asked a lot of great questions, tough questions that helped us refine our proposal. We worked with the American Academy of Hospice and Palliative Care, directly with CMMI to advance key elements of the proposal that we reviewed with you into new payment models and heavily informed the CMMI primary care's initiative so number one, thank you for your feedback and know that you are having impact.

The second thing is that we had a realization that as sophisticated as the model of care that we submitted was, it wasn't enough -- next slide, please -- because to really
reach those who are completely outside the system, we have to work not just through Medicare eligible providers but really intentionally, in partnership with the community. And that brings us to the story of Shirley Roberson. Shirley was a colleague of mine, a friend, in fact, and recently a board member of C-TAC. She lived with advanced cancer for over a decade, and during that time, she really taught us that trust is key, the relationship with the patient is the key to the entire discussion around total cost of care. And really, she -- it was during many ups and downs, many challenges with social isolation, challenges with transportation, food, pain for her that her cancer was causing, that her faith community really stepped up. And Shirley would often say to me, "When you feel like giving up, it's the community that's going to keep you going." And that's always stuck with me.

And now she thought of community as including her oncologist who would not just help her with her pain but also remember to give her a hug and check in and see how her
heart was doing. But it also included their agency on aging and included her church, Hartford Memorial Baptist. And I think as we think about where to go next, where the greatest opportunity for innovation lies, we believe that it's reaching those who are completely outside the system, those who have been underserved for too long, and those who need investment and trust and trusted relationships.

So as we think about how to get there, we have to think seriously about investing in the organizations that folks like Shirley believed in, not just as a charity, not just as community benefit but as true partners as we move this $4 trillion health system that we have towards more person-centered care.

And I'm going to turn it to my colleague, Gary Bacher, to talk about some of the practical elements behind our recommendations there.

MR. BACHER: Great. Thank you, Jon. So thank you again for having us. It's a pleasure to get to come before the panel again.
As Jon mentioned, we got to do this a few years ago.

There are a couple of important themes to pull through that came from the earlier discussion with the PTAC, and I had the pleasure following our PTAC presentation to actually become the Chief Strategy Officer for CMMI and help oversee the architecting and development of a wide range of the models that are being used today. I think there are two important themes that emerge kind of from the conversation we had with the PTAC earlier and part of our work today. So one is we're strong believers in the power of total cost of care for a lot of the conversations that have been conducted today. But it's also important to ask about total cost of care for who and to think about the different subpopulations that are being served under any particular model to make sure that things, in a sense, don't get over-averaged, so paying attention to important subpopulations, not necessarily carving them out but being aware in model design that if you're taking care of a substantial portion of
people that are of a particular subpopulation, it may be important to kind of make sure that the model parameters are flexible enough that it can accommodate those populations to make it feasible to successfully serve those people.

Second point is -- has to do with nested models, and I say this all the time. One of the things that I remember from the PTAC discussions was the discussion around does it make sense to have broader nested models or standalone models. And the idea as we talked about -- at the time, we were proposing a model to focus on the seriously ill, which really did inform a lot of CMMI's work. And one of the discussion points was, well, why would you want a standalone model to focus on the seriously ill if you already have many longitudinal total cost of care models where their incentives are already being placed to actually focus on the seriously ill, people with advanced illness? And we thought and we still think that that's actually a very, very valid point, but there are also some issues where if build it or -- they won't necessarily come.
And so one of the questions is how do you really have the right balance between broader population-based models where you are creating the right incentives or even minimum requirements to be able to offer certain kinds of services, a minimum of services, for instance, that should be used to make sure that everyone that has serious illness receives the right care, how do you do that, and balancing between a nested design where you have that as part of a broader longitudinal model versus a standalone model.

And our view is in general, we should try to avoid -- and I'll use the term disintermediating those that would be taking total cost of care and total quality responsibility for a population but at the same time, you want to make sure that there are for those patients that are not going to be aligned to some kind of a longitudinal model, that there is, for instance, a standalone opportunity so they can receive services that are important to their care.

And then another point that we've
taken away is really systematically identifying and addressing and assessing populations' needs. And Jon made this point very well. The importance of actually focusing on those around people that are giving them the support, and so really honing in on caregivers who do amazing work but recognizing that they suffer a great burden and how can we, in the different models, actually, for instance, do a better job of supporting caregivers.

That leads to the final point which is how do we do a better job of bridging the divide between health care in the community, the divide that Jon spoke about. And if you think about our models, most of them really have a sort of a medical provider construct to them. So very typical in a model, there will be a participant provider and a preferred provider, but we don't really have formal room for the community in our models. And so beginning to think about how do we do that and how do we actually create new infrastructure on the ground. Sometimes we refer to it as a hub or a marketplace where we can, for instance,
bring together health care organizations and
community-based organizations and provide
support for those community-based
organizations, whether it's with contracting or
data management and reporting.

And then finally, the one hard issue
we're going to have to address is ultimately
how do we pay for these services, because if
we're talking about Medicare beneficiaries,
Medicare has a big gap in terms of its
coverage. And that's because it really doesn't
pay for non-medical services. It doesn't
really have a clear payment stream for services
that meet people's social determinants of
health. It doesn't have a payment stream that
meets what in the Medicaid world, what we would
call long-term services and supports. And it
doesn't really have payments for long-term
care. And so we really have to begin to figure
out, given those deficits and those caps, how
do we, for instance, find ways to pay for
services that would close the gaps that people
have. And a lot of that, I think, begins with
bridging the design between the health care
world and the community.

So with that, I'm going to turn it back to the panel. Thank you very much for having us.

MR. BROYLES: And I'll just say, to end our presentation, that we've included two emerging community-led models that are partnering with health systems in the appendix of our slides, the Alameda County Care Alliance, and the Coalition for Serious Illness Care in Arizona. So thank you.

VICE CHAIR HARDIN: Thank you so much, Jon and Gary. You can tell from these presentations, we've covered a lot of really rich and interesting ground. I'm going to open it up now for the Committee to ask questions. You can raise your hand to be added to the queue, but please go forward Committee members.

MR. STEINWALD: I'll start. Jon and Gary, as I recall your 2017 proposal, one of your objectives was to break down the silos between curative and palliative care. Have you been able to accomplish that in the work that you've been doing in the places where you're
operational?

MR. BROYLES: That's a great question, Bruce. I'd say it's an ongoing journey, but we have made lots of progress, and we'd like to share what we've learned with you. I turn to Gary to comment and then we also have our colleague, Torrie Fields, who has been working on this issue really closely at the operational level. And Torrie, maybe you can speak to this after Gary.

MR. BACHER: So one thing I'll mention, there's actually a couple of the models that CMMI has put in place that directly address the idea of concurrent care. So two examples of that would be in both Direct Contracting of what will become the REACH ACO Model, and then also in the Kidney Care Choices Model, there's actually a concurrent care hospice waiver. And a lot of that inspiration really came from the idea that we should be looking at ways to make it easier for people at the periphery to be able to access hospice and a lot of that, you know, there also has been the Medicare Care Choices Model, or MCCM, which
was designed also sort of to test what the effectiveness of being able to provide people some degree of conventional care in addition to supportive care. So there have actually been several models that have moved in the direction of trying to provide more flexibility for concurrent care, and I think it'll be really important to see what those lessons are.

So in the KCC Model and Direct Contracting Model, the KCC or the DCE, can allow the beneficiary to continue having Medicare pay for conventional services while the beneficiary actually elects hospice. And that's one of those waivers that's built into each of those models. But Jon, I'll turn it over to you and Torrie to provide some additional perspective.

MR. BROYLES: Torrie?

MS. FIELDS: Sure. Thanks for having me today. My background is largely in the private sector and also in the Medicaid Managed Care space. And from that perspective, there's been a lot of movement since 2017 really looking to build out more holistic
models and concurrent models for people with serious illness. So the Blue Cross Blue Shield plan has spent a lot of time really working on this and embedding palliative care services or advanced care planning into their Accountable Care Organization models to require that these populations are then assessed for different services and are actually being delivered those services like palliative care and hospice.

And those models are largely on a sub-delegated arrangement where there is an ACO who is actually paying a per enrolled member per month for those services, and they're included in total cost of care. There is a paper that just was recently released about the California model, and the five health plans who actually delivered palliative care services across this model all saved money but also improved population outcomes. They also proved that you could have a multi-payer collaborative across the states and do the same thing. So I think that's also worth noting.

And on the Medicaid side, there are now two states who are implementing palliative
care benefits as a concurrent care model both for adults and for kids, California being the first one that did that on a state mandate through legislation. Hawaii is working now on submitting a state plan amendment that includes palliative care as a benefit. If that gets approved, then there are multiple states' state Medicaid programs who are looking to do the same thing. And as part of that, what we have to do and what my team has done for some of those state Medicaid agencies is to actually look at their total population, stratify them based on their risk and their need, and actually look at that seriously ill population differently to determine what the gaps are in their care.

So there has been a lot of momentum and movement on the private side, and as Gary was saying, in the model side, but value-based insurance design for hospice is also an additional place where the carve-in is being tested and health plans are testing palliative care services with that.

VICE CHAIR HARDIN: Thank you so
much, Torrie. I'm going to go next to Larry Kosinski with his question.

DR. KOSINSKI: Thank you. I have a question for Valinda. The CCM codes have not had traction for their entire existence, but there was a change in this -- in the last year's final rule that opened up opportunities for PCM codes. And we're seeing independent companies develop products now around the promotion of PCM codes, so we should expect to see an increase in their use.

The problem I have with this, these are not first dollar claims. Patients are going to be hit with deductibles and copays --

MS. RUTLEDGE: Yes.

DR. KOSINSKI: -- on them, and I don't know how you place -- I'm interested in your input -- I don't know how you insert a PCM or CCM code into the chronic care of a patient when they're going to get hit with monthly --

MS. RUTLEDGE: Right.

DR. KOSINSKI: -- copays and hits in

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their deductible. I just don't see it as a solution.

MS. RUTLEDGE: Right. There have been several medical associations, and certainly APG was one of them, in which we pushed for CMS to not have that be one of the copays like annual wellness visit, do you mean, is not a copay and yet it's classified, Larry, under that. If you look under, you know, clinical code services in which you have ACP, you know, advanced care planning, PCM, CCM, annual wellness visit, you are exactly correct. That should have no copay.

And, you know, I think that is an opportunity for advocacy. I do know that there are some physicians that have said, I feel guilty, you know, doing a CCM code and charging the patient 20 percent. We have found there is success and decrease in hospitalizations and readmissions using the code, so you're exactly correct. I think it is an effort of CMS not to have it on one of the lists of no copay.

MS. FIELDS: If I may add, Valinda? Can I just add? On the advanced care planning
component of that, the copays have been a huge deterrent for people with serious illness. And what we're finding is that 50 percent of the population who have an advanced care planning billing code dropped is by a specialist outside of the annual wellness visit. So the initial intention of trying to couple these things with primary care or an annual wellness visit just really has not worked out.

VICE CHAIR HARDIN: So helpful. Chinni, you're next.

DR. PULLURU: Now my question is for Christina. You spoke about sort of some of the quality as well as economic value in your organization, and what I wanted to ask is how - - what is your strategy for managing specialists as well as post-acute spending? How do you bring them into your total cost of care methodology?

MS. SEVERIN: Yes. I mean figuring out how to engage specialists in the total cost of care methodology is a -- it's a difficult nut to crack, so I will not tell you that we have completely solved that. I would say that
when we look at the patient population, the needs of the patient population, the resulting spend pattern by major category of service that the majority, because -- and our biggest ACO product line which is Medicaid -- of course, in Medicaid, you know, 80 percent of what shows up as health care need is not pathology -- not clinical pathology-based, it's not about physical health.

But in some respects, in the Medicaid population, some of those really difficult to solve issues with specialists are slightly less germane. Probably the best example is the need for access to the specialist under the behavioral health umbrella. This is a place where health centers and organizations like health centers have some advantage, because there is a lot in the behavioral outpatient continuum of care that may reside inside of the FQHC, access to ongoing therapy, integrative behavioral health clinicians and psychiatrists who do prescribing, that it's all part of primary care team. So that sort of building out what lives
under the house of primary care and making that increasingly expansive has been a good way to address some of these specialty issues by no longer really classifying them as specialty in bringing them into the primary care home.

Another idea that we have been working and we're testing with regards to all of the other specialists is the use of telehealth, both e-consult, so asynchronous e-consult where it's clinician to clinician via email essentially using e-consult as a primary modality to get the need met around specialist care with, of course, then an exit ramp for individuals who need face-to-face specialist care immediately or where the e-consult has determined that the patient now needs a visit with the specialist.

In certain markets, the other thing that we've been able to do when we find that there's a significant difference in the quality of specialty services is redirect care over to a different system. This is not done through traditional methods of network management or prior authorization. This is really done with
speaking with clinicians and having clinicians develop different patterns of referrals based on where they are most comfortable having their patients go. Getting back to the issue of trust, we find that the best way to advise patient -- to have patients go to preferred specialists, if you will, is through the clinician, the PCP, the behavioral health provider, the nurse practitioner, et cetera, having more of a clinical comfort with those particular specialists and developing those relationships.

VICE CHAIR HARDIN: Thank you so much, Christina. Walter, you're next.

DR. LIN: Thanks, Lauran. So this is a question for Valinda. Valinda, on your solution slide, you mentioned the idea of curating a central repository, which is actually very timely as this committee was only this morning discussing the development of a library of care transformation and practice redesign best practices garnered from, you know, other disease-specific and episode-based kind of models like the oncology care model and
the ESRD care model.

My question is how has UpStream populated its essential repository with strategies and best practices and disseminated these practices to its participating providers?

MS. RUTLEDGE: Yes. So I'm going to defer the question since I've only been in UpStream for a month; okay? So can you ask me that question in about six months; okay?

DR. LIN: Fair enough. Okay. Thank you.

MS. RUTLEDGE: I can answer it from an APG perspective that, you know, we tried through a lot of webinars and having a central repository in the website to be able, because a lot of our members were independent practices, and they had very little access to know what was working. They weren't a part of large organizations that big health systems could purchase to be able to go in, so we tried to provide that. But certainly having a national database that would be open to everyone would be optimal.

VICE CHAIR HARDIN: Thank you,
Valinda. Jennifer, you're next.

DR. WILER: Thanks to all of our presenters for excellent presentations. My question is going to be for Christina, although a number of you have talked about this issue. My question is around -- Christina, impressive results with your organization. And being a risk-bearing entity, I was wondering if you could address the two specific concerns that we've heard regarding barriers to participating and total cost of care programs. One is the infrastructure cost, so you describe an impressive data analytics program and plan, which I am assuming required a lot of capital. And then also this concern around diminishing returns in a program around performance and how you thought about those not only in developing your program but also in maintaining the successes you've seen.

MS. SEVERIN: Yes. So on the first one, barriers to entry because of infrastructure costs, there are definitely infrastructure costs. I would say initially for us, based on our scale and start-up, we had
to spend approximately $5 million in building infrastructure.

One of the ideas that we have put forward -- and this comment is particularly relevant to entities in the health care market who have traditionally had less access to capital because perhaps they're a safety net organization, or they are a 501(c)(3), or there have been other constraints on building up the balance sheet that some of these programs, both local programs that might be run by local Medicaid authorities or commercial carriers, or federal programs also come with start-up capital. When you think about sort of the intricacies of risk-based capital and requirements that the Department of Insurance will have on an HMO\textsuperscript{29}, this is based on how much risk the HMO is bearing. When an HMO gets involved in doing business with a provider organization on total cost of care, this is a risk transfer.

So I think that one could argue that

\textsuperscript{29} Health maintenance organization
a source of start-up funds for building infrastructure would be the health plan sort of having a redistribution of the risk-based capital that has been held against that account before it was a total cost of care risk account over to the provider organization who wants to enter into risk as a capital investment in that organization's ability to build their infrastructure.

On the second point around the law of diminishing returns for high performers, it's a really, really important point. In the Massachusetts Medicaid program, the state has taken some very good steps, not that it couldn't go further, and we advocate for it going further, in having a market blend into the development of benchmark so that if we are beating the market, right, and we're managing that in our own experience, that we have a way of having a blend of our experience with the average cost of what's happening in the market so that it has the ability to lift up our budget. This has been critically important to us at this point in the program given our
success. If we could choose, we would choose a purely market-driven rate. So I think that that is a way for that to happen across the board locally, nationally, public payers, private payers to be able to have higher performers choose between experience-rated benchmarks or market-rated benchmarks or a blend.

VICE CHAIR HARDIN: Thank you so much, Christina. We have one more question from Paul. This has been really rich discussion. I'm sure we could talk for hours. But Paul, can you ask our final question before we go to the break?

CHAIR CASALE: Yes. Thank you, and I also want to thank all the presenters for those great presentations. This question is for Valinda. And Valinda, I know -- well, first, let me say I'm grateful for your work for BPCI\textsuperscript{30} because in my former role leading population health in a tertiary community hospital with multiple specialty groups, I saw

\textsuperscript{30} Bundled Payments for Care Improvement
firsthand the engagement of the specialties in BPCI, BPCI the classic, and then with advanced. So I think we've learned a lot for -- absolutely.

So now as we're thinking towards these population-based total cost of care models, and I know you've been involved in some of these listening sessions, and I'm sure you've been thinking a lot about it, I guess my question is, still, and from your perspective and in your roles how best to engage specialists going forward as we move to these larger total cost of care models?

MS. RUTLEDGE: So, you know, Paul, I really believe that episodic payment models are the best for specialists and you need them, or you're just not going to get the level of engagement that you need in terms of moving them to value-based. Total cost of care models are the ultimate way that we need to be there.

I have recommended that they really look and look at lessons learned. Particularly in APG, we have a lot of members that were out in California that have had decades of
experience in terms of taking capitated delegated risk in the MA\textsuperscript{31} population. And as they took it, they started with different relationships with the specialists. The specialists, they would do things like, you know, you have to meet a time, a framework, or a service, or patient satisfaction to get on the list. And they found that that was just not enough, that they actually had to figure out a way to sub-cap it or look at a bundle payment with them.

And I had recommended to CMMI that you take the lessons from that. And so whether that ends up being nesting, does it end up being something that's a blend of both but certainly, I think the specialists need to have one, an episodic payment to be engaged, and two, the overall platform in terms of total cost of care does not -- they are not engaged in an ACO. So somehow I think take the lessons that have decades of experience and sub-capping and having the specialists be their partners in

\textsuperscript{31} Medicare Advantage
that and not treat them in terms of commodities, unless you achieve these service goals, we're going to kick you off the list, you know. That didn't work. It doesn't work with anyone. People want true partnerships.

CHAIR CASALE: Thank you.

VICE CHAIR HARDIN: What a great note to end on. Thank you so much, Valinda. My great thanks to each of you, each of our experts for sharing your time and experiences with us. At this time, we'll take a break until 10:15 a.m. Pacific, which is 1:15 p.m. Eastern. We'll return with a roundtable panel discussion, and I hope to see you then. Thank you all so much.

(Whereupon, the above-entitled matter went off the record at 12:51 p.m. and resumed at 1:16 p.m.)

* Panel Discussion on Definitional Issues Related to Population-Based TCOC Models

CHAIR CASALE: So welcome back. I'm excited to kick off our afternoon panel. I think all of our panelists have their video
turned on and are ready to go. So to further inform us about issues related to population-based total cost of care models, we've invited a variety of esteemed experts from across the country. They represent many points of view, including providers, payers, academic policy researchers, and patient advocates.

This morning we learned about a handful of specific initiatives and some research findings. I think these panelists will offer some additional perspectives that will help us explore our theme. PTAC members, you'll have an opportunity to ask our guests questions as well.

The full biographies of our panelists can be found on the ASPE PTAC website along with other materials for today's meeting. So I'll briefly introduce our guests and their current organizations. First, we have Jennifer Kowalski who is the Vice President of the Public Policy Institute at Anthem. Dr. Emily Maxson joins us from Aledade, where she is the Chief Medical Officer. Next, we have Judy Stein. She is an Executive Director and
Attorney at the Center for Medicare Advocacy, which she founded. And lastly, we have Dr. Gail Wilensky, an Economist and Senior Fellow for Project HOPE.

So, let's get started. In Medicare Alternative Payment Models, all Medicare Part A and Part B services are typically included in benchmarks labeled "total cost of care." Based on your experience, what types of services are typically included in this calculation, and what kinds of additional services could be appropriate for inclusion in future population-based total cost of care models, and what would be the rationale for including this? Dr. Wilensky, I'd like to start with you.

DR. WILENSKY: The costs that are included are the costs that are part of Part A and Part B. Therefore, you would include hospital inpatient and outpatient. You would include physician expenditures. More recently, the use of both outpatient, as well as inpatient, prescription drug expenditures.

The question that has been around for a long time is that there are a variety of
services that are not included in Part A or Part B. Some of them are included in Medicare Advantage plans, vision, and some of the hearing, or alternative health types of payments. And one of the questions that has been raised is should the definition be broader to include health care that is not a part of traditional Medicare, or should it be focused primarily on traditional Medicare as that which is under the direct purview of the CMS and Medicare programs?

CHAIR CASALE: Great. Thank you, Gail. Jennifer?

MS. KOWALSKI: Sure. Thank you very much for having me today. And at Anthem, we're using these models in both the Medicare space as well as the commercial space, so I might offer sort of a little bit higher level approach to this. We sort of think about it in two prongs when we think about, you know, what services or what spending should be included in a total cost of care model.

And I would describe the first prong as sort of what degree control does the
provider have over impacting the services or spending to be included? So for instance, if you want to think about prescription drugs, if you think about a primary care provider, what levers do they have to control the spending on the drugs that are prescribed outside of their office? So if there's a whole set of specialists that an individual might see outside of that provider's office, you know, do they have any degree of control over what's being prescribed and, you know, the costs of those drugs? And in some cases, the answer to that is no, and so perhaps it doesn't make sense to include that in the total cost of care benchmark. On the other hand, you may have contractual alignment between a PCP and a group of specialists, you know, probably more common in some of the fully capitated models where the PCP can build out a specialist network. And in that case, perhaps it does make more sense to hold the PCP accountable for the drug spending in those scenarios.

And likewise, when we start to think about some of the non-medical benefits that are
being added to help plan benefit designs today, so if you start to think about transportation or some of the things to address health-related social needs like maybe a patient with COPD\textsuperscript{32} needs an air conditioner, for instance. Should the PCP be on the hook or accountable for, if you will, those types of costs as part of a total cost of care calculation? And again, I think the answer goes back to what sort of control does the provider have over the spending on those types of services? Is the plan largely, you know, the one making the decisions about who gets what and when and to what extent, or is the provider, you know, maybe a large health system that said, hey, give us a care management fee that includes, you know, some of these services, and as part of that management, we want to be the ones to, you know, provide transportation or to provide and address some of these social drivers of health type things? And in those cases, you know, it probably does make more sense to

\textsuperscript{32} Chronic obstructive pulmonary disease
include that in the total cost of care measure.

And I think related to this is the second prong which is, you know, what level of capabilities and services does the provider really have to support the patient population, to support a clinically complex population, and so how much financial risk can you expect the provider to take on for that set of services?

And then I just want to address, before I wrap up on this question, you know, to some extent, the services and components that are included in total cost of care models have to differ across payers, across lines of business. So if we go back to the prescription drug example again, if you think about the commercial insurance populations of a large employer group population, in a fully-insured product, individuals generally get their medical and drug benefits from the same health plan. So we can put the drugs in the total cost of care calculation for those individuals. But in self-insured employer arrangements, more commonly, employers kind of break up who manages which parts of the benefit. So you may
have a health plan managing the medical side, but you may have a totally separate PBM managing the drug side. And so operationally speaking, it's much more difficult to include drugs in the total cost of care calculation in those cases. So I think we'll get into some of this in the second question, but there is some variability for a variety of reasons.

CHAIR CASALE: Great. Thank you, Jennifer. Judy?

MS. STEIN: Yes. Thank you, and thank you for having me today. I don't pretend to be an expert in total cost of care economic issues. My expertise is in 36 years of representing Medicare beneficiaries. So from the beneficiary's point of view, all these models are, at best, confusing and not understood. And it is increasingly concerning the incredible number of mergers of large health organizations. In Connecticut, we have -- for example, where my organization is based, in both Connecticut, Washington, D.C., and then

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attorneys around the country. But increasingly our health care is run by two very large hospital organizations which have kind of eaten up primary care practices, SNFs, nursing homes, and home health agencies. And that tends to limit access to care for beneficiaries, for patients, to those affiliated providers.

So I'm concerned that the continued look to total cost of care as has been experienced within these large affiliated hospital systems and as understood or experienced, I should say, within Medicare Advantage by beneficiaries, has not been shown to increase quality or choice, real choice between -- by beneficiaries to access to a full range of providers that they might want to see and that they can understand from the beginning of the year to the end will be available to them both within the geographic area and in the Medicare traditional world versus Medicare Advantage throughout the country.

So I'm very interested in what the risks, if you will, quote, unquote, are to beneficiaries and what the advantages are to
patients and will they pan out in practice because finally, I'll say that the appeal system, the review systems, the ability to speak directly to providers versus, in Medicare Advantage, the Medicare Advantage plan, and now to the AI\textsuperscript{34}, the proprietary entity that may be making determinations regarding coverage, has become more and more opaque even for professionals who represent beneficiaries.

So there are some warning signs that this is not the way to add to choice or quality of care for the people who need it. Thank you.

CHAIR CASALE: Thanks, Judy. Emily?

DR. MAXSON: Thank you. I just want to emphasize the Part D question. We at Aledade bring together previously unaffiliated primary care practices and form Accountable Care Organizations and help them succeed in the transition from fee-for-service to value-based care. And we're managing contracts beyond Medicare, including Medicaid and commercially insured patients. And so what we find is that

\textsuperscript{34} Artificial intelligence
there is an amazing amount of appropriate pharmaceutical stewardship to be had. And if we don't include Part D prescriptions in total cost of care, we miss out on the opportunity to shed light on that and to bring that management that can benefit patients to bear.

We do this for commercially insured patients, and there are a lot of generic opportunities for switching that bring lower cost share to the patient, and I do think that beneficiaries could benefit. I know that it's administratively complex, but it may be worth, if we're considering different services to carve into total cost of care and include that aren't there already, it may be worth figuring out that administrative complexity so that we may better manage Part D prescriptions and their associated costs.

CHAIR CASALE: Great. Thanks, Emily. I'll now open it up to PTAC members for any follow-up questions. You can either raise your hand or simply start speaking.

As you're thinking about potentially some questions, just to add on to this Part D
question because, Jennifer, you had mentioned primary care, if they don't, if it doesn't appear they have sort of control over the drugs, you know, maybe it doesn't make sense for them to be accountable. You can think of oncology as an example. But on the other hand, as they're thinking about total cost of care models in general, it seems that it becomes more complicated if you sort of parse it by, you know, sort of drug categories or specialty categories. So -- and Emily, you may have -- and others may have a comment as well about this, particularly around Part D, which is something we talked about yesterday, as well with some of the panelists. I'm just curious your further thoughts on that.

MS. KOWALSKI: Yes. I think that's a great point, and I don't want to give the impression that we never include drugs. We certainly do --

CHAIR CASALE: No.

MS. KOWALSKI: -- in some of our models. I think the other thing to note is that in total cost of care models, cost is not
the only metric, right? There's a whole set of quality measures as well. And so, while you may not necessarily be holding a provider accountable with spending, you may still be holding them accountable on things like medication adherence or generic utilization or things that are more easily, you know, measured or that they can be, you know, more accountable for without the financial risk so tightly tied to it. So I think there are multiple ways to sort of come at some of the same aims, and it doesn't always necessarily need to be part of the cost of care benchmark.

DR. WILENSKY: I think you need to be careful about what happens to the costs that are excluded. I am sympathetic to having costs included that are outside the control of a particular group or payer. But to the extent that these are significant costs, and the example of oncology drugs certainly would be one of those examples, you really then are finding yourself excluding what might be the determinative factor of real importance in total cost of care. And so I think that it is
-- it's not obvious which way you are better off in terms of understanding what the variations in total cost of care are and who would be accountable if not putting it in the single metric.

CHAIR CASALE: Any other comments before we move to another --

DR. MAXSON: Sure.

MS. STEIN: Yes. Oops, excuse me.

DR. MAXSON: Oh, please. After you.

MS. STEIN: Let me explain one area of Medicare and health care where there's kind of a total cost of care that we're, at the Center for Medicare Advocacy, very familiar with. Both -- well, the models are both at the nursing home/SNF level and at the in-home health.

Let me talk about home health for a minute. In January 2020, the patient-driven grouping model came in, PDGM. It pays the agencies now for 30 days or six and -- we'll say 30 days for all the care that is provided to Medicare beneficiaries under -- that are available under the Medicare program. So it's
one payment, one type of payment based on the various services that are received by the beneficiary.

What will happen sometimes very often is that you follow the money, so it used to be that people could get home health aides which are part of that pocket of services that are available under Medicare, as well as therapy and nursing which are also coverable.

But as the payment system came into play, we found more and more that the services were not provided or were provided at the beginning of service which the agencies are paid more for or for people who have hospitalizations, because they're paid a little bit more for that. And then as the 30 days went on, they did not necessarily receive the full package of care that had been ordered by their doctor.

And very concerningly, increasingly, even before COVID, there were less and less home health aides available and therapy because the agencies are no longer paid more under this payment model to provide those services.
So an err of caution with regard to what is included in this total cost of care and is it truly the care that is then going to be provided to the beneficiaries in need.

CHAIR CASALE: Yes. Thank you. Before moving to Emily, on that note -- and you brought this up initially around certainly the -- a lot of confusion potentially for beneficiaries -- any thoughts on how best to inform beneficiaries about their choices or when, you know, they may now be in a total cost of care model moving forward?

MS. STEIN: As you may know, most beneficiaries, if they're in a Medicare Advantage plan, don't make a choice after their initial decision. That's according to the Kaiser Family Foundation. Between 20 to 30 percent never make a change. Twenty percent of those who are in such plans didn't choose but were set in such plans by their former employer or their -- sometimes the state or municipality. It's very hard because the plans aren't standardized. I think standardizing choices may not be popular in some areas but
for beneficiaries, it's very, very important. You can choose Medigap plans much more easily because there are not 50 of them. For most people, there are a dozen, and they are standardized. I think that's important.

Cutting down on what's allowed to be marketed versus people getting education from the Medicare agency is important. Having clarity with regard to what's an ACO, what's a Medicare Advantage plan. I mean there are just so many myriad models these days, it is, in fact, very confusing. And I think that's part of the problem that professionals need to take into consideration, because it gets to a point where -- I'll give you an example. Two years ago I was asked by my daughter to go to the store and get some granola bars for my grandchildren as they were coming to visit. I stood in front of the granola bars and realized there were dozens upon dozens of granola bars. I had no idea if these kids preferred the chewy kind, whether the parent did or didn't want chocolate chips in them, et cetera. It may sound like a silly metaphor, but we need to
understand that choice -- there's a book called
Paradox of Choice by a professor at Swarthmore
-- this is an increasing problem. It is
difficult to make a choice. And when there is
so much choice, the average beneficiary has 39
MA plans alone to choose from this year, it's
almost impossible to properly educate, and I
consider that my organization's job in part.
Thank you.

CHAIR CASALE: Yes. Thanks, Judy.
Appreciate that. Emily, I don't know if you
want to make some comments on the--

MS. STEIN: Well, I can wait for the
next question. It's really--

CHAIR CASALE: Okay. Great --
great. Thank you. Okay. So next question, do
you think there should be a single standardized
definition of total cost of care in future
population-based total cost of care models, why
or why not? So this time, Jennifer, we'll
start with you.

MS. KOWALSKI: Okay, great. Thank
you. I think I probably hinted at my answer to
this one in my response to the first question a
bit but no, I don't think there should be or really can be a single standardized definition for total cost of care, at least not if we're thinking about, you know, there's going to be one thing that applies to every plan and every provider and every line of business out there. And, you know, this is for, to some extent, some of the reasons I started to get into in the previous discussion, you know, there's different degrees of provider readiness in terms of taking on some of this risk. There's different expectations and different incentives that we might want to put in place in terms of providers' ability to be accountable for services and spending. There's different benefit structures across employers, across, you know, Medicare versus Medicaid versus commercial and so forth.

In addition, I'd note that like in our experience, particularly in the commercial space, we have a starting point. You know, there's sort of a template that we use for these types of models but, you know, if you think about the large self-insured employers,
you know, they're -- they have a desire to customize sort of every aspect of their benefits, including, you know, what these sort of models look like. Sometimes large health systems, you know, are far more advanced on these sorts of value-based arrangements. They want to be able to customize to their own particular capabilities. And so there needs to be some room. You know, there needs to be some room for that. There needs to be some room for innovation, but there certainly does not need to be unlimited variation.

I think we can probably think about, you know, grouping providers or grouping lines of business into, you know, kind of a couple of situations of, you know, how much risk can they take on, what suite of services might they be accountable for, able to take control for, and at least have some, you know, commonalities and starting points across, you know, some, you know, x number of groupings for instance.

CHAIR CASALE: Great. Thanks, Jennifer. Emily?

DR. MAXSON: I’ll take the opposite
perspective. I would love to see a single standardized definition of total cost of care, especially for Medicare models and across Medicare models. I think that using multiple versions of total cost of care ends up creating the possibility that providers are needing to choose between models. And sometimes they would opt to do this based on perceived favorability of the benchmarking, which gets you into an arbitrage situation rather than really focusing on the tools that they need to transform care.

Even if we had a standardized definition of total cost of care, we would still have plenty of room for experimentation with new payment and service delivery models. I think we saw this with Direct Contracting. We had a lot of organizations that we witnessed really carefully dissecting the Direct Contracting benchmarks to see whether they were going to be more favorable than Medicare shared savings programs, and then were going to make decisions based on that. And it really didn't end up as a productive use of energy and
resources.

The other thing that I wanted to mention related to the previous question and tying into this one is that we've learned a lot in engaging providers in this space. And when we started doing this, we really recognized that we needed to encourage a frame shift, so that practices could really embrace the total cost of care. We know that physicians are used to being evaluated on process measures that they know are in control, right? So did every patient who walked into their office get a blood pressure? Did the PCPs prescribe the appropriate medicine? And it was less natural at the beginning for our PCPs to think about taking accountability for whether the patient with severely poorly controlled blood pressure actually took that medicine, whether they followed the dietary recommendations that they received, whether they needed the emergency room, and whether they actually avoided that stroke or heart attack.

And once you really get buy-in from this practice group or these providers that
anything that happens to the patient is your responsibility and that of the Accountable Care Organization, you see creativity and innovation start to emerge. And I worry that carving out certain disease states or overly customizing and allowing different cost of care definitions and carve-outs disincentivizes truly jumping into the value-based care canoe when you have one foot in each, value-based care and fee-for-service.

CHAIR CASALE: Great. Thanks, Emily. Gail?

DR. WILENSKY: I think that within the components of total cost of care, there ought to be standardization but because some models may include a different number of components, that it is desirable to not only have a single metric of total cost of care. So I would say that it is a useful concept when viewed in terms of the components, but it would become too rigid and probably not useful for some of the models that are being tried on occasion to have a single standardized cost of care, so continue the flavor that that raises
but not apply it in a rigid manner.

CHAIR CASALE: Great. Thanks, Gail.

Judy, any other further comments on?

MS. STEIN: No, except that I think from the point of view of what is beneficiary facing, as less complicated and clearly understandable and, therefore, some standardization would be valuable so that they know what they're comparing to.

DR. WILENSKY: Judy and I have had these conversations for probably the last 30 years.

CHAIR CASALE: Yes. I'm going to open it up to PTAC members, and I apologize. There were two members who had questions for the first, but I suspect they may carry over. So Bruce, I'm going to turn to you for your question.

MR. STEINWALD: Question for -- I hear an echo. Do you hear an echo? No. Okay, good. -- for Gail Wilensky as an economist and a former Medicare administrator. What's your take on the argument about large models versus, that are primary care-oriented for the most
part, and smaller models that are specialty-oriented, can they co-exist, and how can they best be made to co-exist?

DR. WILENSKY: Well, they need to co-exist. The only alternative is to look at those organizations that include all of the physicians, primary care and specialty care. To the extent that you can have some agreement of the minds on definitions, on operationally, how to define the concepts in ways that are not inconsistent with the care that are being provided, you might be able to reduce a little of the tension. But there is an awful lot of friction between how much of what goes on in the specialty world ought to be under the responsibility and purview of the primary care physicians. I mean this has been going on for a long while.

To have them be too separate and independent loses the whole point of thinking about a total cost of care. But you get into this dilemma of how to have attribution to groups who have no control or responsibility. So it is going to be a blend of trying to get
it right so that you don't miss the important components of control.

CHAIR CASALE: Sorry, I muted myself.

DR. WILENSKY: Yes.

CHAIR CASALE: Larry, I think you had a -- thank you, Gail -- Larry, I think you had a question?

DR. KOSINSKI: Yes, I do. I've really enjoyed this discussion. The different flavors from each of the speakers has been enticing to listen to. Judith keeps catching my attention because my personal focus is a patient-focused one. And, how do we move design from provider-focused to patient-focused? That really should be our challenge. As a physician, I should be prescribing the right drug for the right patient at the right time for the right reason, not because the health plan wants me to use a biosimilar and oh, by the way, if I use that biosimilar, I may make more money, but the patient still pays the same copay and deductible, and the patient may not know they're getting a different drug. So
how -- in our design of these programs and in talking about total cost of care, don't we owe the beneficiary a definition of total cost of care so that when they're in the market looking at other health -- other plans, other alternatives, they can tell what they're getting for their -- for the money that's being spent?

DR. WILENSKY: I'd like to respond to -- it's an issue, I think, that goes to what Larry has raised, that's come up before in related discussions, and that is trying to distinguish between having agreed upon definitions of component terms but allowing the total to have some variation depending on the components that are included. I say that because I think you do need to have it understood that when you use a particular term with regard to cost of the type of health care, that that should be the same across different plans, different organizations, but recognizing, especially because Medicare excludes, in traditional Medicare, a variety of components of care that may be included in MA
plans or other type of plans and in any case are certainly included in the conceptual total cost of care model, that if the components are standardized, it can be easier to clarify which components are a part of a definition of total and which are not. So it's an attempt to try to have some balance between the issues that Larry raised. I don't know whether he thinks that helps or not.

DR. KOSINSKI: It does -- it does help -- it does help. We almost need a Monroney sticker like what's on the -- a sticker of a new car in a showroom --

DR. WILENSKY: Yes.

DR. KOSINSKI: -- so that you know what you're getting in this MA plan, and you can be an informed consumer.

DR. KOSINSKI: That's not a bad analogy.

MS. STEIN: Yes. But the problem is that there are not only all those different cars on the lot at Hyundai, but also the ones over there at VW and at Chevrolet and at -- and traditional Medicare is standardized. You can
tell what it is, but all those other, if you will -- I'll drop the metaphor -- MA plans have all different pieces to them, and they are allowed and do market actively.

I mean I'm now Medicare age. My husband's a family doctor, by the way. He's Medicare age. We are pummeled with this stuff and blessingingly, my mother is still alive and she says to me, "I don't know, Judy. Is there something different this year" -- this was last year -- "because I'm seeing all these ads with Joe Namath and I'm wondering, you know, whether I should, in fact, make a change this year."

So I think it's -- the marketplace for selling insurance, health insurance, to people who are, by definition, older and may have disabilities and/or age into disabilities really need to step back and look at -- Gail won't be surprised -- at what we're doing here and whether it's best, and can you teach all of this, or is it the paradox of choice, and what people really want is to know this is going to be covered and in practice, it's going to be covered because, you know, I deal with all the
people who go to the doctor or try to get the drug and not this year or not this month, and they want to choose between the doctor.

My mother wants to be able to go see the cardiologist she's comfortable with. And having had flaming blood pressure problems and lost much of her family to it, she was really scared when this year she chose a certain plan with professional advice, not mine, my colleague's, and a month after -- and in the end of January finds that, oh, that plan no longer covers that drug. It was on the plan finder, and it was on the plan's own website.

These are the problems that real-life people live with that need to be taken into consideration when we theoreticians think through the various models that seem like they might make sense. The consumer will not -- and I am one -- will not understand this space, and it doesn't always serve them well.

CHAIR CASALE: Yes. Thanks, Judy. And, you know, I think that speaks to, in a way, CMMI's current thought about smaller number -- and this is in the fee-for-service
side of things -- smaller number of large models as opposed to, you know, the 50 or so models that are currently -- in order to try to engage beneficiaries as part of that.

Before we leave this question, Jennifer, I'm just curious. As you had articulated your thoughts around total cost of care, is this -- are you thinking this has sort of a transitional period, or is it sort of the ultimate goal for 2030, again, thinking where CMMI is headed around having sort of a more clear definition, you know, sort of a unified definition around total cost of care?

MS. KOWALSKI: am I thinking that there can't be a standardized definition ever or that in 10 years we can have one? Is that the question?

CHAIR CASALE: Yes. As you're thinking around total -- yes, are you feeling -- are you thinking that, yes, could we ever have one, or is it that we need this transition period to ultimately get to one?

MS. KOWALSKI: I mean yes, I don't think we're ready for one now. Maybe at some
point in the future if we've moved enough, you know, providers along the spectrum to where everyone is, you know, really comfortably taking risk, then perhaps that makes sense. I sort of like Gail's approach, which is let's define the components consistently perhaps and -- but the actual what's in and what's out can be a little bit variable depending upon, you know, the underlying factors of the provider, the line of business, the model.

I mean I also think that when you're thinking about it from a health plan perspective, you know, in a Medicare Advantage plan and a commercial plan, the plan is ultimately, in a way, taking on risk for the total cost of care, right? We're paid a capitated amount, so we're still managing that patient, we're still managing spending. There is a responsible entity for, you know, managing to a budget, if you will, and then we work with the providers in terms of what they're comfortable, kind of, taking on in terms of accountability for their patients. That's a little different from a fee-for-service model
where, yes, CMS is the ultimate accountable party, but they're sort of looking to an entity that's not a health plan to take on some of that management for them.

And then I think you do need to think maybe more about, if you keep this out or you keep this in, what are the incentives you're creating in terms of who's managing this cost or what are we doing in terms of access and so forth and where does that beneficiary and fee-for-service go to, you know, if there's -- is there an appeals process like there is in an MA plan or in a commercial plan, right, like what's sort of the options for the beneficiary to learn more about what they're getting, not getting, and how to get it covered. Does that answer your question?

CHAIR CASALE: Yes. That's great. Thanks, Jennifer. Jen, do you have a question?

DR. WILER: I do. Thanks again to the panelists for a wonderful discussion. We talked a lot about consolidation of options in the marketplace, not as a means to restrict access or choice but actually to improve
quality of choice I'll describe it as. We've heard that, as Paul just said, from CMMI leadership and also CMS leadership that that's ultimately their goal.

So my question for the panel is, you know, since we're using a lot of metaphors today, you have a magic wand and you get the opportunity to consolidate the current choices within the marketplace, or organize them might be a better description, how might you go about thinking about solving that problem, or if you prefer to answer the question to be actually tactical around, you know, what programs might you eliminate and why?

MS. STEIN: I'll try. I may as well jump in. I feel like I'm -- anyway, a voice that may be sounding -- ringing a bell that is hard. At any rate, I think that when we -- first of all, traditional Medicare, we've been trying to figure out what's the right name for it. It is so rarely fee-for-service, which has become like a four-letter word. So it's really unfair to refer to the traditional Medicare program as fee-for service. It's really made
up of a wide variety of capitated rates and different care settings except for in some instances, of course, physician services. But hospital, home health, nursing home, they all have capitated rates. And all those capitated rates have produced problems for patients, because it's -- one thing that needs to be looked at -- and I'll get directly to your question -- is when you pay a capitated rate, you can't tell whether that service was actually provided for the capitated rate and especially not with the data that is currently available.

Back to the home health arena; for example, the patient may have had an order for home health aides, PT\textsuperscript{35} and ST\textsuperscript{36} and nursing, such as one of my clients, for a 60-day period, and that may have been provided for the first three weeks, and that's based on how the capitated rate is paid. But by the end of the 60 days, many of those services are no longer being provided and may have been removed.

\textsuperscript{35} Physical therapy
\textsuperscript{36} Speech-language therapy
gradually over time with or without the authorized practitioner's understanding of that.

So I want to -- I am using this time to make it clear that traditional Medicare is not fee-for-service, and it's dangerous to keep calling it that, with all much, much respect, because it misunderstands right away what we're comparing to. And also, that capitated rates are not the be all and end all with regard to fraud and/or just misuse.

Having said that, the traditional Medicare program and all these models ought to be -- there ought to be parity. They ought to be paid the same amount per beneficiary. If the private models are going to, as was promised, be better for the program and for taxpayers, they should not need four cents more on the dollar to provide those services. They ought to be standardized like the Medigap plans were back in the 1990's, so that people can understand what their options are.

A Plan A Medigap plan is a Plan A plan whether it's from Golden Gate or, you
know, New England Services United or whatever
the name is. You can compare. We can make a
chart, show it to our beneficiary and give our
audiences, these are your options, this is what
Medicare offers, these are the gaps, these are
what the gap plans will cover, can you afford
that.

Now we have to sandwich in always
asking about their income, where they live,
what their family and their medical history is
in order to understand what Medicare Advantage
plan might or might not serve them, where do
they travel, a lot more personal, by the way,
digging into someone's history. I wouldn't
think many people who value privacy would like
professionals to have to do that in order to
choose the right plan for folks.

So there needs to be simplification
and standardization. If any of you, as I have,
have had to choose health insurance for your
employees, you know what it's like to make a
choice every year. Most people who've had the
good fortune of being employed have not done
that for themselves all these years. And when
they're faced now with Medicare, instead of it being a blessing and a simplification, it's hugely confusing. I have a friend who has a law degree and two PhDs who left me a message that he had a Medicare crisis, and the crisis was he had to make a -- decide what to do when he turned 65.

So we need to standardize. If you're thinking about the beneficiary, there ought to be parity of payment between all these plans on a level playing field, and if MA can offer meals, people in traditional Medicare should be able to get a meal. If MA is going to be able to do medically necessary oral health care and actually provide it, so should people in traditional. Otherwise, you're saying there's choice when you're actually putting a thumb on the scale. Medigap is expensive. In most states, once you make a choice, you can't choose again. It looks cheaper right away to get into a Medicare Advantage plan. It may not be. You may travel and get in an urgent situation and be covered right away but not for the rest of what goes on
with your care.

So there's many things to think about, but standardization and parity as much as possible so that the consumer can understand this and know that the same value is existing regardless of their Medicare model is imperative.

DR. WILENSKY: I'll buy the standardization of terms, not the parity because I think some models are more efficient than others and can use those funds differently. The notion of having people be able to more easily understand the components of the program is an appropriate one. I think there ought to be ways. We can, of course. It does occur. It just doesn't occur to the same extent that Judy would like to see it. I think it's fair to say let's see how we can make it an easier comparison to -- for the beneficiary or the beneficiary's advisors who, after all, are actually usually the people that are helping the beneficiary make a choice, not some independent third-party person as much as it is likely to be a family member or a trusted
source through the person's church or senior community. But there are, I think, things we can do to increase the amount of standardization so it's a little easier to be able to make these choices. The fact is there are some differences in efficiency and advantages to some plans over other plans that will be important to some people but not to others.

CHAIR CASALE: Thank you.

DR. WILENSKY: There are also some efficiencies in traditional Medicare that are not --

CHAIR CASALE: Yes.

DR. WILENSKY: -- not to be forgotten.

CHAIR CASALE: Thank you. And Jen -- before we leave Jen's question, I don't know if Jennifer or Emily had any comments specific for Jen's question. And if not, we can -- no, okay.

All right. Chinni, I think you had a question before we --

DR. PULLURU: Yes. I just wanted to
hear the panel's thoughts actually on -- our strategic vision is to support the vision of everybody, all Medicare members being in advanced payment or value payment methodologies by 2030. Now, what are the goalposts that you would recommend, or how do you recommend that transition occur? We want to make sure we, you know, we're thoughtful about what the position we take as far as that's concerned.

CHAIR CASALE: Emily, you have --

DR. WILENSKY: I think you need to decide on a limited subset of advanced payment methodologies that would be acceptable. We are still in a phase of Medicare development/payment development. It goes actually beyond Medicare and is true for private sector payers as well where we are still struggling with defining the quote, unquote, best advance payment methodologies. Hopefully, by or before 2030, we'll be able to have agreement on a subset that we would like to maintain going forward. It would make everybody better off, physicians, other health care providers, and certainly beneficiaries.
CHAIR CASALE: Thanks, Gail. Emily, do you have any thoughts on that?

DR. MAXSON: Yes. I was going to say that to the extent that we can use data to empirically derive that answer, to me, I think that that would be powerful. I would start with where are our Medicare patients are getting their primary care today? How many of them are getting primary care, and how many still need to be better engaged in the system so that we cannot only get them to value-based care in an advanced payment model but get them access, period, and then start to think about the offerings that we have in each of those arenas.

I think that the data is bearing out for physician-led and NP/PA provider-led accountable care models in advance of some of the hospital and health system-led models. And so we need to understand how to catch up for patients who do get their primary care and will be quarterbacked in the health system or hospital-based model. And I think we can start there and would agree with Gail that we need to
make sure that these models are really rich for all patients regardless of where they seek their care and make sure to not leave behind our patients who are disenfranchised from health care currently.

Chair Casale Thanks, Emily. So I'm going to move to the next questions and sort of combine the next two questions. So in discussing how to enhance provider readiness to participate in population-based total cost of care models, from your perspective, what are some of the provider-level barriers to participating in these models; and also, as you think about these models, any experiences on how to structure payments to influence provider participation. So what are some of the barriers that you feel are there for provider participation, and then thoughts on how to structure payment to encourage participation. So Jennifer, I'll start with you.

MS. KOWALSKI: Great. Let me just very briefly -- before I talk about a few of the barriers, maybe I'll just mention there are four main ways that we are forming questions, I
guess, that we ask providers to start to gauge their readiness and, you know, they have to do with, is the provider kind of ready to make this transition over the next 12 to 18 months; is there some urgency and enthusiasm there; do they have a plan in place in terms of, you know, the resources, the services, the supports that they need; what gaps have been identified that we might need to help them fill; are they aligned with leadership in terms of making this shift; and do they have some budget to support a transition? And so, you know, providers who can answer yes to those questions are sort of more ready to move. Ones who can answer yes to like the enthusiasm and leadership alignment, you know, maybe need more support from us in terms of specific planning or budgeting.

And so I think that gets into some of the barriers that we see, the first being that, you know, the provider maybe doesn't have yet some of those factors in place that we view as important enablers of success in taking on more risk and, you know, some of those might be some sort of electronic infrastructure to help
identify care gaps, you know, perhaps links to the EMR\(^{37}\). Oftentimes, you know, we see it valuable to have a care team around the providers that, you know, do some of the patient management and other sorts of services.

You know, are they successful in whatever value-based arrangement they have today? You know, if they are doing some sort of pay for performance type model, are they consistently, you know, getting to where they need to be on that, that they're, you know, demonstrating the ability to take on more risk and financial risk, downside risk as well? So I would say lack of those things is a barrier that we'll work with them to address.

Another common barrier that we see is often the patient panel size, and this is, you know, more true obviously for the independent providers relative to the large health care systems. They may be too small to take on financial risk on their own without, you know, coming into some sort of bigger

\(^{37}\) Electronic medical record
model, or they might not have the economies of scale to do some of the population health management that we'd like them to do, at least not without a partner of some sort.

And then another barrier that I would highlight can sometimes be what I'll call local market dynamics. So, you know, on the one hand, you have the small providers who have, you know, some challenges, but then on the other hand, you may have a very large dominant, you know, monopolistic, if you will, health system in a market. And while they have the right economies of scale or the right ability to take on financial risk, they -- if they're not sort of interested in, you know, kind of moving to more of a risk-based arrangement, they often don't really have to, right, because they're a must-have provider in terms of the health plan's network. You know, there isn't that same sort of feeling of gee, I need to, you know, be engaged in a risk-based arrangement if I want to remain in the network, because they know that plans need them in the network. And that's not to say that there
aren't plenty of large, you know, dominant provider systems that are participating in these models, but we do see that as, you know, sometimes a barrier to getting those larger systems on board.

So to address the second part of the question in terms of how do we, you know, structure financial arrangements, I think generally speaking, you know, there's the financial piece but there's also the resources or the enablement piece. So as providers can take on more risk, there's the opportunity for more reward. I can't speak for, you know, what other payers are doing, but I think generally as providers take on upside and downside risk, we share more of the savings with them. And so we generally work with providers to put them on a glide path, right, so providers that want into the spectrum may need some more hands-on support from us, maybe that software, maybe that's help with care management or reports on care gaps and, you know, we can give them not only, you know, financial incentives but some of those resource incentives that help them
move along the glide path towards greater risk and greater reward over time.

And then at the far end of the spectrum, there are providers that have already made their own investments in this infrastructure and staffing and so forth, and they just want to be, you know, able to do better or to, you know, to get greater incentive to make those investments pay off. And so what they'll need from the health plan is data, the contract, and they're sort of ready to go.

And then maybe I'll just wrap up and say, you know -- and this sort of gets to one of the questions that I think just came up -- that said, our experience sort of suggests that at some point, there's sort of a saturation point or a point of diminishing returns in terms of provider participation or in terms of patient attribution in the models. And, you know, maybe this will change over time but, you know, generally speaking, the more providers or patients you get into these models, the more cost savings you see and so forth. But at some
point, an extra provider or an extra panel of patients doesn't really equal the same sort of benefit or cost savings, and maybe that's because you reached a point where all of your sort of willing-to-be engaged providers are in, the pool or the providers that are left are just sort of too small to make a difference or, you know, not really ready to be engaged. And so we probably need kind of different solutions, and I don't know what those are, but we probably need different solutions for that last x percent where to date we see that getting them in isn't making the same difference as the first, you know, y percent is.

CHAIR CASALE: Great. Thanks, Jennifer. Gail, your thoughts?

DR. WILENSKY: About -- I was trying to think back when I had initially thought it was time to limit the number of variations and decide how to define value-based payment and move on. And I think it was about 2017 or 2018. My inclination is it's time for at least the public payer, Medicare, to make some
decisions about how best to measure value-based payments, implement that, and stop having quite so many variations. When I stop to think about the burdens we must put on individual providers, physicians and nurses, and other provider types or institutional providers, I occasionally cringe.

So I think that it has been important to try to increase and improve our knowledge about how best to redefine some of these concepts, but I think maybe it's time to do it. And that in and of itself would allow for a lot less burden on those that are providing care. Obviously, there will be points of time where there will be an agreement that some concepts need to be redefined or changed, and we should do that.

Based on my earlier comments, it probably won't come as a surprise to say I am much more comfortable having standardization of the component parts than what they have to all add up to where I would allow for more variation for all sorts of reasons because of state of knowledge, state of practice,
attributes at the part of the country, or interest on the part of the beneficiaries. But I think having more standardization is the direction we need to move.

CHAIR CASALE: Great. Thanks, Gail. Emily, your thoughts on provider-level barriers and thoughts on payment structure?

DR. MAXSON: Sure. I definitely agree with a number of the comments that Jennifer has made, especially that many providers need help to transition to value-based care and that entry-level access to claims-based data is insufficient. The data and the insights you can get from it are pretty inaccessible to many who seek to transform care and also essential to stratifying appropriate clinical initiatives.

I think one thing that I'd like to really emphasize is what happens when you try to bring specialists into Medicare shared savings programs and other non-hyper-focused specialty-oriented APMs. It's really difficult to assign accountability to specialists who participate in a Medicare shared savings
program ACO, because most specialists are participating in care but not driving it. And they impact total cost of care, but they're not quarterbacking it and because attribution is assigned at the NPI\textsuperscript{38} level, if you take specialists into traditional total cost of care models, you end up accountable for patients you are literally managing end to end, and lots of patients really aren't managing end to end. So think about for that example, escalations in the frequency of specialist visits for nephrology and oncology patients who are undergoing an acute escalation or episode, right? You're going to have plurality of services in a specialist's hands even if someone else is following their blood pressure, their coexisting diabetes, et cetera.

And so, I think the more we can anchor to primary care practices who are best positioned to quarterback the total cost of care, the more successful we'll be, which just means it is important to empower high-value

\textsuperscript{38} National Provider Identifier
referral and specialist management. We need to leverage all available data to help patients get the highest-value care possible when they leave their PCPs' offices.

So, I think Jennifer and others really covered the need for workflow redesign and a really different take from practices who are totally optimized to take in patients and care for what comes into their offices and not really hone towards population health and understanding the attributes of the patients who aren't coming in. And so, we need to overcome those barriers. It's years and years of training and practice to operate a business, and the business of health care is complicated, and shifting towards taking care of a total cost of care of an entire population is quite different.

The more that we can incentivize innovation in the form of advanced payments or starters, there is also great fee-for-service. And I don't necessarily think that fee-for-service is a four-letter word. I think that there can be really productive fee-for-service
when the design is optimized and oriented towards what the patient needs to get out of it. I think annual wellness visits are a great example of transitional care management, are really high-value visits that can prevent readmission if done well. And we've made a lot of progress with care management. And so I think when we do appropriate design of services that are reimbursed, it is easier for practices who are trying to survive in both models to leverage the fee-for-service to the best benefit of the patient population. So investing more in primary care where we can then expect dividends in the form of reduced emergency room utilization and unnecessary hospitalizations and readmissions seems to be in our best interest.

CHAIR CASALE: Great. Thanks, Emily. Looking at the time -- and this has been terrific discussion -- I'm going to move to the next question which I think is a really important one and be sure we get everyone's input.

So, equity is a focus for us here
and was actually our last theme-based meeting along with social determinants of health. So, in your opinion, what are the potential equity implications of holding APM entities accountable for total cost of care in population-based models? And asking that both in general and for beneficiary subpopulations such as historically underserved populations and individuals with chronic conditions. So, with that, I'll start with you, Judy.

MS. STEIN: We certainly haven't found the key to fixing our inequitable society and certainly not our health care delivery system. And I am concerned that more and more diversity and how one receives one's health care and how you define quality within those health care models will not best serve vulnerable people with chronic conditions and underserved folks. And I know that Commonwealth and Kaiser and others have shown that Medicare Advantage has, in fact, not demonstrated, in fact, that it serves those populations better. And our experience as attorneys, mostly for people with longstanding
chronic conditions, shows that, in fact, people who have such conditions often have problems with health insurance. They're not favored, if you will, to continue getting the care they need for the period of time and with the intensity that is required. And I think that reality ought to be seriously studied as these models are built so that we know that we're incorporating the needs of people who need perhaps more intense care and/or care for the longer term and more health education.

CHAIR CASALE: Great. Thank you, Judy. Emily.

DR. MAXSON: I'd like to start with the Medicare HCC risk adjustment model. There was a great paper by Brian Powers that was published a couple of years ago now that the systematic evaluation of how our Medicare HCC risk adjustment model, and many like it, systematically underestimates the risk of Black patients versus white patients, and that is at the same HCC risk score. And for those who
aren't deeper initiated in this, the HCC risk adjustment methodology is actuarial, and it takes into account all of the patient’s and the patient population’s diagnoses that have been seen in the calendar year, evaluated, and billed. And so what you see is that because of delays in diagnosis and health care in-access that's really borne by the 400-plus years of structural racism in our country, at the same HCC risk level, a Black patient is much more likely to be sicker than the white patient. And it's just true that a lot of organizations use HCC score as a stand-in for clinical acuity and absent of any other indicator and use that score to identify and stratify patients for additional clinical services and benefits.

So I think a first step would be that we really need to adjust our risk adjustment methodology to account for this finding and potentially reduce disparities in the provision of extra clinical services and attention to patients by risk adjustment level.

I've been encouraged by the progress with the Area Deprivation Index. I think it
might be a step in the right direction as a payment innovation, and I'd love to see more in payment innovation that honors that social complexity is expensive but also makes further downstream resources available rather than simply bonusing up the care of socially complex and economically disadvantaged populations.

So the more that we can actually care for these populations by making social determinants of health screenings more mainstream, potentially paying for them with good fee-for-service and connecting patients to resources -- a lot of good data on community health workers, how can we incentivize that and make that mainstream here. How do we pay for the downstream resources once we identify patients and need and embrace that and advance payment models?

CHAIR CASALE: Great. Thanks, Emily. Gail?

DR. WILENSKY: Yes. A few closing thoughts. I was a little surprised by Judy's comments with regard to the use of Medicare Advantage and its various names by lower-income
individuals since for a long time, and to some extent still today, minorities and lower-income individuals have disproportionately made use of Medicare Advantage as a way to increase the benefits that were provided, and as a Medicare Advantage proponent for its potential ability, not always realized, to integrate services in a way that is even more complex for the traditional Medicare programs to do. I have been happy to see that.

A comment with regard to the social determinants of health and how to try to bring them more into the Medicare program, or the Medicare program more into the concept of social determinants of health. You decide which way best to go do it. It would be enormously helpful if we could see some significant consolidation of the many programs that exist sponsored by the federal, or federal and state, or federal, state, and local governments into a smaller group of services. There are many overlapping and competing programs, and they make it much more difficult and complicated to unify the services that we
are trying to provide to needy populations. I think our potential for being able to incorporate the social determinants of health or at least some aspects that are most directly related to medical care would improve considerably if we were able to do that.

It is frustrating to me that it's an issue that I know I personally have been speaking and writing about now for 30 years, and I do not see a lot of evidence of movement in that direction and some of this funding so much better and more wisely if we could find a way to have more rational consolidation. I'm open as to who gets to be the consolidator.

CHAIR CASALE: Great. Thanks, Gail. Jennifer?

MS. KOWALSKI: Thanks. Yes. I mean I'd like to kind of loop back, I think, related to what Emily was talking about, you know, how do we think about the various levers that might exist to drive improvements in health equity through these total cost of care or value-based payment models? And I think to start, we first probably need better, more comprehensive, and
more complete data to know where the inequities, you know, truly exist and how to best address them in the first place. I think as plans, as, you know, CMS, we probably have good data on the communities that we're serving, disparities at the geographic level, but I would say we really don't have nearly as complete data as we'd like to have on individual-level data so even race, ethnicity of members and health plans or, you know, better information about health-related social needs. There's certainly movement to collect, you know, whether it's the Z Codes, but I think that's still pretty spotty.

So, you know, how do we encourage, you know first, better identification of where the needs exist at the individual level and then actual, you know, improvement upon those health inequities within value-based care models? You know, I think one thing you can think about is how do you include some measures around this in the so-called kind of quality gate of your total cost of care models? But I think we also have to be careful to balance
that with how do we ensure that we're not unduly penalizing and disadvantaging those providers who may see a greater share of patients who have those health-related social needs or who are seeing populations who are historically underserved, have more chronic conditions, and so forth? You know, how do we ensure that they're not being sort of downgraded, not because of true performance but because of inequities in their own practices?

And likewise, we have to think about, you know, what's fair to ask primary care providers to take on. Some things may not really be within their capability to do within the medical setting when we think about this broader set of social needs. You know, large health systems have the infrastructure in some cases or want to have infrastructure to address these things. Smaller practices, independent physicians, they just may not be able to do those things.

So I think we have to think about what's the right structure, what's the -- or what's the right flavor to improve health
equity and what circumstances do we want providers to be accountable for some of these things and to take the lead, when might it be the health plan, when might it be a partner or a vendor, when might it be the government or some other entity that's situated to be responsible for these things. So I think it is a goal that we're all working toward for sure, but we need to be thoughtful about, you know, where the resources are and how best to deploy them.

CHAIR CASALE: Great. Thanks, Jennifer. And I realize we're over time but if our panelists -- we'd like to -- this discussion has been really rich, and we'd like to continue for another 15 minutes if all our panelists are available. If so, maybe I'll open it up to PTAC members if you have any questions on this topic of equity.

DR. WILENSKY: I can stay on for about another five minutes --

CHAIR CASALE: Okay.

DR. WILENSKY: -- but I need to pick up another Zoom.
CHAIR CASALE: Okay.

MS. STEIN: Same. I have another call. I can stay --

CHAIR CASALE: Okay.

MS. STEIN: -- for another five or so. Thank you very much.

CHAIR CASALE: Okay.

VICE CHAIR HARDIN: I was just going to follow on Gail's comment about consolidation, Paul. I think that's such an interesting comment nationally. So I work deeply with underserved and marginalized populations, and the proliferation of organizations trying to meet social needs, and the under-financing and the under-resourcing of those organizations is a real issue. And the coordination into integrated networks with supportive leadership and contracting and financing is so important as we look at meeting equity and meeting social needs in our communities. So I just wanted to follow on that comment. I felt the consolidation piece is critical from what I'm seeing on the ground in different communities. I don't know if you
wanted to say any more about that, Gail.

DR. WILENSKY: Just as somebody who has worked with a variety of these organizations because of the various hats that I have worn over the years, it has come up numerous times, the concept that there are overlapping programs that tend to make dealing with as conceptual -- broadly conceptual idea of the social determinants of health more complicated because they have their own constituencies, they have their own groups that they have to report to in terms of a power structure, to use a phrase, that if there could be more consolidation, it would allow for a much better integration. And since the whole concept of social determinants of health really is to integrate the medical and social service components that are necessary to improve health and well-being, it is part and parcel of the objective.

So it is very hard because each of these groups have their own political constituencies, or they frequently will have their own interest groups who support them, and
the political, both "big P" and "little p" challenges of trying to have consolidation is formidable. I've been at a couple of groups that have made faint-hearted attempts to try this, but it really is keeping us from accomplishing the goal.

Many people for many reasons have commented it's not that we don't spend enough money, it's how we spend it and how the care is provided that gets in our way. I think there is widespread agreement across people of very different political persuasions. It's figuring out how to crack this that has proven so challenging. So thank you, Lauran.

VICE CHAIR HARDIN: Yes. I completely agree.

CHAIR CASALE: Any other -- and I know we're pretty much out of time. Any PTAC members' last-minute questions for this great group of panelists? Okay. If not, I want to thank, on behalf of the Committee and our audience, each of you for your insights today. We're grateful. You've certainly been generous of your time and sharing your expertise. And
we -- if you can stay on for the remainder of our meeting, we would certainly welcome you and again, want to thank you all for participating.

So, with that, I'm going to move to the public comment period. We --

MS. STEIN: Thank you very much, Paul and everybody. I really appreciated participating. Thank you very much.

CHAIR CASALE: Thanks, Judy.

Thanks, Jennifer and Emily.

* Public Comment Period

We have one person who has signed up for public comment. I will introduce them, and then our moderator will unmute so that you can speak. So I want to open up to Sandy Marks, Senior Assistant Director of Federal Affairs at the American Medical Association.

MS. MARKS: Thank you. So last fall, CMS Innovation Center staff asked AMA to identify barriers that prevent ACOs from partnering with specialists and ways to encourage specialists to engage in an integrated model like an ACO without financial risk-sharing becoming a point of contention.
They also wanted feedback on related questions dealing with attribution, overlap, and improving care coordination and equity. To address these questions, we drafted a payment model proposal which we are calling Payments for Accountable Specialty Care, or PASC. Here's how it would work.

Specialists would enter into voluntary agreements with ACOs to improve care for ACO patients with certain health conditions in a way that would help the ACO meet its overall quality and spending goals. For each patient referred by an ACO primary care physician to a specialist with a PASC agreement, the specialist would get an enhanced condition services, or ECS, payment to help support comprehensive diagnostic workups and use of patient-physician shared decision and clinical pathways to arrive at an accurate diagnosis, patient education about their condition, treatment plan, and self-management to improve outcomes and prevent exacerbations, and assistance to get tests, medications, or therapies that require scheduling or prior
authorization.

With concurrence of the primary care physician, additional payments called continued ECS payments and special ECS payments would be made if the specialist needs to continue treatment after the initial month or for patients whose care is significantly more challenging due to social determinants or other factors.

Specialty societies and organizations representing ACOs would help develop a standard template for the PASC agreements specifying how appropriate patients for referral to the specialist would be selected, how specialists would coordinate with primary care, quality or utilization measures related to the condition and target performance levels, and data the ACO would provide to support care for the conditions listed in the agreement.

Much more detail is provided in a discussion paper that we've shared with CMMI. Some benefits of the PASC approach are that more specialists might decide to participate in
ACOs, more ACOs would engage with specialists, primary care physicians would have a basis for choosing specialists for referrals and getting feedback from and coordinating care with them. Performance measures would be appropriate to the conditions in the agreement so there would not be repayments tied to factors that specialists cannot influence.

We'd be happy to share the discussion draft if you'd like to learn more. Thank you.

CHAIR CASALE: Thank you, Sandy. So I'll check with the host before we move on. Are there any other folks who wanted to contribute?

MS. AMERSON: No additional comments.

CHAIR CASALE: Hearing none, that is the end of the public comments. We are now going to take approximately a 15-minute break and then return for the Committee discussion, so we'll plan to return at 3:00, and we'll begin our Committee discussion at that time. Thank you.
(Whereupon, the above-entitled
matter went off the record at 2:41 p.m. and
resumed at 3:02 p.m.)

CHAIR CASALE: Thank you for returning.

* Committee Discussion

Now, the Committee members and I are going to discuss what we have learned today, as well as from yesterday, from our guest presenters, the roundtable discussion, the background materials. As you know, this two-day meeting is part one in our three-meeting series on population-based total cost of care models.

After the series, we will submit a report to the Secretary of Health and Human Services. So, the report will include our findings from the June and September theme-based discussions as well.

But while this topic is fresh in our minds, we want to discuss what we learned yesterday and today about definitions, structural issues, and opportunities related to designing population-based total cost of care models.
There's a lot of information to sift through. For our Committee members, please check the pocket of the binder for the meeting materials. There are potential topics for our deliberation.

And then, of course, we can begin the discussion either raising your hands through Webex or simply start with your comments.

We had this list up yesterday around potential topics. And I think we don't need to keep that list up, as we all have a hard copy of the information.

And we'll plan to go to approximately 3:45 in our discussion and deliberations.

So, let me open it up to PTAC members for any initial thoughts or comments on the discussion either from yesterday or today or on the combination of them. Hey, Larry, yes. You're on mute maybe. I don't know. Still on mute.

(Pause.)

CHAIR CASALE: While Larry's getting
it off mute, Bruce, do you have a question or a thought?

MR. STEINWALD: So, my broad question is kind of related to the fact that Medicare Advantage came up several times in both yesterday and today's discussion. And I think Gail Wilensky even said that she was a big believer in what Medicare Advantage could be. I don't think she said it quite that way. But she likes the concept but doesn't like the reality of it all is my interpretation.

So, my question is, how would a total cost of care model that was sufficiently well educated, had good sources of data, had good methods, had social determinants of health as one of its objectives, how would that differ from a Medicare Advantage plan that was designed to focus on total cost of care?

And it seems to me -- and I wonder if we're going to go in a direction, is that a direction we could consider going in?

CHAIR CASALE: Comments from other Committee members on this --

MR. STEINWALD: Or not.
CHAIR CASALE: Yeah, I don't know. I was going to sort of not pick on, but sort of ask, Lee, given your experience, do you have any thoughts as to whether this is a direction we might want to even consider or whether that's not really --

DR. MILLS: Well, a lot of reach conversation and robust models around Medicare Advantage out there. It's really in where some of the most innovative things pushing the edge of what's appropriate as medical benefit and what's effective, especially with social determinants, is being done.

So, I think the call this morning for less confusion and some standardization around it makes perfect sense. I agree with the consumer perspective of having helped my parents weed through that marketplace, which is very confusing and challenging.

But we don't want to lose view or grip of it's that very mission to provide all Medicare benefits plus additional things, often at no cost to the beneficiary. And it is, it's creating innovation.
So, I'm not sure what the parsimonious choice in the middle of all that is. But it was points well made this morning.

DR. PULLURU: I think on the provider network side, the salient difference is often access, the ability to access.

So, Medicare Advantage is typically much, you know, can be a narrower network, particularly in, when the provider takes on, or when the payer takes on risk versus Medicare. So, I think that -- and then the way the attribution works. So, you know, that's a salient difference that we would have to solve for.

And then the other difference would be, I believe, regulatory, you know, Medicare Advantage functions with the ability to have some waivers in place rather than things that allow for it to integrate care. And maybe that is a model that we look at and say, you know, are some of those components something that should translate to larger Medicare?

And, you know, the question I asked about goalposts, I think that maybe those are
things we think about as goalposts in order to lead, you know, sort of lead the country to that sort of goal in 2030.

CHAIR CASALE: Thank you, Chinni. That's helpful. Larry, you're still on mute. You're still on mute.

DR. KOSINSKI: I'm still on mute?

CHAIR CASALE: No, now you're off. Now you're off.

DR. KOSINSKI: I'm off. I'm talking into my phone. It's got to be right.

So, I really enjoyed the two days. I learned a lot. And what I have as takeaways in my mind from what I heard specifically today was that total cost of care can be defined, probably should be defined, that episode-based models should not just be eliminated but should be, a way should be figured out to have them nesting inside larger models.

And then the third thing that I think is important, it came out yesterday in our discussion around high beta when we were talking about my high beta concept, and it came out again today, is I'm struck with our future
as designing episode models around patients rather than around types of providers.

And that's challenging, but it would -- if we could succeed in doing that, we would bridge that gap between primary care and specialty care and designate responsibilities accordingly.

It's a big task. And maybe it's aspirational more than reality. But those were my three takeaways.

CHAIR CASALE: Thanks, Larry. Very helpful. Other thoughts from Committee members on what you heard over the last two days or anything specifically today?

DR. PULLURU: I think the other thing to add to what Larry said that seemed to really stand out is that yesterday and today, to limit the subset of APMs and to harmonize them seems to be a very common theme in that sort of movement to total cost of care.

CHAIR CASALE: Yeah, I agree. And then bringing in the beneficiary perspective, the thought, you know, the challenge around them understanding if they move into a model,
you know, what that model is, again, not even talking about Medicare Advantage and all the plans there, but just thinking through the advantage of having a smaller number of larger models, thinking of the education piece, because we know certainly the challenges around engaging the beneficiary understanding around whether they're in any kind of model on the fee-for-service side, whether it's a bundle or a larger population-based model.

Other comments? Walter, did you hear anything on physician incentives that was interesting to you or thought-provoking?

DR. LIN: Not so much on that, Paul, but what did strike me from today's presentation, especially Christina Severin's from C3, and this actually kind of gets to Bruce's question about Medicare Advantage, I think one kind of key tool that Medicare Advantage plan providers have access to is real-time, robust data.

You know, you should show that slide of all the data sources integrating into a data warehouse, you know, the claims data, the ADT
data, the labs data. And it just struck me how important that was to help these new payment models succeed, you know.

And I think it's almost kind of --, I mean, that without which it's really hard to improve care and, at least in a timely way. And this was also our experience when we were involved with Model 3 BPCI, part of the BPCI classic program.

It was kind of really hard to improve care when you're getting your data nine months later, and, you know, you have multiple true-ups before you get your final data.

So, anyways, I just -- that was really striking just how important data is and kind of -- I'm not sure how we solve that problem, but I just wanted to raise that point.

CHAIR CASALE: Yeah, thanks, Walter. So, it was an interesting discussion.

I know we've referenced carve-out several times in our thoughts around total cost of care. And I think several of the speakers raised the concern around how to use carve-outs and how unintended consequences in terms of how
providers or others may determine what's in and out of a carve-out.

And so, again, I think this gets back to this whole, one of the questions around engaging, you know, having payment models inside of total cost of care model and how that would work.

MR. STEINWALD: Yeah, you remember Mike Chernew's example of waste as an asset? And that was one of his points is, how do you allocate the elimination of the waste? And if you have a carve-out, they are going to try to take credit for as much of that as they can and take it away from, you know, the basic plan.

I liked also, though, the notion that with the right platform and if it's big enough that a lot of these decisions can be made organically, that the decision of whether to have a nested model or some other way of accommodating a certain patient subpopulation can be made within the entity as opposed to imposed on the entity.

At least at the conceptual level, I very much like that approach much better. And
I'm interested in what others have to say.

DR. WILER: Bruce, I agree with you. I found a number of things interesting over these last two days. But one thing that kept bubbling up for me was this idea of essential versus ideal elements that would need to be in future state of either programmatic development or consolidation in the marketplace.

What I heard around essential elements are, one, access to data as was previously (audio interference) access to data which Walter previously described.

In addition, I heard often around this idea of a non-fair playing field with programs being voluntary to participate, as opposed to involuntary, and incentives that keep high performers in the game, and that any program to be successful needs those elements.

CHAIR CASALE: That's great, Jen. Thank you. Other comments on what you heard over the last few days or themes you'd like to bring out?

DR. KOSINSKI: Can you hear me?

CHAIR CASALE: Yes.
DR. KOSINSKI: A couple of great terms that I wrote down when I heard them, pharmaceutical stewardship. And there may be a way of compensating a provider group for pharmaceutical stewardship. I thought that was an interesting thought.

I also thought that I think Emily Maxson I was very impressed with. And she said most specialists are participating in care but not driving it. And there's probably a lot of truth to that.

And then what still permeates everything, what we heard from Liz Fowler in the beginning, can we bring something together with CMMI, MedPAC, and PTAC, how do we define transformational care, and how do we define success?

Just things to remember, some very good concepts, though. I love the pharmaceutical stewardship.

DR. PULLURU: One of the things that I thought was interesting was the first speaker today, Sherry, who spoke about fee-for-service and, you know, just thought about things in a
way that I hadn't thought about before. You know, it's a four-letter word, and so the way she articulated that.

And I think that one of the things that we can potentially think about as a Committee as well is, you know, there's total cost of care. And, obviously, we all want to drive there, define it, social determinants of health, equity.

All these things need to be worked on. But also, what are things that could be accretive to fee-for-service that lend itself to building up infrastructure for total cost of care?

Like someone today mentioned increasing care coordination codes and decreasing just the one-off sort of fee-for-service codes, because I think that would incent provider and organizations to sort of build that care team.

CHAIR CASALE: Yeah, Chinni, I agree. I was struck -- she did articulate that whole fee-for-service quite well actually.

I think we all sort of knew those,
you know, that we often say, oh, we need to move from fee-for-service to value-based. But given what's going -- you know, sort of not promoting fee-for-service but understanding some of these sort of strengths of fee-for-service as it relates to simplification and et cetera. And --

MR. STEINWALD: But she left -- I'm sorry. Go ahead.

CHAIR CASALE: Yep, go ahead, Bruce.

MR. STEINWALD: She left out something very important, which is the other countries manage the level of fees much better than we do. And we have this paradoxical situation where the providers in those other countries that use fee-for-service would love to have Medicare's fees.

CHAIR CASALE: Yeah.

MR. STEINWALD: And yet, within the context of the U.S., Medicare is seen as a stingy payer.

And so, there's a lot of things that are different between those other systems than ours that result in our spending much more per
capita than they do, and that includes the Medicare population.

CHAIR CASALE: Yeah, no, no, I agree. I just -- but to Chinni's point, are there sort of strategies within fee-for-service that help to build this infrastructure that as, you know, for organizations or practices as they prepare to move towards more of either total cost of care or other kind of payment model, and recognizing Larry's comment, which is an important one, about, you know, any burden to the beneficiary on certain fees on care management and others?

But it often will at least get the, begin to get the providers in the mindset around activities for coordination of care, which, of course, is foundational to move to any kind of, you know, alternative payment.

MR. STEINWALD: There's nothing wrong with the concept of paying people for what you want them to do, which I think is what she was getting at.

But, you know, the other side of that coin, and I think she mentioned that too,
was, well, maybe you pay less for the things that don't take you in the direction that you want to go.

But in our system, it's been very hard to pay less. It's not so difficult to pay more for some things, very difficult to finance the payment of more for some things by paying less for others.

CHAIR CASALE: Other comments and thoughts? Jay, do you have any thoughts on what you’ve heard today?

DR. FELDSTEIN: Well, actually, almost what I didn't hear today that I thought was rather interesting, and maybe, you know, the group can comment on it.

You know, for the last 15 years, we've lived in a relatively low inflation environment. And even though people would always point to health care being, you know, higher inflation than CPI, you know, we're entering a phase of hyperinflation.

So, in terms of what our ability to

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40 Consumer Price Index
pay for in the upcoming years in models, social
determinants of health, you know, I think we
need to be cognizant from an outcome
perspective of what works and what real value
is, and that we just need to be cognizant of
that moving forward, because I don't think --
you know, the health care dollars are going to
compete in a different space moving forward to
a degree they haven't in the last 10 to 15
years.

And I think everybody needs to be
cognizant of that whatever model we choose or
push forward, what is the real economic impact.

MR. STEINWALD: Jay, hyperinflation?
Yikes.

DR. FELDSTEIN: We're just going to
be in an inflationary environment that we
haven't seen for a while, and we haven't
operated in.

DR. PULLURU: Yeah, I mean, that's
brilliant. And I think that it will also lend
itself to increased payment for providers, not
just physicians I'm talking about, but more
ancillary medical staff that need to make the
function, need to make the system work, because post-COVID, we've seen that already.

DR. FELDSTEIN: I mean, we've lost, you know, close to 25 percent of the workforce, I mean, from a nursing shortage standpoint, physician staffing shortage standpoint. You know, just to have the individuals in place to deliver the services is going to be a challenge in a lot of systems.

CHAIR CASALE: Yeah, it's a great point, yeah. It may go beyond the scope of our Committee, but important point though --

DR. FELDSTEIN: Well, you know --

CHAIR CASALE: -- in the context of --

DR. FELDSTEIN: -- as we have two more --

CHAIR CASALE: Yeah.

DR. FELDSTEIN: As we have two more sessions --

CHAIR CASALE: Yeah.

DR. FELDSTEIN: -- you know, there may be some discussion for -- with a panel.

DR. PULLURU: I think the earlier
call for having actuarial representation at both the June meeting and September meeting, you know, makes so much sense in light of some of these pressures.

CHAIR CASALE: Yeah.

MR. STEINWALD: You just reminded me to request a -- thank you for saying that. Could we get ASPE or NORC to provide us with the specific responsibilities that the actuaries have? I know it's set forth in legislation, but it might be expanded upon in regulation or through other methods.

I know that they have the certification responsibility, but I don't really know much more than what we've talked about today, which was enough. But we could learn more, I think, if we had the right source of information.

CHAIR CASALE: Yeah, I'm sure they can provide that to us. Josh, any thoughts? I know you've been listening closely I'm sure over the last couple days.

DR. LIAO: Yeah, no, I think I echo a lot of what's been said. I've been quiet now
because I don't disagree.

And I think one of the things, and I mentioned it a few times in our comments even yesterday, is, you know, just this thing that, I hope all of us are clear-eyed about this idea of coordinating and nesting requires imposing some structure that takes away flexibility.

So, I kind of triage every comment that I hear about we need to let people pick which conditions and which patients and how much risk to take on and how to create the network. That is -- at some level there's a tension at least with that in saying we want to lay these tracks down around this episode or that thing would have been a broader model.

And at the risk of perpetuating that point, I don't think there's a one-size-fits-all there. But I think as we test models, it's important just to keep that top of mind.

CHAIR CASALE: So maybe we're asking the wrong question about how to engage providers, getting back to the earlier point, how do we engage patients, because, you know, that, you know, if you have a model and you
engage the patients then that will drive and allow the flexibility.

DR. LIAO: I think so. And I think, you know, hope this is accurate. But I would imagine if we looked at every ACO in the country, there are differences, right, for the patient population and for the environment.

And I think I took away from today the importance of making sure people know what they're getting, the beneficiaries and individuals. And yet that variation, if we want that, that's what some of the current state is.

The moment we start like appending, you know, an episode model with requirements and, you know, specifications, that provides consistency, but there's limitations there, too.

CHAIR CASALE: Yeah.

DR. WILER: Josh, I think your comments are really important. And, you know, it makes me mindful that the stated goal that we heard from CMMI leadership was from the patient lens around participation, 100 percent
participation of patients in value-based arrangements.

But what about the provider community? Our models are focused on providers. Is there the same expectation that providers are 100 percent engaged? They seem to be to your description, Josh, right.

Potentially from what we've heard of polarity, it's not possible to have both flexibility and 100 percent participation of those two entities, much like the comments previously made before that one entity's waste is another entity's opportunity.

DR. LIAO: That's right. And to maybe still turn back to this idea of the essential elements here.

You know, I think this is an essential consideration I would say, because I know we haven't been talking about it the last couple days.

But in my work from my perspective, you know, when we think about models, there are voluntary models, which tend, that tend to kind of be related to you can choose, again, and not
and that gets, Jen, to your point about what
the provider has, you know, if there's 100
percent participation.

You can mandate participation,
right, and you can get 100 percent
participation. It creates a whole host of
other issues all of us are aware of.

And so somewhere in what we're
talking about the last couple days, there is
some rough analog to that. How much do we want
to impose on the payment models to get
providers and, you know, patients and
beneficiaries engaged? And there's a tradeoff
somewhere there. So --

CHAIR CASALE: Great. Thank you,
Josh.

DR. PULLURU: You know, one thing
that we might want to think about in our
models, and that was a really good point, Josh,
something I haven't thought about personally,
is when you do this nesting, and to Josh's
point there's less flexibility, but is that
less flexibility because of the attribution
methodology?
I mean, should we take a step back and say that, you know, maybe there needs to be some revisiting the attribution methodology because it does lend itself to those swings and making it more difficult to induce harmonized models?

DR. LIAO: I think just reacting to that I would say, you know, one of the comments that came up from the earlier part of our session today was this idea of, you know, APMs you have to attribute, right, in some way. And there are some challenges there.

And I think it’s been well documented when you have beneficiaries who are receiving care under bundled payments and ACOs, you know, that attribution thing becomes, who’s responsible for the care becomes the challenge. Those are the types of challenges I think will come up if we do nesting or coordinate plugging in, you know, models within each other.

I'm not saying it's not an issue today. But part of the flexibility that exists in ACOs and other population-based models that exist now is that you don't need to have that,
right, that an ACO can decide as that accountable entity, I will spin up this service line, this initiative, and it will involve these specialists and these parts of the clinical team.

But it creates less feasibility. So, some comments from earlier today I think were very appropriate in that point.

I think kind of a related point, Chinni, is that when I think about it, one of the premises of having a nesting of the models, I think it was Valinda who said this, you know, I think -- she was just pretty clear about it. She said I think the way to engage specialists is through an episode-based model. And we can debate that.

But if we believe that that's the way to engage specialists, then not having it leaves that uncovered so to speak, right. If we think there's a better way, that's what I'm hoping the sessions that we do, you know, going forward, and through PTAC will address, because that's the need to test to challenge the question to agree with or not.
DR. PULLURU: Because one of the challenges that we had, you know, we had about 100,000 patients in a Medicare ACO. And, you know, quarter upon quarter I saw -- I saw almost a quarter of our patients swing, so 25 to 30 percent of our patients swung in and out of our ACO attribution, because we had other hospital systems that, for example, had cardiologists. And they would gain that plurality and eventually swing out.

And so, you know, if we're engaging specialists, and having that sort of structure change, could help better engage specialists in that ACO model.

CHAIR CASALE: Yeah, I agree. I think that's an ongoing question. Throughout the June and September, we need to continue to think through important questions, and do we need these additional models or not, and in what areas? And if we don't need them, then what are the other ways that would work to engage, you know, specialists in these total cost of care models?

DR. LIAO: Yeah, I think looping
back to an earlier comment, I think engagement is one thing, communication, and those comments about participating versus driving. Like we talked about this, but accountability I think is really important. I think we have an opportunity in the forthcoming meetings to think about it.

As we hear about delivery models, yes, it's the nuts and bolts of what's happening and who's doing what. But also, if we can get underneath that to say who really assumes accountability, who feels that they have accountability over this part of care, I think will be incredibly important, because you could imagine two worlds, one in which you, both in which you engage specialists, but one you imply that attribution proscription, so it's Dr. A or Dr. B or Clinician C.

And it will if you don't do that. And I think that just takes us to very different outcomes.

(Simultaneous speaking.)

DR. LIN: On that point, you know, engaging specialists, I think it was Emily
Maxson from Aledade who said that really their focus is on having the primary care provider drive the care as opposed to the specialists.

I know that in my own clinical practice, I feel like the specialists that I refer my patients to is a reflection of the care that I provide my patients. And so, I try to be very thoughtful, especially since, you know, I take care of a very frail, elderly population where goals of care discussions are really important. And not all specialists are kind of tuned in to that particular aspect of the frail elderly's care.

And so, you know, just the thought that, you know, I think Valinda did say calculating specialists or having somehow primary care providers be very involved with kind of the specialist spend I think is an interesting idea.

MR. STEINWALD: You know, as an older person, I'm, you know, a consumer of health care services. I'm more than just an analyst.

And I have two primary care
providers. One is in general internal medicine, and I get an annual physical and occasionally other services. My other primary care provider is an orthopedist. And he's the person I'm likely to see more often during the course of the year. So how do you reconcile that? I don't go to my primary care internist to send me to the orthopedist anymore.

But when you're in a plan environment, how do you deal with a participant like me who sees a specialist because that's where most of the need arises and doesn't see the primary care doctor all that often?

DR. LIAO: I don't have an answer for that. I would say -- but I think as a general internist and not an orthopedist, I don't have an answer to that.

But I do think it raises this, another point I want to highlight just for the discussion, which is that, you know, when we talk about beneficiaries or individuals receiving care under some form of accountability, that is neither at odds nor completely consistent with everything in their
care being under that, right.

So, imagine if, to use Bruce's example, one of his two clinicians was in a payment model, assumed accountability, but the other didn't. I mean, his care is under accountability, some of it, not all of it. Does it need to be? And how would you help connect those proverbial pipes?

And so I think we could be in that situation, because I don't know that it's just orthopedists. I think we've heard from multiple people, you know, nephrology, oncology. I mean, there are multiple specialties where that might be the case.

But if four out of my five clinicians are within a payment model or two out of five, is that good? Is that sufficient? I just think that's an issue we're pointing at also.

DR. LIN: Some ACOs, I'm not sure about Aledade, but some ACOs have kind of taken a page from the MA playbook and establish networks of specialists, right, within their ACO to refer to to address that problem.
CHAIR CASALE: But even with that, I think, doesn't the data suggest that for most ACOs, maybe 50 percent of the care is outside their ACO or something like that? I mean, it's a large percentage of the care that's actually within, you know, the providers in their ACO.

(Simultaneous speaking.)

DR. KOSINSKI: You know, one of the issues that arises there is hospital-based ACOs employ its certain sets of specialists. The patient really doesn't have a choice in who they're going to be able to go to.

And, you know, if you talk to a lot of commercial health plans, they'll tell you that this is an issue that they have a difficult time dealing with in some of their ACO population.

DR. MILLS: Yeah, I was going to make a similar comment, which is just the challenge of network, or to think of it another way, the challenge of geography in linking your specialists into any value-based paradigm, which is potentially in, you know, some very large urban centers where you have more
specialists than you need, it's easy to use the power of the primary care doctor's referring pen to a high-quality, lower-cost specialist network. It's very thoughtful and approaches care the right way.

But in the vast majority of geographies, that is not true. And you simply have to play the specialists you have access to.

So that gives rise to this idea of essentially there's, you know, there's individual sections of this total cost of care concept which are separately standardized and separately valued.

And in working in a given geography, there may be some subtotal cost of care model which is the best you can do given the parameters you have. And how that's valued and operated, of course, the devil is in the details.

DR. KOSINSKI: That's probably why you got 50 percent of the care being provided outside of the network.

DR. MILLS: Yeah.
DR. PULLURU: And particularly in areas where there isn't a wide uptake of APM models, it's in those areas typically, there aren't any specialists you can refer to that would be willing to take that on. So, it becomes that much harder.

DR. MILLS: Yeah. Now the, you know, Aledade and similar models have been successful because in the less urban, more rural, large tracts of the country, they are working with the only specialists they have.

But then they have the power of relationship with those specialists. And they are, you know, a large part of that specialist's incoming patient stream. And there's a relationship to maintain. But that's a harder tool to wield frankly.

DR. PULLURU: Well, and then it brings to light, you know, should incentives follow the virtualization of that or digitalization of that, you know?

For example, if you're looking at, you know, companies like Rubicon that have digitalized, you know, over 250 specialties,
you know, should -- right now the reimbursement for telehealth, you know, has a mandatory in-person care requirement.

And so that takes that geography and makes it sort of a stranglehold. Maybe we take that off, you know. And those are things to look at.

CHAIR CASALE: Other thoughts about today or yesterday or --

DR. LIAO: I just have one final, I mean, kind of appended to Lee's comment, which I think is that, you know, there are all these forces, right, that -- you know, if a sub-specialty group signs up to be a part of an ACO, they declared it in that participation that they're signaling some interest or a willingness to take accountability or partner in that care.

You know, the other way for groups like that to signal it would be to sign up, right, formally as a participant in a payment model, like BPCI, for example.

And I think going back to that prior point, like when you think about geography and
the supply of clinicians and groups and kind of factor in like the natural way this can happen, and Lee articulated some of those, right, if you have market share, if you have existing relationships, the one way around that, I'm not saying it's desirable, but it may come up in the next few meetings is, again, mandating participation for some total or sub-total part.

I mean, you can apply a very strong policy there. And again, there's a host of issues that come up there. But short of that, I think you're not going to get away from those unique market and geographical factors that Lee gave us insight to.

And so that in some ways is at odds with getting scale, either at the provider or the beneficiary level.

DR. WILER: We know, right, at the end of the day that unpredictability increases risk. Increased risk is, has already been a barrier to participation or an intolerance to participate. So, if that's not mitigated, it's hard to imagine how this 100 percent goal will be achieved.
CHAIR CASALE: That's great. We only have just a couple minutes. I just want to be sure. Any final thoughts from any of the Committee members on --

DR. LIN: Paul, one quick kind of aha moment for me from these two days was actually just from our last panelist discussion.

You know, we've really focused on kind of defining total cost of care with this meeting. And I just thought the whole idea of standardizing definitions around components of total cost of care while leaving some flexibility for each organization to choose those components and kind of have different definitions of total cost of care to remain flexible was really interesting. You know, and that's not something I had thought of before.

CHAIR CASALE: Yeah, I agree. I thought, I found that very interesting as well, Walter. And I hadn't thought of it in that way.

But it may be a way forward in terms of having flexibility and not a strict
definition of total cost of care that has to apply, you know, across, but have enough structure so that people understand what the definition is for that particular group.

MR. STEINWALD: Yeah, I agree, too. And I think it's maybe an avenue for us to provide some concrete information in our eventual report to the Secretary that makes a real contribution to the goal eventually.

CHAIR CASALE: Yeah. Any other final thoughts? All right.

* Closing Remarks

So, I want to thank everyone for participating today, our guest presenters, panelists, members of the public, and, of course, my PTAC colleagues. We explored many different facets of population-based total cost of care models.

Again, a special thanks to my colleagues on PTAC. A lot of information packed into the two days. Appreciate everyone's active participation and thoughtful comments.

We will continue to gather
information on our theme through a Request for Input. We're posting it on the ASPE PTAC website and sending it out through the PTAC listserv. You can offer your input on questions by April 15th.

* Adjourn

Now that we have a better handle on defining the relevant concepts and understanding the broad issues, the next step is studying implementation.

So, our June public meeting will focus on the best practices for care delivery, improving quality, and measuring the success of population-based total cost of care models. I certainly hope that everyone will join us then.

So, before we adjourn, I want to express my deep appreciation to the entire ASPE team and the NORC staff for all of their work in making these past two days of meetings so successful.

So, with that, the meeting is adjourned. Thank you.

(Whereupon, the above-entitled matter went off the record at 3:46 p.m.)
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